



NON-INVASIVE VENTILATION FORM

FAX TO: 586-755-4450

Referral Source

Referral Name: _____
 Contact Name: _____
 Phone: _____ Fax: _____
 Order Date: _____

Patient Information

Name: _____
 Delivery Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Mobile: _____
 Date of Birth: _____

Non-Invasive Positive Pressure Ventilation is covered for the following conditions: Severe neuromuscular or restrictive thoracic diseases and chronic respiratory failure consequent to severe chronic obstructive pulmonary disease.

Diagnosis ICD-10 Codes: Chronic Respiratory Failure (J96.10) consequent to Chronic Obstructive Pulmonary Disease (J44.9)
 Other: _____

Estimated Length of Need: _____ Months (99 = Lifetime)

PLEASE INCLUDE ALL OF THE FOLLOWING REQUIRED DOCUMENTATION

- Copy of patient demographics and insurance information
- **For hospital discharge ONLY**, the patient has completed a trial on the device that is being ordered.
- Face-to-Face evaluation/physician chart notes, which document the following:

Patient's medical history and respiratory ailment

For COPD patients ONLY, test results showing pCO2 ≥52mm Hg or FEV1 >50% of predicted

Why the patient needs pressure support ventilation, due to severe and/or life-threatening disease state, and the consequences if the patient does not receive the benefit of pressure support ventilation (e.g., longer hospital stay, risk of repeat acute episode)

- Other documentation (ONLY IF AVAILABLE)
 If another form of therapy was considered and ruled out _____
 Last hospital admission/readmission _____

EQUIPMENT ORDERED

Pressure support ventilator with related supplies and accessories (E0466)

- E0562 Heated Humidifier
- Non-Invasive Interface: Fit to patient comfort, **OR**
- Non-Invasive Interface: Make: _____
 Model: _____ Size: _____
- Mouthpiece Ventilation (MPV) Circuit

DEVICE MODES AND SETTINGS

TRILOGY (AVAPS-AE)

Max Press: _____
 Epap Min/Max _____/
 PS Min/Max _____/
 Vt: _____
 Rate: _____
 ITime: _____
 Rise Time: _____

Astral (IVAPS)

Epap Press: _____
 PS Min/Max _____/
 Target Rate: _____
 Target Va: _____
 Rise Time: _____
 ITime Min/Max _____/
 Trigger: _____
 Cycle: _____

Supplemental O2 _____ LPM

Hours of use: ____ During Sleep PRN While Awake
 Dual Settings: Yes No

If yes, please complete daytime mouthpiece ventilation (MPV) settings: (Complete AC Mode or PC Mode, not both)

AC Mode: ITime: _____ Vt: _____ **OR**
 PC Mode: IPAP _____ ITime: _____

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) items(s) for this patient is a clinical decision made by me, based on the patient's clinical needs and that my medical records support the medical need for the items prescribed.

Physician Name: _____ NPI #: _____
 Physician's Signature: _____ Signature Date: _____



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 not

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5250 Auto Club Dr

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21571 Kelly Rd

FARMINGTON HILLS
Tri-Atria Building
32255 Northwestern Hwy

FLINT
G-4433 Miller Rd

LIVONIA
13450 Farmington Rd

LIVONIA
St. Mary Mercy Hospital
36475 5 Mile Rd

ROYAL OAK
30475 Woodward Ave

SOUTHGATE
18800 Eureka Rd

TROY
6475 Rochester Rd

STERLING HEIGHTS
43900 Schoenherr Rd

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