



CPAP/BiPAP Detailed Written Order Prior to Delivery

Patient Name: Account #: Patient DOB: <input type="checkbox"/> Face Sheet/Demographics Faxed	Order Date <input type="checkbox"/> Chart Notes Attached (Chart notes must include the need for the equipment being ordered) <input type="checkbox"/> Sleep Study Faxed (Baseline & titration if not please attach)
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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:

<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Impaired Cognition	<input type="checkbox"/> Mood Disorder
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Ischemic Heart Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Other: _____		

CPAP EQUIPMENT

<input type="checkbox"/> CPAP w/Humidifier (E0601/E0562)	Setting:	Cm H2O Ramp:	CFlex/ERR:
<input type="checkbox"/> Oxygen Bleed-In	LPM	O2 Sat	% (Qualifying Sat from sleep study must be within the last 3 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:

<input type="checkbox"/>	ABG patient's CO ₂ ≥ 52mmHg on patient's normal FIO ₂ (no BiPAP) AND...
<input type="checkbox"/>	Overnight Oximetry on patient's normal FIO ₂ (no BiPAP) < 88% for < 5 minutes (test must be for a two (2) hour period) AND...
<input type="checkbox"/>	OSA and treatment with CPAP have been considered and ruled out.

BIPAP EQUIPMENT

<input type="checkbox"/> BiPAP w/ Humidifier (E0470/E0562)	IPAP	EPAP	Ramp	C Flex/ERR
<input type="checkbox"/> BiPAP ST w/ Humidifier (E0471/E0562)	IPAP	EPAP	Backup Rate	
<input type="checkbox"/> BiPAP Auto SV w/ Humidifier (E0471)	IPAP Max	EPAP Min/Max	Pressure Support Min/Max	
<input type="checkbox"/>	Backup Rate			
<input type="checkbox"/> 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)**

<input type="checkbox"/> Mask fit per patient's preference/tolerance	<input type="checkbox"/> Tubing w/Heating (A4604) 1 every 3 mo. OR
<input type="checkbox"/> Full Face Mask (A7030) 1 every 3 mo.	<input type="checkbox"/> Tubing (A7037) 1 every 3 mo.

Mouth Cushion (A7029) 2 every mo.
 Full Face Cushion (A7031) 1 per mo.

Check all appropriate accessories below:

<input type="checkbox"/> Nasal Mask (A7034) 1 every 3 mo.	<input type="checkbox"/> Headgear (A7035) 1 every 6 mo.
<input type="checkbox"/> Nasal Cushions (A7032) 5 every 3 mo.	<input type="checkbox"/> Chin Strap (A7036) 1 every 6 mo.
<input type="checkbox"/> Pillows (A7033) 5 every 3 mo.	<input type="checkbox"/> Fine Filter (A7038) 6 every 3 mo.
<input type="checkbox"/> Oral/Nasal Mask (A7027) 1 every 3 mo.	<input type="checkbox"/> Foam Filters (A7039) 1 every 6 mo.
<input type="checkbox"/> Oral Cushion (A7028) 2 every mo.	<input type="checkbox"/> Water Chamber (A7046) 1 every 6 mo.
<input type="checkbox"/> Oral Interface (A7044) 1 per mo.	

Prescribing Physician's Information

Name & Credentials	NPI #
Telephone	Fax
Signature	Signature Date

(Stamped signature not accepted)

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 LOCATIONS

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
