Use of this template is voluntary / optional

Home Oxygen Therapy

F2F Encounter Template Guidance

Purpose

This template is designed to assist a clinician in documenting the Face-to-Face (F2F) encounter for Medicare home oxygen therapy eligibility and coverage. A F2F encounter, as required by Medicare, must be completed within a six-month timeframe prior to completion of the Detailed Written Order (DWO) or Written Order Prior to Delivery (WOPD). This template is available to the clinician and can be kept on file with the patient’s medical record or can be used to develop the progress note template for use with the system containing the patient’s electronic medical record.

Patient eligibility

Eligibility for coverage of home oxygen therapy under Medicare requires the ordering physician or allowed Non-Physician Practitioner (NPP)\(^1\) to complete a Certificate of Medical Necessity (CMN), OBM Form CMS-484, to establish that coverage criteria are met. This helps to ensure the oxygen equipment and services to be provided are consistent with the physician’s prescription and supported in the patient’s medical record.

The physician or an allowed NPP must certify (attest) that the patient meets all the following criteria:

1. The patient has a diagnosis of a severe lung disease or symptoms and signs of hypoxia;
2. The patient’s home oxygen therapy laboratory test results meet criteria for eligibility and coverage in accordance with the requirements of the National Coverage Determination (NCD) for Home Use of Oxygen – 240.2;
3. The qualifying home oxygen therapy laboratory testing was performed by a physician or allowed provider / supplier of oxygen laboratory services;
4. Alternative treatment measures have been tried or considered and deemed clinically ineffective;
5. The patient’s condition is stable;
6. The patient had a F2F encounter:
   a. Within 30 days prior to completing the initial certification or
   b. Within 90 days prior to recertification; and
   c. Provides information in the medical documentation substantiating the patient has a diagnosis or condition that was evaluated and/or treated, supporting the need for home oxygen therapy.

Completing the “Home Oxygen Therapy F2F Encounter Template” does not guarantee eligibility and coverage but does provide guidance in support of home oxygen therapy equipment and services ordered and billed to Medicare. This template may be used with the “Home Oxygen Therapy Laboratory Test Results Template” and “Home Oxygen Therapy Order Template”.

\(^1\) A Medicare allowed NPP as defined is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861 (aa) (5) of the Social Security Act) who is working in accordance with State law.
Basis for Certification of Home Oxygen Therapy?

The patient’s medical record must contain sufficient documentation of the patient’s medical condition substantiating the need for home oxygen therapy. Pertinent information should include, but is not limited to, the following:

- Diagnosis of a severe lung disease or symptoms and signs of hypoxia;
- Duration of the patient’s condition;
- Clinical course;
- Prognosis;
- Nature and extent of relevant functional limitations;
- Other therapeutic interventions and results of those interventions;
- Past pertinent medical / surgical history or experience; and
- Blood gas results or O2 Saturation results.

Oxygen testing timing requirements

For arterial blood gas measurement or oximetry – O2 saturation

- Initial Certification Testing
  - Within 2 days prior to dismissal from an acute inpatient hospitalization when ordering home oxygen therapy for a patient who is transitioning to a different level of care
  - Within 30 days prior to the start of home oxygen therapy.

- Retesting for recertification
  - Group I – Oxygen Concentrators / Portable Oxygen Systems
    - Within or by the end of the first 12 months from the start of home oxygen therapy
  - Group II – Oxygen Concentrators / Portable Oxygen Systems
    - Between the 61st and 90th day from the start of home oxygen therapy

Who can complete the Home Oxygen Therapy F2F Encounter Template?

Physician or an allowed NPP who performs a F2F encounter of the patient (within six months prior to completion of a DWO for home oxygen therapy) and certifies (completes the CMN) the patient’s eligibility and need for home oxygen therapy.

Note: If the order template is used:

1) CDEs in black Calibri are required
2) CDEs in burnt orange Italics Calibri are required if the condition is met
3) CDEs in blue Times New Roman are recommended but not required
Use of this template is voluntary / optional

**Home Oxygen Therapy Face-to-Face Encounter Template**

<table>
<thead>
<tr>
<th>Patient information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name: __________ First name: __________ MI: ______</td>
</tr>
<tr>
<td>DOB (MM/DD/YYYY): ______ Gender: ___M ___F ___Other  Medicare ID: __________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider (physician/NPP) who performed the face-to-face evaluation if different than signing provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name: __________ First name: __________ MI: ______ Suffix: ______</td>
</tr>
<tr>
<td>NPI: __________ Date of face-to-face evaluation (MM/DD/YYYY): __________</td>
</tr>
</tbody>
</table>

Is this a face-to-face encounter for oxygen therapy?  ___Yes ___No

*If No, purpose of the encounter:*

Is this encounter an inpatient hospital stay?  ___Yes ___No

Is patient currently mobile in their home?  ___Yes ___No

*If No and portable O2 is required, describe:*

Was blood gas study ordered and evaluated?  ___Yes ___No (required for certification)

*If Yes, date of testing (MM/DD/YYYY): __________*

Is patient in a chronic stable state?  ___Yes ___No

*Describe:*

Is there an expectation that home oxygen therapy will improve O2 Saturation?  ___Yes ___No

