

## Longwood, FL Fax: 407-691-3021

**CPAP/BiPAP Detailed Written Order Prior to Delivery** 

Pati	ent Name:			Order Date				
Acc	count #:	Patient DOB:		Chart Notes Attached (Chart notes must include the need for the equipment being ordered)				
	Face Sheet/Demographics	Faxed			∟ (Baseline & tit	Sleep Study Faxed tration if not please attach)		
☐ I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. <b>Date of visit prior to order:</b>								
	AP (Covers Medical Necessity for			e/Obsolete Equipm	nent)			
DIA	GNOSIS (Check appropriate diag	nosis below)	Length of Nee	d in Months	(99 = Lifetime	)		
□ OSA □ Other:								
Additional Diagnosis Required if AHI is below 15/hr:								
	Excessive Daytime Sleepiness		l Cognition		☐ Mood Disorder			
	Hypertension							
□ Other:								
CPAP EQUIPMENT								
	CPAP w/Humidifier (E0601	l/E0562) Sett	ing: Cr	n H2O Ramp:	CFlex/ER	R:		
	Oxygen Bleed-In	LPM	O2 Sat % (	Qualifying Sat fro	om sleep study must be	within the last 3 days)		
BIPAP (Covers Medical Necessity for New, Repair/Replacement of Irreparable/Obsolete Equipment)								
<b>DIAGNOSIS</b> (Check appropriate diagnosis below)  Length of Need in Months (99 = Lifetime)								
	CSA	□ COPD			□ OSA			
	CompSA	☐ Other: _						
	i i i i i i i i i i i i i i i i i i i	☐ ABG pat	tient's CO2>52mmHg	on patient's norm	al FIO2 (no BiPAP).			
Necessity for BiPAP: Overnight Oximetry on patient's normal FIO2 (no BiPAP) <88% for <5 minutes								
1,00	cooling for Birth.	(test mus	t be for a two (2) hour p					
DID	OSA and treatment with CPAP have been considered and ruled out.							
	AP EQUIPMENT BiPAP w/ Humidifier (E0470/F	E0562) IPAP	EPAP	Ra	mp C Flex/EI	D D		
	BiPAP ST w/ Humidifier (E047)	-	EPAP			XX		
	BiPAP Auto SV w/ Humidifier			Backup Rate in/Max Pressure Support Min/Max				
Ш		Backup Rate						
	Oxygen Bleed-In LPM O2 Sat % (Qualifying Sat from sleep study must be within the last 3 days)							
Please check one mask option below: The following accessories are medically necessary. (Check appropriate accessories below)								
	se check one mask option below:	M O2 Sa :	t % (Qualify The following access	ories are medically	necessary. (Check approp	•		
	:	M O2 Sa :	t % (Qualify The following access		necessary. (Check approp	•		
	se check one mask option below:  Mask fit per patient's preferer  Full Face Mask (A7030) 1 ev	M O2 Sa : nce/tolerance very 3 mo.	t % (Qualify The following access	ories are medically ing (A4604) 1 eve	necessary. (Check approp	•		
	se check one mask option below:  Mask fit per patient's preferer  Full Face Mask (A7030) 1 ev  Mouth Cushion (A7029) 2 ev	M O2 Sa : nce/tolerance very 3 mo. very mo.	tt % (Qualify  The following accessor  □ Tubing w/Heati □ Tubing (A7037	ories are medically ing (A4604) 1 eve 1) 1 every 3 mo.	necessary. (Check appropry 3 mo. <b>OR</b>	•		
	se check one mask option below: Mask fit per patient's preferer Full Face Mask (A7030) 1 ev Mouth Cushion (A7029) 2 ev Full Face Cushion (A7031) 1	M O2 Sa : nce/tolerance very 3 mo. very mo. per mo.	**Moderate	ories are medically ing (A4604) 1 eve 1) 1 every 3 mo.	necessary. (Check appropry 3 mo. <b>OR</b>	•		
	se check one mask option below: Mask fit per patient's preferer Full Face Mask (A7030) 1 ev Mouth Cushion (A7029) 2 ev Full Face Cushion (A7031) 1 Nasal Mask (A7034) 1 every	M O2 Sa : nce/tolerance very 3 mo. very mo. per mo. 3 mo.	The following accessor  Tubing w/Heati  Tubing (A7037  Check all appropria	ories are medically ing (A4604) 1 even 1 1 every 3 mo.	necessary. (Check appropry 3 mo. <b>OR</b>	•		
	Mask fit per patient's preferer Full Face Mask (A7030) 1 ev Mouth Cushion (A7029) 2 ev Full Face Cushion (A7031) 1 Nasal Mask (A7034) 1 every Nasal Cushions (A7032) 5 ev	M O2 Sa : nce/tolerance very 3 mo. very mo. per mo. 3 mo. very 3 mo.	tt % (Qualify  The following access  Tubing w/Heati  Tubing (A7037  Check all appropria	ories are medically ing (A4604) 1 even 1 every 3 mo.  ate accessories beautiful accessor	necessary. (Check appropry 3 mo. OR	•		
	se check one mask option below: Mask fit per patient's preferer Full Face Mask (A7030) 1 ev Mouth Cushion (A7029) 2 ev Full Face Cushion (A7031) 1 Nasal Mask (A7034) 1 every Nasal Cushions (A7032) 5 ev Pillows (A7033) 5 every 3 me	M O2 Sa : nce/tolerance very 3 mo. very mo. per mo. 3 mo. very 3 mo. very 3 mo.	te % (Qualify  The following accessor  Tubing w/Heati  Tubing (A7037  Check all appropria  Headgear (A70  Chin Strap (A7	ories are medically ing (A4604) 1 every 3 mo.  In the accessories beautiful accessories	necessary. (Check appropry 3 mo. OR	•		
