Home Oxygen Therapy

Order Template Guidance

Purpose
This template is designed to assist a clinician when completing an order for home oxygen therapy to meet requirements for Medicare eligibility and coverage. This template meets the requirements for both the Detailed Written Order (DWO) and 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 an order 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.

Completing the “Home Oxygen Therapy Order 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 F2F Encounter Template”.

What needs to be specified on the order?
- Beneficiary’s name
- Detailed description of Modalities and delivery devices item(s) being ordered
- Ordering Physician or an allowed NPP signature
- Date of the order and the start date, if start date is different from the date of the order
- The prescribing practitioner’s National Provider Identifier (NPI) (required if this is a WOPD)
- O2 Flow Rate
- Estimated frequency and duration of use (e.g., 2L/minute, 10 minutes/Hour, 12 Hours/Day) and
- Duration of need (e.g., 6 Months, 12 Months, 99 Months/Lifetime).

\(^1\) 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.
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.

Oxygen flow rate requirements

When there are differing awake and asleep prescribed flow rates, the average flow rate should be entered in addition to the peak flow rate in the template.

- For beneficiaries with a single flow rate for day and night, the same value should be entered in both the peak and average flow rate.
- For beneficiaries with differing day and night flow rates
  - Calculate the average of the day and night flow rates with the formula:
  - \((\text{day flow rate} + \text{night flow rate}) / 2 = \text{average flow rate}\)
  - Enter the result as the average flow rate

Who can complete the Home Oxygen Therapy Order Template?

Physician or an allowed NPP who has recently examined the patient (within 30 days prior to the start of 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

Version V4.2

Template Footnotes:
1 Hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy
2 Widespread Pulmonary Neoplasm
3 Physician changed maximum flow rate or type of stationary system
**Home Oxygen Therapy Order Template**

**Patient Information:**

Last name: ___________________________ First name: ___________________________ MI: __________

DOB (MM/DD/YYYY): ___________ Gender: __ M __ F __ Other Medicare ID: ___________

Provider (physician/NPP) who is performing the face-to-face evaluation:

Last name: ___________________________ First name: ___________________________ MI: ___ Suffix: ___

NPI: ___________ Date of face-to-face evaluation (MM/DD/YYYY): ___________

**Patient Diagnoses (check all that apply):**

___ COPD
___ Bronchiectasis
___ Hypoxemia
___ Diffuse interstitial lung disease
___ Cystic fibrosis
___ Pulmonary neoplasm
___ Erythrocytosis
___ Pulmonary hypertension
___ Recurring CHF d/t Cor Pulmonale
___ Other:

**Start date, if different than date of order (MM/DD/YYYY):** ___________

Length of need: _______ (months) (99 = lifetime) Peak Flow rate: _______ / _______ (LPM/oxygen %)

Note: Average Flow Rate is required for CMN Avg. Flow rate: _______ / _______ (LPM/oxygen %)

Frequency of use (check all that apply): ___ At rest / awake ___ During exertion ___ During sleep

Target O2 Sat: _____ % or range _____ % to _____ %

Frequency of O2 Sat monitoring: Q _____ hrs. ___ At rest / awake ___ During exertion ___ During sleep

Portable system: maximum length of need for a single trip (e.g. without recharge): _______ / _______ hrs./min.

**Means of oxygen delivery and accessories – the following items do not require a F2F evaluation**

**Group 1 Codes**

- E0445 - OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NON-INVASIVELY
- E1405 - OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITH HEATED DELIVERY
- E1406 - OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITHOUT HEATED DELIVERY

**Group 2 Codes**

- A4606 - OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, REPLACEMENT
- A4608 - TRANSTRACHEAL OXYGEN CATHETER, EACH
- A4615 - CANNULA, NASAL
- A4616 - TUBING (OXYGEN), PER FOOT
- A4617 - MOUTH PIECE
- A4619 - FACE TENT
- A4620 - VARIABLE CONCENTRATION MASK
- A7525 - TRACHEOSTOMY MASK, EACH
- A9900 - MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE
- E0455 - OXYGEN TENT, EXCLUDING GROUP OR PEDIATRIC TENTS
- E0555 - HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER
- E0580 - NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER
- E1352 - OXYGEN ACCESSORY, FLOW REGULATOR CAPABLE OF POSITIVE INSPIRATORY PRESSURE
- E1353 - REGULATOR
- E1354 - OXYGEN ACCESSORY, WHEELED CART FOR PORTABLE CYLINDER OR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
- E1355 - STAND/RACK
- E1356 - OXYGEN ACCESSORY, BATTERY PACK/CARTRIDGE FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
- E1357 - OXYGEN ACCESSORY, BATTERY CHARGER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
- E1358 - OXYGEN ACCESSORY, DC POWER ADAPTER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
Oxygen supply:

Note: for portable modalities, patient must be mobile in the home
Select from list below or specify oxygen supply by checking the specific HCPCS codes:

**Portable:**  ___ Liquid ___ Compressed gas ___ Concentrator
  ___ E0433 – Portable liquid oxygen system (including liquefier), rental (F2F required)
  ___ E0434 – Portable liquid oxygen system, rental (F2F required)
  ___ E0444 – Portable liquid oxygen contents, 1 month’s supply (F2F required)
  ___ E0431 – Portable gaseous oxygen system, rental (F2F required)
  ___ K0738 – Portable gaseous oxygen system (includes compressor), rental
  ___ E0443 – Portable gaseous oxygen contents, 1 month’s supply (F2F required)
  ___ E1392 – Portable Oxygen Concentrator, Rental

**Stationary:**  ___ Liquid ___ Compressed gas ___ Concentrator
  ___ E0439 – Stationary liquid oxygen system, rental (F2F required)
  ___ E0442 – Stationary liquid oxygen contents, 1 month’s supply (F2F required)
  ___ E0424 – Stationary gaseous oxygen system, rental (F2F required)
  ___ E0441 – Stationary gaseous oxygen contents, 1 month’s supply (F2F required)
  ___ E1390 – Oxygen concentrator, single delivery port
  ___ E1391 – Oxygen concentrator, dual delivery port

Means of oxygen delivery and accessories:

___ Nasal cannula ___ Non-rebreather ___ Ventilator ___ Mask ___ PAP bleed in
___ Oxygen conserving device ___ High flow oxygen therapy ___ Other __________________

**Other options or functions:**

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From delivery and accessories above:

Type of order (check one category and one or more subcategory items):

___ Initial or original order for certification
___ Change in status:  ___ Patient relocated  ___ Different supplier  ___ Other __________________
___ Revision or change in equipment:  ___ New Physician order  ___ beneficiary requested upgrade with
  signed ABN  ___ Other: __________________
___ Replacement:  ___ lost or stolen  ___ end of lifetime  ___ repair exceeds 60% of cost

Signature, name, date ordered and NPI (if written order prior to delivery)

Signature: __________________________
Name (Printed): __________________________
Date (MM/DD/YYYY): __________________________  NPI: __________________________