APRIA®

Sleep Therapy Order Form

Fax completed form to: _____

Apria Representative _____ **Branch Location** _____ **Phone** _____

REFERRAL SOURCE

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PLEASE SEND PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION, ALONG WITH A SIGNED AND DATED COPY OF THE FACE-TO-FACE EVALUATION AND/OR TEST RESULTS FROM THE PATIENT'S CHART

PATIENT INFORMATION

Patient name _____ DOB _____
Last First

Address _____ MBI/INS ID # _____

Home phone _____ Mobile phone _____ Email _____

Diagnosis ICD-10: Each diagnosis requires a corresponding ICD-10 code and must be corroborated in the patient's medical record. Please enter the appropriate qualifying diagnoses and corresponding ICD-10 codes. (Note: ranges are not acceptable.)

☐ G47.33 Obstructive Sleep Apnea (OSA) (Adult and Child) ☐ Other _____

☐ Secondary condition (if AHI/RDI is 5–14) _____

Estimated length of need _____ months (99 = lifetime) ☐ E1390 Oxygen; bleed in at _____ LPM

THERAPY ORDERED

STEP 1 Select ONLY one:

☐ E0601 CPAP **IPAP and EPAP RANGE: 4–25 cmH_2O; EPAP must be lower than IPAP*

- ☐ Setting _____ cmH_2O (4–20 cmH_2O) Ramp time _____ min(s) (OFF–45 min) ***OR*** ☐ Check box to adjust to ramp comfort
- ☐ Auto Adjusting CPAP with settings of 4–20 cmH_2O with comfort settings ☐ AutoSet for Her mode
- ☐ Auto Adjusting CPAP with settings of _____ cmH_2O to _____ cmH_2O with comfort settings (4–20 cmH_2O) ☐ AutoSet for Her mode

☐ E0470 Bi-level

- ☐ Setting: IPAP _____ cmH_2O (4–25 cmH_2O*) EPAP _____ cmH_2O (4–25 cmH_2O*)
- ☐ Auto Adjusting Bi-level Max IPAP 25 cmH_2O Min EPAP 4 cmH_2O PS 4 cmH_2O
- ☐ Auto Adjusting Bi-level Max IPAP _____ cmH_2O Min EPAP _____ cmH_2O* PS _____ (0–10 cmH_2O)

Alternate PS setting: PS Min _____ (0–8 cmH_2O) PS Max _____ (0–8 cmH_2O)

STEP 2 STANDARD E0562 Heated humidifier ***OR*** ☐ E0561 Non-heated humidifier (select if heated humidification is not desired)

STEP 3 ☐ Overnight oximetry testing to be performed on [CPAP/Bi-level] @ _____ cmH_2O [without o2 / with O2 @ _____ LPM] to be scheduled on or about 30 days following set up.**

**For most payers, overnight oximetry testing cannot be used to qualify oxygen with patients on a CPAP or Bi-level, and will require testing during a facility-based sleep study.

SUPPLIES ORDERED

STEP 4

STANDARD A4604 Tubing w/heating element (1x3 mo)

OR ☐ A7037 Tubing (1x3 mo)
(select only if heated tubing or heated humidifier is not desired)

STEP 5

Check ALL that apply:

☐ A7035 Headgear (1x6 mo)
☐ A7036 Chinstrap (1x6 mo)
☐ A7038 Disposable filters (2x1 mo)
☐ A7039 Non-disposable filters (1x6 mo)
☐ A7046 Humidifier water chamber — replacement (1x6 mo)
☐ A7045 Exhalation port — replacement

STEP 6

Check ONLY those that apply:

☐ **FULL FACE MASK STYLE**
- A7030 Full face mask (1x3 mo)
- A7031 Full face mask cushion — replacement (1x1 mo)

☐ **NASAL MASK STYLE**
- A7034 Nasal interface — mask or cannula (pillow type) (1x3 mo)
- A7032 Nasal mask cushion — replacement (2x1 mo)
- A7028 Oral cushion for combo oral/nasal mask — replacement (2x1 mo)

☐ **NASAL PILLOWS MASK STYLE**
- A7034 Nasal pillows interface — mask or cannula (pillow type) (1x3 mo)
- A7033 Nasal mask pillows cushion — replacement (2x1 mo)
- A7029 Nasal pillows for combo oral/nasal mask — replacement (2x1 mo)

☐ **SPECIFIC MASK NAME:** _____

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Prescriber's name _____ **Prescriber email** _____

Prescriber's address _____

Prescriber's signature _____ **Date** _____ **NPI #** _____

CPAP ReFresh – Streamline Your Recertification Process

CPAP MACHINE REPLACEMENT CHECKLIST

1 . Patient Evaluation

- ☐ Conduct a face-to-face evaluation with the patient.
- ☐ Document that the patient continues to use and benefit from CPAP therapy.

2 . Medical Necessity

- ☐ Reaffirm the medical necessity of the CPAP machine.
- ☐ Ensure the patient's condition still requires CPAP therapy.

3 . Prescription

- ☐ Write a new prescription for the CPAP machine.
- ☐ Include specific details about the type of machine and any additional features needed.

4. Insurance Documentation

- ☐ Verify the patient's insurance coverage for a new CPAP machine.
- ☐ Provide necessary documentation to the insurance company, including the face-to-face evaluation and prescription.

5. Equipment Condition

- ☐ Assess the current CPAP machine for irreparable wear and tear.
- ☐ Document any issues with the machine that justify the need for replacement.

6. Patient Education

- ☐ Inform the patient about the process of getting a new machine.
- ☐ Discuss any new features or improvements in the latest CPAP machines.

7. Supplier Coordination

- ☐ Coordinate with Apria to order the new CPAP machine.
- ☐ Ensure the Apria has all necessary documentation and prescription details.

8. Follow-Up

- ☐ Schedule a follow-up appointment to ensure the patient is adjusting well to the new machine.
- ☐ Address any issues or concerns the patient may have with the new equipment.

Medicare CPAP Qualifications (E0601)

Patient must meet all the following criteria to qualify for an E0601 device (CPAP).

- Patient has had a face-to-face clinical evaluation by the treating prescriber prior to the sleep test being performed.
- Patient has had a sleep test that meets either of the following criteria:
  a. AHI/RDI* is ≥ 15 events per hour with a minimum of 30 events; **or**
  b. AHI/RDI* is ≥ 5 and ≤ 14 events per hour with a minimum of 10 events and documentation of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease or history of stroke.
- Obstructive Sleep Apnea (OSA) (ICD-10 code G47.33).
- Patient and/or caregiver has received instruction from the supplier in the proper use and care of the equipment and accessories from the supplier of the CPAP device.

****The apnea-hypopnea index (AHI)** is defined as the average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device. For purposes of this policy, respiratory effort related arousals (RERAs) are not included in the calculation of the AHI.*

***The respiratory disturbance index (RDI)** is defined as the average number of apneas plus hypopneas per hour of recording without the use of a positive airway pressure device. For purposes of this policy, respiratory effort related arousals (RERAs) are not included in the calculation of the RDI.*

***Hypopnea** is defined as an abnormal respiratory event lasting at least 10 seconds associated with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation.*

Documentation for Continued Coverage (beyond months 1 – 13)

- Between the 31st and 91st day, the treating physician must conduct a face-to-face clinical re-evaluation with the patient documenting improvement in subjective symptoms of OSA.
- Adherence to therapy demonstrating use of PAP 4 hours per night on 70% of the nights during a consecutive 30-day period anytime during the first 3 months of initial usage.

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