

Use of this template is voluntary / optional

Ventilator

Order Template Guidance

Purpose

This template is designed to assist a clinician in completing an order for a ventilator and accessories to meet requirements for Medicare eligibility and coverage. When completed appropriately, this template meets requirements for a Detailed Written Order (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 a ventilator under Medicare

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

Indications for use of a ventilator and accessories is divided into three categories:

- Neuromuscular diseases;
- Thoracic restrictive diseases;
- Chronic respiratory failure consequent to chronic obstructive pulmonary disease

Initial coverage

Medical record must document:

The beneficiary has one (1) of the disorders listed above.

Continued coverage

Medical records support that the beneficiary is benefitting from consistent use of the device.

Beneficiaries entering Medicare

- There must be documentation of the following:
 - A qualifying diagnosis confirming that the beneficiary met criteria for use of a ventilator and accessories prior to Fee-for-Service (FFS) Medicare enrollment and 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

¹ 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.

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- There must be an in-person physician/NPP clinical evaluation/progress note following enrollment in FFS Medicare that confirms the following:
 - The beneficiary has the qualifying medical condition for the applicable scenario;
 - Neuromuscular diseases;
 - Thoracic restrictive diseases;
 - Chronic respiratory failure consequent to chronic obstructive pulmonary disease, and
 - Any testing performed, date of the testing used for qualification and results; and
 - The beneficiary has a medical need for the device; and
 - The beneficiary is benefitting from the treatment.

Other guidance

Completing the Ventilator Order Template does not guarantee eligibility and coverage but does provide an area within the patient's medical record that is readily identifiable and available in support of the need for a ventilator and accessories ordered and billed to Medicare. This template may be used in conjunction with the Ventilator Progress Note Template.

Who can complete this order template?

Physician/NPP who performs the in-person 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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Ventilator Order Template				
Patient Information:				
Last name: _____ First name: _____ MI: _____				
DOB (MM/DD/YYYY): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other Medicare ID: _____				
Provider (physician/NPP) who performed the in-person evaluation:				
Check here if same as ordering provider: _____				
Last name: _____ First name: _____ MI: _____ Suffix: _____				
NPI: _____				
Date of in-person evaluation (MM/DD/YYYY): _____				
Patient Diagnoses (check all that apply):				
<input type="checkbox"/> Neuromuscular disease, describe: _____				
<input type="checkbox"/> Thoracic restrictive disease, describe: _____				
<input type="checkbox"/> Chronic respiratory failure consequent to COPD				
<input type="checkbox"/> Other, describe: _____				
<i>Order start date, if different from date of order (MM/DD/YYYY): _____</i>				
Type of order:				
<i>Device: <input type="checkbox"/> Initial <input type="checkbox"/> Revision or change in equipment <input type="checkbox"/> Replacement</i>				
<i>Supplies: <input type="checkbox"/> Initial <input type="checkbox"/> Reorder <input type="checkbox"/> Other: _____</i>				
<i>Device Order (description of device): _____</i>				
Specify appropriate device if known; otherwise leave blank:				
<input type="checkbox"/> E0465 Home Ventilator used with invasive interface (e.g. tracheostomy tube)				
<input type="checkbox"/> E0466 Home Ventilator used with non-invasive interface (e.g. mask, chest shell)				
<i>Accessory Order (complete where appropriate):</i>				
<i>Item Description</i>	<i>Frequency</i>	<i>Duration</i>	<i>Quantity</i>	<i>Refills</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<i>Other: _____</i>				
Signature, name, date ordered and NPI				
Signature: _____				
Name (Printed): _____				
Date (MM/DD/YYYY): _____ NPI: _____				