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Use of this template is voluntary / optional

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:
  - (day flow rate + night flow rate) / 2 = 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

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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

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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[1] ___ Diffuse interstitial lung disease
___ Cystic fibrosis ___ Pulmonary neoplasm[2] ___ 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 CROUP 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:*_____

From delivery and accessories above:

HCPCS	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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*[3] ____ *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:* _____