



NON-INVASIVE VENTILATION DETAILED WRITTEN ORDER

FAX Completed Form To: 407-691-3021 Phone: 1-407-691-3009

Patient Name, Date Prescribed, Address, Insurance, City/State/Zip, Home Phone, Cell Phone, Height, Weight, DOB, All services require a method of payment...

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

ASTRAL TRILOGY Device Mode, IPAP, EPAP, Min PS, Max PS, Target Pt Rate, Target VA, PS, PEEP, PS Max, cmH2O, Resp Rate, Vt, Rise Time, Ti Min, Ti Max, Trigger, Cycle, Max Pressure, PS Min, PS Max, EPAP Min, EPAP Max, Target Vt, AVAPS Rate of Change, Resp Rate, Insp Time, Rise Time

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, PEEP, cmH2O, Breath Rate, bpm, Insp time, sec, PC Settings IPAP, cmH2O, EPAP, cmH2O, Breath Rate, bpm, Insp time, sec, Rise Time

OXYGEN Oxygen Bleed In: lpm or FiO2 % For O2 Bleed In, titrate O2 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: pCO2 >= 52 mmHg or/and FEV1 < 50% of predicted; OR pCO2 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, pCO2 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

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 that 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.