*Describe:*

Does patient live or travel to an area at high elevation?  ___Yes ___No

*If Yes, describe if relevant:*

Does patient have a reduced O2 carrying capacity?  ___Yes ___No

*If Yes, describe:*

**Primary diagnosis (to support need for home oxygen):**

- End Stage / Severe Lung Disease
  - COPD
  - Diffuse interstitial lung disease
  - Cystic fibrosis
  - Bronchiectasis
  - Widespread pulmonary neoplasm
  - Other pulmonary/lung diseases

- Hypoxemia (expected to improve with oxygen therapy) and supporting evidence
  - Pulmonary hypertension / Cor Pulmonale
  - Pulmonary arterial Pressure (PaP): Result: _______mmHg
  - Recurring heart failure secondary to chronic Cor Pulmonale
  - Edema
  - Pulmonary Rales
  - Fluid on CXR
  - Gated blood pool scan
  - “p” Pulmonale on ECG
  - Echocardiogram

*Continued on next page*
Erythrocythemia

Erythrocytosis
Hematocrit/hemoglobin result (Hct/Hgb):

Cognitive impairment

Mental status exam

Nocturnal restlessness, morning headache, and/or daytime somnolence

Nocturnal oximetry
Sleep Study

Exertional hypoxia / desaturation

O₂ test
“6” minute walk (optional)

Clinical trials

Long-term O₂ therapy
Cluster headache

Other

Chief complaint / history of present illness and associated signs / symptoms:

Related past medical / surgical history:

Allergies / immunizations:

Current medications:

Review of systems (Significant as per history of present problem and home oxygen need):

General:

weight gain, weight loss, sleeping problems, fatigue, fever,
chills, night sweats / diaphoresis
other:

Neck:

lumps, pain on movement
other:

Pulmonary:
cough, shortness of breath, pain, wheezing, hemoptysis,
sputum production
other:

Cardiac:

chest pain, palpitations, orthopnea, murmur, syncope
other:

Vascular:
edema, claudication, varicose veins, thrombophlebitis, ulcers
other:

Gastrointestinal:

swallowing problems, abdominal pain, constipation, diarrhea,
incontinence, nausea, vomiting, ulcers, melena, rectal bleeding,
jaundice, heartburn, hematemes
other:
### Musculoskeletal
- pain
- swelling
- stiffness
- limitation of range of motion
- arthritis
- gout
- cramps
- myalgia
- fasciculation
- atrophy
- fracture
- deformity
- weakness
- other:

### Neurologic
- seizures
- poor memory
- poor concentration
- numbness / tingling
- pins and needles sensation
- hyperpathia
- dysesthesia
- weakness
- paralysis
- tremors
- involuntary movements
- unstable gait
- fall
- vertigo
- headache
- stroke
- speech disorders
- other:

### Psychiatric
- hallucinations
- delusions
- anxiety
- nervous breakdown
- mood changes
- other:

### Hematology
- anemia
- bruising
- bleeding disorders (conditional)
- other:

### Endocrine
- heat or cold intolerance
- diabetes
- lipid disorders
- goiter
- other:

### Other:
- 
- 

### Physical examination:

<table>
<thead>
<tr>
<th>Vital signs:</th>
<th>T=______</th>
<th>P=______</th>
<th>R=______</th>
<th>BP=______</th>
<th>Height=______</th>
<th>Weight=______</th>
<th>O2 Sat=______ (RA at Rest)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>General appearance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and neck:</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Chest / lungs:</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Cardiovascular:</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Abdominal:</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Musculoskeletal / extremities:</td>
</tr>
<tr>
<td>--------------</td>
</tr>
</tbody>
</table>
Have treatments for respiratory-related symptoms been tried in the past? Yes No

**If Yes:** Indicate the treatments that have been tried:

- **Bronchodilators:** Short-Acting Long-Acting
- **Steroids:** IV PO Inhaled
- **Ventilation:** Non-Invasive Invasive
- **Anti-Inflammatory:** Cromolyn Sodium Interleukin(IL)-10 Interferon-gamma Specific PDE4-inhibitors (cilomilast and roflumilast)
- **Other:** Antibiotics Surfactin PAP/CPAP Pulmonary Rehabilitation

Indicate effectiveness for the above treatments:

- No improvement Limited improvement Some improvement
- Able to avoid O2 except with exercise Requires nocturnal O2 only

**If No:** Were any of the above treatments considered? Yes No

If Yes, Contraindications?

If No: Why?
Treatment plan

1) If home oxygen will be included in the treatment plan, the laboratory test results must be documented in the medical record [the Home Oxygen Therapy Laboratory Test Results Template (see CMS.gov/eClinical template) or its equivalent may be used].

2) Intent to order home oxygen therapy requires a home oxygen therapy lab test be performed, and a written order for home oxygen therapy [the Home Oxygen Therapy Order Template (see CMS.gov/eClinical template) or its equivalent may be used] and/or a CMN be completed.

<table>
<thead>
<tr>
<th>Signature, Name, Date and NPI of physician or an allowed NPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature: _______________________________________________</td>
</tr>
<tr>
<td>Name (Printed): ___________________________________________</td>
</tr>
<tr>
<td>Date (MM/DD/YYYY): ___________ NPI: ________________________</td>
</tr>
</tbody>
</table>