BECN 13317021433

BINSON'S Medical Equipment & Supplies Since 1953

reset form

NON-INVASIVE VENTILATION DETAILED WRITTEN ORDER

FAX Completed Form To: 586-755-4450
Phone: 1-888-246-76667

Patient Name _____ Date Prescribed _____

Address _____ Insurance _____

City/State/Zip _____ _____ _____ ☐ Male ☐ Female Length of Need _____

Home Phone _____ Cell Phone _____ **Diagnosis**

Height _____ Weight _____ DOB _____ ☐ Chronic Respiratory Failure (J96.10) subsequent to Chronic Obstructive Pulmonary Disease (J44.9)

All services require a method of payment (credit card, bank information) in addition to insurance information prior to delivery.

☐ Other _____

MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY:
*****Reason for Medical Necessity (other than diagnosis):** _____

DEVICE MODES & SETTINGS ☐ Non-Invasive Ventilation (E0466) Hours of Use: ☐ During Sleep ☐ Continuous ☐ Other _____

☐ ASTRAL

Device Mode ☐ iVAPS ☐ PS/SV

IPAP _____ EPAP _____ cmH_2O (2-40)

Min PS _____ Max PS _____ Target Pt Rate _____

Target VA _____ PS _____ PEEP _____

PS Max _____ cmH_2O (2-40) Resp Rate _____ Vt _____

Rise Time _____ Ti Min _____ Ti Max _____

Trigger _____ Cycle _____

☐ TRILOGY

Device Mode ☐ iVAPS AE ☐ Other _____

Max Pressure **35** cmH_2O (6-50)

PS Min **10** cmH_2O (2-40) PS Max **20** cmH_2O (2-40)

EPAP Min **5** cmH_2O (4-25) EPAP Max **15** cmH_2O (4-25)

Target Vt _____ AVAPS Rate of Change _____ cmH_2O/min (1-5)

Resp Rate _____ ☐ Auto *or* ☐ Fixed _____ bpm (0-60)

Insp Time (if not auto rate) _____ Rise Time _____ (1-6)

MASK Non-Invasive Interface ☐ Fit to patient comfort ☐ Prescribed Make _____ Model _____ Size _____

MOUTHPIECE VENTILATION ☐ AC *or* ☐ PC AC Flow Pattern ☐ Ramp ☐ Square

AC Settings Vt mL _____ (200 to 1500) PEEP _____ cmH_2O (0-25) Breath Rate _____ bpm (0-30) Insp time _____ sec (0.4-3.0)

PC Settings IPAP _____ cmH_2O (4-40) EPAP _____ cmH_2O (0-25) Breath Rate _____ bpm (0-60) Insp time _____ sec (0.3-5.0) Rise Time _____ (1-6)

OXYGEN

Oxygen Bleed In: _____ lpm or FiO_2 _____% For O_2 Bleed In, titrate O_2 to 90% or to _____% ☐ Oximetry at set up ☐ Overnight Oximetry

Please include the following documentation:

- Face to Face evaluation documenting:
  - Patient's medical history and respiratory ailment.
  - For COPD patients *ONLY* one of the following:
    - $pCO_2 \geq 52$ mmHg or/and FEV1<50% of predicted; *OR*
    - pCO_2 between 48-51 mmHg or FEV1<51-60% of predicted obtained AND have two or more respiratory-related hospital admissions within the past 12 months.
  - Reason for medical necessity, including why the patient requires mechanical ventilatory support due to severe and/or life-threatening disease state and consequences if patient does not receive.
  - If patient was on Bi-Level therapy as an outpatient, why the current therapy is being replaced by NIV.
- Other documentation if available:
  - For neuromuscular patients, FVC or MIP/NIF test results.
  - For Restrictive Thoracic patients, pCO_2 or FVC test results.
  - Last hospital admission/re-admission.

☐ Please expedite Prior Authorization Date of Discharge _____

Physician's Signature _____	Signature Date _____
Physician's Printed Name _____	Phone _____ Fax _____
Address _____	NPI _____

BECN 13317021433

If filled out completely, this form serves as the Detailed Written Order (DWO) and proof that patient was seen by the physician within 6 months prior to the date of order. This must be received by supplier before equipment is dispensed.

The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations Manual (Internet-Only Manual, Publ. 100-03) in Chapter 1, Part 4, Section 280.1 stipulates ventilators, (E0465, E0466) are covered for the following conditions:

"[N]euromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease."

Each of these disease categories are comprised of conditions that can vary from severe and life-threatening to less serious forms. These ventilator-related disease groups overlap conditions described in this Respiratory Assist Devices LCD used to determine coverage for bi-level PAP devices. Each of these disease categories are conditions where the specific presentation of the disease can vary from patient to patient. For conditions such as these, the specific treatment plan for any individual patient will vary as well. Choice of an appropriate treatment plan, including the determination to use a ventilator vs. a bi-level PAP device, is made based upon the specifics of each individual beneficiary's medical condition. In the event of a claim review, there must be sufficient detailed information in the medical record to justify the treatment selected.

Ventilators fall under the Frequent and Substantial Servicing (FSS) payment category, and payment policy requirements preclude FSS payment for devices used to deliver continuous and/or intermittent positive airway pressure, regardless of the illness treated by the device. (Social Security Act 1834(a)(3)(A)) This means that products currently classified as HCPCS code E0465 or E0466 when used to provide CPAP or bi-level PAP (with or without backup rate) therapy, regardless of the underlying medical condition, shall not be paid in the FSS payment category. A ventilator is not eligible for reimbursement for any of the conditions described in this RAD LCD even though the ventilator equipment may have the capability of operating in a bi-level PAP (E0470, E0471) mode. Claims for ventilators used to provide CPAP or bi-level CPAP therapy for conditions described in this RAD policy will be denied as not reasonable and necessary.

General principles of correct coding require that products assigned to a specific HCPCS code only be billed using the assigned code. Thus, using the HCPCS codes for CPAP (E0601) or bi-level PAP (E0470, E0471) devices for a ventilator (E0465, E0466) used to provide CPAP or bi-level PAP therapy is incorrect coding. Claims for ventilators billed using the CPAP or bi-level PAP device HCPCS codes will be denied as incorrect coding.

Medicare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary. The chart note from the office visit exam must be signed and dated by the author of the note. If completed by a PA, NP, or CNS, the physician (MD, DO or DPM) must cosign and date the note.