



MEDICARE COMPLIANCE FORM POST-PAP SET UP

TOLL FREE FAX: 866-799-0601
PHONE: 877-SLEEPHC or 877-753-3742
info@sleephealth.com – www.sleephealth.com

RE: Patient Name: _____ DOB: _____

Medicare requires documentation of the following information within 90 days of PAP initiation in order for them to continue paying for your patient's CPAP or Bi-level PAP treatment for obstructive sleep apnea. To comply with this new Medicare regulation, please select and complete **either** Option 1 **OR** Option 2 below.

Option 1 – Sleep HealthCenters Manages Medicare Compliance

I would like my patient to be evaluated by a Sleep HealthCenters' sleep specialist to monitor compliance and response to PAP therapy. Sleep HealthCenters will complete Medicare required documentation.

Option 2 – Physician Manages Medicare Compliance

I will comply with Medicare regulations by ensuring both of the following two criteria for Medicare have been met.

A. Documentation of Use of PAP Therapy. Over a 30 day period, your patient has used CPAP or Bi-level PAP for ≥ 4 hours/night _____ % of the time. Medicare requires 4+ hours/night of use $\geq 70\%$ of the nights in 30 consecutive days for continued coverage for PAP therapy.

Note: If this number is below 70%, please work closely with your patient in concert with our respiratory therapists to increase this number to $\geq 70\%$ before the end of the 90 day period.

B. Documentation of Symptomatic Improvement. Medicare also requires the documentation of benefit from PAP treatment of obstructive sleep apnea. There needs to be a face-to-face meeting between you and your patient documenting one of the following symptomatic improvements:

	<u>Improved</u>
Daytime sleepiness/fatigue	<input type="radio"/>
Observed apneas/choking/gasping during sleep	<input type="radio"/>
Morning headache	<input type="radio"/>
Other: _____	<input type="radio"/>

SIGNATURE AND DATE

Please add additional comments if desired, then sign AND date this form and fax back to 866-799-0601.

Physician Signature

Date

NEW MEDICARE PAP GUIDELINES

Coverage of a PAP device for the treatment of OSA is limited to claims where the diagnosis of OSA is based upon a Medicare-covered sleep test (Type I, II, III, IV). A Medicare-covered sleep test must be either a polysomnogram performed in a facility-based laboratory (Type I study) or a home sleep test (HST) (Types II, III, or IV.) The test must be ordered by the beneficiary's treating physician and conducted by an entity that qualifies as a Medicare provider of sleep tests and is in compliance with all applicable state regulatory requirements.

Follow-Up

Continued coverage of a PAP device (CPAP or BiPAP) beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating physician must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy. Documentation of clinical benefit is demonstrated by:

1. Face-to-face clinical re-evaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved; and,
2. Objective evidence of adherence to use of the PAP device, reviewed by the treating physician.

Adherence to therapy is defined as use of PAP \geq 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

If the above criteria are not met, continued coverage of a PAP device and related accessories will be denied as not medically necessary.

* Reference LCD for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L11528)