



Boston University Medical Campus



# MEDICARE COMPLIANCE FORM PRE-SLEEP STUDY

TOLL FREE FAX: 866-799-0601

PHONE: 877-SLEEPHC or 877-753-3742

info@sleephealth.com – www.bumc.bu.edu/sleepmed

RE: Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medicare now **requires** a **face-to-face sleep evaluation prior to a patient's sleep study** in order to provide 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 – BU Physician Manages Medicare Compliance

If you select this option, please **DO NOT** complete the information in Option 2. We will schedule our mutual patient for a consult with one of our Sleep Specialists, who will determine if a sleep study is needed based on consult results. Please sign and return form.

- I would like my patient to be evaluated by a BU Medical Group sleep specialist for the possibility of obstructive sleep apnea with the appropriate sleep study to follow. BU Medical Group will complete Medicare required documentation.

## OPTION 2 – Physician Manages Medicare Compliance

If you select this option, please **DO NOT** check the box in Option 1. We will schedule our mutual patient for a sleep study. Please sign and return form.

- I will comply with Medicare regulations by completing the rest of this form.
  - A. Sleep Evaluation. Which of the following symptoms were noted on the patient's sleep history?
 

<input type="radio"/> Snoring	<input type="radio"/> Choking / gasping during sleep
<input type="radio"/> Daytime sleepiness	<input type="radio"/> Morning headaches
<input type="radio"/> Observed apneas	<input type="radio"/> Other: _____
  - B. Focused Physical Examination (include as much information as possible).
 

Body Mass Index \_\_\_\_\_ (or height \_\_\_\_\_ and weight \_\_\_\_\_ )

Neck Circumference \_\_\_\_\_ inches (or \_\_\_\_\_ cm)

Upper Airway Evaluation \_\_\_\_\_

Cardiopulmonary Evaluation \_\_\_\_\_
  - C. Epworth Sleepiness Scale (the Epworth scale is provided on page 2).
 

The result of the Epworth Sleepiness Scale is \_\_\_\_\_ out of a total possible score of 24.

### SIGNATURE AND DATE

Please sign AND date this form and fax back to 866-799-0601.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

**NOTE:** To comply with Medicare regulations, a follow-up form will be sent within the next 90 days in order to monitor compliance of your patient's PAP Therapy.



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## EPWORTH SLEEPINESS SCALE

In the last 30 days, how likely are you to doze off or fall asleep in the following situations (in contrast to feeling just tired)?

<i>Please check only one box per row.</i>	High Chance of Dozing	Moderate Chance of Dozing	Slight Chance of Dozing	Would Never Doze
1. Sitting and reading				
2. Watching TV				
3. Sitting inactive in a public place (e.g. theater, meeting)				
4. As a passenger in a car for an hour without a break				
5. Lying down to rest in the afternoon				
6. Sitting and talking to someone				
7. Sitting quietly after lunch (when you've had no alcohol)				
8. In a car while stopped for a few minutes in traffic				
<b>TOTAL SCORE</b>				

Scoring Key:

High Chance of Dozing = 3 points

Moderate Chance of Dozing = 2 points

Slight Chance of Dozing = 1 point

Would Never Doze = 0 points



## **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.

### **Initial Consultation**

Physicians shall document the face-to-face clinical evaluations and re-evaluations in a detailed narrative note in their charts in the format that they use for other entries. For the initial evaluation, the report would commonly document pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

#### History

- Signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches
- Duration of symptoms
- Validated sleep hygiene inventory such as the Epworth Sleepiness Scale

#### Physical Exam

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

### **Follow-Up**

Continued coverage of a PAP device (CPAP or Bi-level PAP) 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  $\geq$  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)*