	se check one mask option below: Mask fit per patient's preferer Full Face Mask (A7030) 1 ev Mouth Cushion (A7029) 2 ev Full Face Cushion (A7031) 1 Nasal Mask (A7034) 1 every Nasal Cushions (A7032) 5 ev Pillows (A7033) 5 every 3 me Oral/Nasal Mask (A7027) 1 every	M O2 Sa : nce/tolerance very 3 mo. very mo. per mo. 3 mo. very 3 mo. very 3 mo. every 3 mo. every 3 mo.	te	ories are medically ing (A4604) 1 every 3 mo.  ate accessories beauties are described in the control of the con	necessary. (Check appropry 3 mo. OR  low:	•		
	Mask fit per patient's preferer Full Face Mask (A7030) 1 ev Mouth Cushion (A7029) 2 ev Full Face Cushion (A7031) 1 Nasal Mask (A7034) 1 every Nasal Cushions (A7032) 5 ev Pillows (A7033) 5 every 3 mc Oral/Nasal Mask (A7027) 1 e Oral Cushion (A7028) 2 ever	M O2 Sa : nce/tolerance very 3 mo. very mo. per mo. 3 mo. very 3 mo. o. every 3 mo. every 3 mo.	tt % (Qualify The following access Tubing w/Heati Tubing (A7037  Check all approprio Headgear (A70 Chin Strap (A7) Fine Filter (A70 Foam Filters (A	ories are medically ing (A4604) 1 every 3 mo.  The accessories beauties are accessories beauties are accessories beauties are accessories beauties are accessories are accessories beauties are accessories accessories are accessories accessories are accessories a	necessary. (Check appropry 3 mo. OR  low:	•		
	se check one mask option below: Mask fit per patient's preferer Full Face Mask (A7030) 1 ev Mouth Cushion (A7029) 2 ev Full Face Cushion (A7031) 1 Nasal Mask (A7034) 1 every Nasal Cushions (A7032) 5 ev Pillows (A7033) 5 every 3 me Oral/Nasal Mask (A7027) 1 every	M O2 Sa : nce/tolerance very 3 mo. very mo. per mo. 3 mo. very 3 mo. o. every 3 mo. every 3 mo.	tt % (Qualify The following access Tubing w/Heati Tubing (A7037  Check all approprio Headgear (A70 Chin Strap (A7) Fine Filter (A70 Foam Filters (A	ories are medically ing (A4604) 1 every 3 mo.  ate accessories beauties are described in the control of the con	necessary. (Check appropry 3 mo. OR  low:	•		
□ □ □ Pres	Mask fit per patient's preferer Full Face Mask (A7030) 1 ev Mouth Cushion (A7029) 2 ev Full Face Cushion (A7031) 1 Nasal Mask (A7034) 1 every Nasal Cushions (A7032) 5 ev Pillows (A7033) 5 every 3 mc Oral/Nasal Mask (A7027) 1 e Oral Cushion (A7028) 2 ever Oral Interface (A7044) 1 per	M O2 Sa : nce/tolerance very 3 mo. very mo. per mo. 3 mo. very 3 mo. o. every 3 mo. every 3 mo.	tt % (Qualify The following access Tubing w/Heati Tubing (A7037  Check all approprio Headgear (A70 Chin Strap (A7) Fine Filter (A70 Foam Filters (A	ories are medically ing (A4604) 1 every 3 mo.  In every 3 mo.  In every 3 mo.  In every 6 mo.	necessary. (Check appropry 3 mo. OR  low:	•		
□ □ Pres Nan	Mask fit per patient's preferer Full Face Mask (A7030) 1 ev Mouth Cushion (A7029) 2 ev Full Face Cushion (A7031) 1 Nasal Mask (A7034) 1 every Nasal Cushions (A7032) 5 ev Pillows (A7033) 5 every 3 mc Oral/Nasal Mask (A7027) 1 e Oral Cushion (A7028) 2 ever Oral Interface (A7044) 1 per cribing Physician's Information ne & Credentials	M O2 Sa : nce/tolerance very 3 mo. very mo. per mo. 3 mo. very 3 mo. o. every 3 mo. every 3 mo.	tt % (Qualify The following access Tubing w/Heati Tubing (A7037  Check all approprio Headgear (A70 Chin Strap (A7) Fine Filter (A70 Foam Filters (A	ories are medically ing (A4604) 1 every 3 mo.  It expression at expression accessories beauties accessories accessories beauties accessories access	necessary. (Check appropry 3 mo. OR  low:	•		
□ □ □ Press Nam Tele	Mask fit per patient's preferer Full Face Mask (A7030) 1 ev Mouth Cushion (A7029) 2 ev Full Face Cushion (A7031) 1 Nasal Mask (A7034) 1 every Nasal Cushions (A7032) 5 ev Pillows (A7033) 5 every 3 mc Oral/Nasal Mask (A7027) 1 e Oral Cushion (A7028) 2 ever Oral Interface (A7044) 1 per	M O2 Sa : nce/tolerance very 3 mo. very mo. per mo. 3 mo. very 3 mo. o. every 3 mo. every 3 mo.	tt % (Qualify The following access Tubing w/Heati Tubing (A7037  Check all approprio Headgear (A70 Chin Strap (A7) Fine Filter (A70 Foam Filters (A	ories are medically ing (A4604) 1 every 3 mo.  In every 3 mo.  In every 3 mo.  In every 6 mo.	necessary. (Check appropry 3 mo. OR  low:  no. 6 mo.	•		

