

Use of this template is voluntary / optional

## Respiratory Assist Device (RAD)

### Order Template Guidance

#### Purpose

This template is designed to assist a clinician in completing a Written Order Prior to Delivery (WOPD) n order for a Respiratory Assist Device (RAD) and Detailed Written Order (DWO) for accessories to meet requirements for Medicare eligibility and coverage. When completed appropriately, this template meets requirements for a WOPD or a DWO. The clinician can keep the completed template on file within the patient's medical record or it can be used to develop an order template for use with the system containing the patient's electronic medical record.

#### Patient eligibility for coverage of RAD therapy under Medicare

Eligibility for coverage of RAD therapy and accessories under Medicare requires a physician or qualified Non-Physician Practitioner (NPP)<sup>1</sup> to establish that coverage criteria are met. This helps to ensure the RAD and accessories provided are consistent with the physician's prescription and supported in the patient's medical record.

A Face-to-Face (F2F) encounter is required by Medicare for the following RAD devices:

**E0470** - RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITHOUT BACKUP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)

**E0471** - RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACK-UP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)

**NOTE:** RAD accessories do not require a F2F encounter, but do require a DWO.

The F2F Encounter must be completed within a 6-month timeframe prior to completion of the WOPD that starts RAD therapy for the treatment of a clinical condition supported by the patient's diagnosis. (See Appendix A.)

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<sup>1</sup> \*A Medicare allowed NPP is defined as 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.

Indications for use of a RAD is divided into four categories:

- Restrictive thoracic disorders, (i.e., progressive neuromuscular disorders or severe thoracic cage abnormalities);
- Severe chronic obstructive pulmonary disease (COPD); use of a RAD in COPD patients requires,
  - A facility-based polysomnogram to rule out obstructive sleep apnea in order to initiate Medicare coverage,
  - A prerequisite trial of noninvasive ventilation without a backup rate, and
  - Treatment with continuous positive airway pressure devices.
- Central sleep apnea, i.e., apnea not due to airway obstruction;
- Hypoventilation; and
- Obstructive sleep apnea (OSA).

See Appendices A&B for further guidance on indications for use and coverage.

### Initial coverage -- first three (3) months of therapy

The medical record must document symptoms characteristic of sleep-associated hypoventilation, e.g.:

- Daytime hypersomnolence;
- Excessive fatigue;
- Morning headache;
- Cognitive dysfunction;
- Dyspnea, etc.; and
- **Beneficiary has one (1) of the disorders listed above and meets all coverage criteria for that disorder as listed below.**

### Continued coverage (beyond the first three months of therapy) - E0470 or E0471

Medical record documentation has a signed and dated statement that the beneficiary was re-evaluated on/after the 61st day of therapy demonstrating:

- Progress of relevant symptoms; **and**
- Beneficiary usage of the device (average 4 hours per 24 hours)

### Beneficiaries entering Medicare

There must be documentation of the following:

- A qualifying test confirming that the beneficiary had testing prior to Fee-for-Service (FFS) Medicare enrollment, that meets the current coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of a replacement device and/or accessory; and
- There must be an F2F clinical evaluation following enrollment in FFS Medicare that confirms all of the following:
  - The beneficiary has the qualifying medical condition for the applicable scenario; and
  - Testing performed, date of the testing used for qualification and results; and
  - The beneficiary continues to use the device; and
  - The beneficiary is benefiting from the treatment.

## Other guidance

Completing the RAD order template does not guarantee eligibility and coverage but does provide an area within the patient's medical file that is readily identifiable and available in support of RAD therapy equipment and accessories ordered and billed to Medicare. This template may be used with the Respiratory Assist Device Laboratory Test Results Template and Respiratory Assist Device Face to Face Template.

## Who can complete the Respiratory Assist Device Order Template?

Physician/NPP who performs the F2F Encounter

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

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<b>Respiratory Assist Device Order Template</b>					
<b>Patient Information:</b> Last name: _____ First name: _____ MI: _____ DOB (MM/DD/YYYY): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other Medicare ID: _____					
<b>Provider (physician/NPP) who performed the Face-to-Face (F2F) evaluation:</b> Check here if same as ordering provider: _____ Last name: _____ First name: _____ MI: _____ Suffix: _____ NPI: _____					
Date of F2F evaluation (MM/DD/YYYY): _____					
<b>Patient diagnoses (check all that apply):</b> <input type="checkbox"/> Restrictive thoracic disorder <input type="checkbox"/> Severe COPD <input type="checkbox"/> Hypoventilation syndrome <input type="checkbox"/> Central sleep apnea <input type="checkbox"/> Complex sleep apnea <input type="checkbox"/> Obstructive sleep apnea (OSA) <input type="checkbox"/> Other (describe) _____					
Order start date, if different from date of order (MM/DD/YYYY): _____					
<b>Type of order:</b> Device: <input type="checkbox"/> Initial <input type="checkbox"/> Revision or change in equipment <input type="checkbox"/> Replacement Supplies: <input type="checkbox"/> Initial <input type="checkbox"/> Reorder <input type="checkbox"/> Other: _____					
Device Order (description of device): _____ _____ Specify appropriate device if known; otherwise leave blank: <input type="checkbox"/> E0470 Respiratory assist device, bi-level without backup rate (requires WOPD and F2F evaluation) <input type="checkbox"/> E0471 Respiratory assist device, bi-level with backup rate (requires WOPD and F2F evaluation) <span style="color: red;">Note: E0471 is not covered for OSA.</span>					
Supply Order (complete where appropriate – see Appendix B for a detailed list of items):					
	<i>Item Description</i>	<i>Frequency</i>	<i>Duration</i>	<i>Quantity</i>	<i>Refills</i>
Other: _____					
<b>Signature, name (required if DWO), date ordered and NPI (required for WOPD)</b> Signature: _____ Name (Printed): _____ Date (MM/DD/YYYY): _____ NPI: _____					