BECN 15279009638

BINSON'S Medical Equipment & Supplies Since 1953

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Reset Form

CPAP/BiPAP Detailed Written Order Prior to Delivery

Patient Name: _____ Order Date _____

Account #: _____ Patient DOB: _____

☐ ***Chart Notes Attached***
(Chart notes must include the need for the equipment being ordered)

☐ ***Face Sheet/Demographics Faxed***

☐ ***Sleep Study Faxed***
(Baseline & titration 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. **Date of visit prior to order:**

CPAP (Covers Medical Necessity for New, Repair/Replacement of Irreparable/Obsolete Equipment)

DIAGNOSIS (Check appropriate diagnosis below) Length of Need in Months _____ (99 = Lifetime)

☐	OSA	☐	Other: _____		
Additional Diagnosis Required if AHI is below 15/hr:					
☐	Excessive Daytime Sleepiness	☐	Impaired Cognition	☐	Mood Disorder
☐	Hypertension	☐	Ischemic Heart Disease	☐	Stroke
☐	Other: _____				

CPAP EQUIPMENT

☐ **CPAP w/Humidifier (E0601/E0562)** **Setting:** _____ **Cm H2O Ramp:** _____ **CFlex/ERR:** _____

☐ **Oxygen Bleed-In** _____ **LPM** ☐ **O2 Sat** _____ **%** (Qualifying Sat from sleep study must be within the last 30 days)

BIPAP (Covers Medical Necessity for New, Repair/Replacement of Irreparable/Obsolete Equipment)

DIAGNOSIS (Check appropriate diagnosis below) Length of Need in Months _____ (99 = Lifetime)

☐	CSA	☐	COPD	☐	OSA
☐	CompSA	☐	Other: _____		
Necessity for BiPAP:		☐	ABG patient's CO2≥52mmHg on patient's normal FIO2 (no BiPAP).		
		☐	Overnight Oximetry on patient's normal FIO2 (no BiPAP) <88% for <5 minutes **(test must be for a two (2) hour period).**		
		☐	OSA and treatment with CPAP have been considered and ruled out.		

BIPAP EQUIPMENT

☐ **BiPAP w/ Humidifier (E0470/E0562)** **IPAP** _____ **EPAP** _____ **Ramp** _____ **C Flex/ERR** _____

☐ **BiPAP ST w/ Humidifier (E0471/E0562)** **IPAP** _____ **EPAP** _____ **Backup Rate** _____

☐ **BiPAP Auto SV w/ Humidifier (E0471)** **IPAP Max** _____ **EPAP Min/Max** _____ **Pressure Support Min/Max** _____ **Backup Rate** _____

☐ **Oxygen Bleed-In** _____ **LPM** ☐ **O2 Sat** _____ **%** (Qualifying Sat from sleep study must be within the last 3 days)

The following accessories are medically necessary. *(Cross off equipment/supplies not ordered)*

☒	Mask fit per patient's preference/tolerance		
☒	Nasal Mask (A7034) and/or Full Face Mask (A7030) 1 every 3 mo. Type:		
☒	Nasal Cushions (A7032) or Pillows (A7033) 5 every 3 mo.	☒	Foam Filters (A7039) 1 every 6 mo.
☒	Full Face Cushion (A7031) 1 per mo.	☒	Fine Filter (A7038) 6 every 3 mo.
☒	Tubing (A7037) 1 every 3 mo.	☒	Oral/Nasal Mask (A7027) 1 every 3 mo.
☒	Tubing w/Heating (A4604) 1 every 3 mo.	☒	Oral Cushion (A7028) 2 every mo.
☒	Water Chamber (A7046) 1 every 6 mo.	☒	Nasal Cushion (A7029) 2 every mo.
☒	Headgear (A7035) 1 every 6 mo.	☒	Oral Interface (A7044) 1 per mo.
☒	Chin Strap (A7036) 1 every 6 mo.		

Prescribing Physician's Information

Name & Credentials _____ NPI # _____

Telephone _____ Fax _____

Signature _____ Signature Date _____
(Stamped signature not accepted)

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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.

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