If filled out completely, this form serves as the Detailed Written Order (DWO) and proof that patient was seen by the physician within 6 months prior to the date of order. This must be received by supplier before equipment is dispensed.

## **History:**

Signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches.

- Duration of symptoms
- Epworth Sleepiness Scale

## **Physical Exam:**

- Focused cardiopulmonary and upper airway system evaluation
- Neck circumference
- Body mass index

The sleep study must be performed after the initial office visit examination and prior to delivery. The sleep study must be interpreted by a physician who holds either:

- ABSM; or, ABMS; or, Completed residency or fellowship training by an ABMS; or,
- Active staff membership of a sleep center or laboratory accredited by AASM, ACHC or TJC, formerly the Joint Commission JCAHO.

## **Continued Coverage Beyond the First Three Months:**

- The re-evaluation must be performed between the 31st and 91st day after initiating therapy.
- The physician is to document the improvement of the symptoms of the OSA. There must be documentation of adherence to the PAP therapy.

The adherence to the therapy is accomplished through direct download or visual inspection of usage data reviewed and documented by the physician. The beneficiary must be using the PAP device =>4 hours per night 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of use.

Beneficiaries that fail the three month trial period are eligible to re-qualify with:

A clinical re-evaluation by the treating physician to determine the reason for failure to respond to PAP therapy; Repeat sleep test in a facility based setting. This may be a repeat diagnostic, titration, or split-night study.

If a CPAP device is tried and found ineffective during the initial 3 month home trial, substitution of a BiPAP does not require a new initial face to face exam or a new sleep study. If a CPAP Device has been used for more than 3 months and the patient is switched to a BiPAP:

- 1. A new initial face to face exam is required.
- 2. A new sleep study is not required.
- 3. A new 3 month trial would begin for the use of the Bipap.

Beneficiaries changing from CPAP to BiPAP, we must have more documentation other than "CPAP tried and failed" written on the RX.

- The beneficiary tried but was unsuccessful using the CPAP.
- Multiple interface options have been tried and the current one is the most comfortable.
- The exhalation with the current pressure of the CPAP is preventing the beneficiary from tolerating the therapy.
- Lower pressure settings of the CPAP have failed to control the OSA or reduce the AHI/RDI to acceptable levels.

Medicare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary. The chart note from the office visit exam must be signed and dated by the author of the note. If completed by a PA, NP, or CNS, the physician (MD, DO or DPM) must cosign and date the note.

MICHIGAN LOCATONS
CENTER LINE
Corporate & Retail Location
26834 Lawrence
Center Line, MI 48015
586-755-2300
888-BINSONS
Fax: 586-755-2322

ANN ARBOR 814 Phoenix Dr DEARBORN 5250 Auto Club Dr EASTPOINTE 21571 Kelly Rd FARMINGTON HILLS Tri-Atria Building 32255 Northwestern Hwy FLINT G-4433 Miller Rd LIVONIA 13450 Farmington Rd LIVONIA
St. Mary Mercy Hospital
36475 5 Mile Rd
ROYAL OAK
30475 Woodward Ave
STERLING HEIGHTS
43900 Schoenherr Rd

SOUTHGATE
18800 Eureka Rd
TROY
6475 Rochester Rd
FLORIDA LOCATION
LONGWOOD
830 S. Ronald Reagan Blvd
866-928-0003