DRAFT

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

Version R4.0

DRAFT

Use of this template is voluntary / optional

Home Oxygen Therapy Face-to-Face Encounter Template

Patient information:

Last name: _____First name: _____MI: _____

DOB (MM/DD/YYYY):_____ Gender: ____M ___F ___Other Medicare ID:_____

Provider (physician/NPP) who performed the face-to-face evaluation if different than signing provider:

Last name:_____First name: _____MI: ___Suffix:_____

NPI: _____Date of face-to-face evaluation (MM/DD/YYYY):_____

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

(check/complete all supporting evidence that is currently in the patient's medical record)

___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*

___*O_2 test* ___*"6" minute walk (optional)*

___*Clinical trials*

___*Long-term O_2 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, ___hematemesis
___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:

Vital signs: T=_____P=_____R=_____BP=_____/_____Height=_____Weight=_____

O2 Sat=_____ (RA at Rest)

General appearance:_____
_____

Head and neck:_____
_____

Chest / lungs:_____
_____

Cardiovascular:_____
_____

Abdominal:_____
_____

Musculoskeletal / extremities:_____
_____

Neurological:_____

_____

Psychiatric:_____

Other:_____

_____

_____

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 (ciolomilast and roflumilast)

Other: _____Antibiotics _____Surfactin _____PAP/CPAP _____Pulmonary Rehabilitation

Other: _____

Indicate effectiveness for the above treatments:

___No improvement _____Limited improvement ____Some improvement

___Able to avoid O2 except with exercise ____Requires nocturnal O2 only

Other:_____

If No: Were any of the above treatments considered? ___Yes ___No

If Yes, Contraindications?_____

If No: Why?_____

Physician/NPP assessment / summary:_____

_____

_____

_____

_____

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.

_____

_____

_____

_____

Signature, Name, Date and NPI of physician or an allowed NPP

Signature: _____

Name (Printed): _____

Date (MM/DD/YYYY): _____ NPI: _____