Patient Name: _____

ABC Patient ID #: _____

Patient Instructions for Home Medical Equipment

In order for ABC Health Care to complete the request for your prescribed home medical equipment, we will need the following documentation requirements completed in full and provided to our office in their entirety.

1. Receive copy of ABC Health Care "Home Medical Equipment – Instructions & Documentation Requirements" packet
   - ☑ Completed

2. Fill out the "ABC Health Care Patient Information Record" document
   - ☐ Completed

3. Using the "Written Order Requirements" document, confirm your prescription / "written order" written by your physician meets the insurance-driven requirements. If not, contact your prescribing physician for a new prescription / "written order" or to make the appropriate changes to your existing prescription ***Important, please note - All edits to an existing prescription must be initialed and dated by the signing physician.***
   - ☐ Completed

4. Using the "Equipment Documentation Requirements" document, confirm all Insurance-required documentation is included. If not, contact your physician to request the Insurance-required medical documentation.
   IMPORTANT - Medical documentation written on a prescription / "written order" is not accepted by Insurance companies. It must be written separately in your medical records and be part of your medical history from your prescribing physician.
   - ☐ Completed

5. Once complete, submit all of the following to ABC's DME department. It will be scanned and returned to you.
   - ☐ "Patient Instruction for Home Medical Equipment" form
   - ☐ "ABC Health Care Patient Information Record" form
   - ☐ Valid Prescription / Written Order
   - ☐ Equipment Documentation form with the accompanying Medical Records / Medical Documentation

6. An ABC Health Care Medicare Quality Assurance associate will review the order and documentation within 48 hours of submission.
   - ☐ If order and documentation are not complete, the Medicare Quality Assurance associate will deny the request for equipment and inform you of reasons.
   - ☐ If order and documentation are complete, the Medicare Quality Assurance associate will approve the request for equipment and inform you of approval and process for receiving your equipment.
     Important, please note – ABC will only provide equipment after patient co-payment, deductible, and/or prior balance is collected.

7. ABC Health Care will file your medical equipment claim with Medicare for you and an Explanation of Benefits from CMS will follow to confirm billing is complete.

Patient Information Record

Date:_____

Patient Information:

Last Name:_____ First Name:_____ MI:_____

Date of Birth: _____ SS#: _____

Home Address: _____

City:_____ State:_____ Zip:_____

Cell phone:_____ Work phone: _____

Home phone:_____ Email:_____

Caregiver / Responsible Party Information:

Last Name:_____ First Name:_____ MI:_____

Cell phone:_____ Work phone: _____

Home phone:_____ Email:_____

Clinical Information:

Gender: ☐Male ☐Female Height:_____ Weight:_____

Health / Infection Risk: ☐Yes ☐ No If Yes, provide detail:_____

Primary Care Physician:_____

PCP Address: _____

City:_____ State:_____ Zip:_____

Health Insurance Information:

Primary Insurance Company:_____

Policy Number:_____ Group Number:_____

Subscriber Name:_____

Relationship to Subscriber: ☐ Self ☐Spouse ☐Child ☐Other:_____

Secondary Insurance Comapny:_____

Policy Number:_____ Group Number:_____

Subscriber Name:_____

Relationship to Subscriber: ☐ Self ☐Spouse ☐Child ☐Other:_____

Tertiary Insurance Company:_____

Policy Number:_____ Group Number:_____

Subscriber Name:_____

Relationship to Subscriber: ☐ Self ☐Spouse ☐Child ☐Other:_____

Written Order Requirements - Example

Home Oxygen Therapy

Per Medicare and the Affordable Care Act, a detailed written order for DME items must be (A) received before the delivery of an item can take place and (B) must include the following information (as shown in the example below):

1. Beneficiary's name
2. Physician's name
3. Physician's NPI
4. Date of the order
5. Detailed description of the item(s) with additional details, as applicable:
    a. Detailed description of item(s) to be dispensed (with HCPC codes, if possible)
    b. Quantity to be dispensed
    c. Frequency of use
    d. Duration / Length of need
    e. Number of refills
    f. Route of administration
    g. Dosage & concentration
6. Physician signature
7. Physician signature date

James S. Doe, M.D. (2)
123 Market Street, Hampton, VA 23666
Phone: (757) 555-1212
(3) **NPI# 1234567890**

Name: Robert Jones (1) Date: 07/01/2016 (4)

Address: 1411 Green Place, Chesapeake, VA 23324 DOB: 05/19/1945

(5)

(a) Home Oxygen therapy (E1390) via concentrator delivered (f) by nasal cannula @ 2 LPM pulse (g) (oxygen conserving device) continuous (c) 24/7. Include portable oxygen (E0431) as well.

Refills: 0 (e) Quantity: 1 (b) Length of Need: 99 months (d)

Signature of Prescriber: James S Doe (6) Signature Date: 07/01/2016 (7)

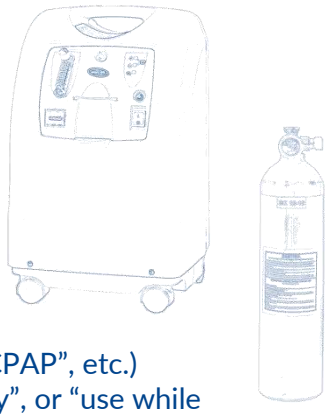
IMPORTANT – Any / each change made to prescription that is already signed, must be initialed and dated by the physician to be accepted by Medicare

Equipment Requirements & Check-Off List

• Home Oxygen Therapy •

In order for ABC Health Care to complete the request for your prescribed home medical equipment, we will need the following documentation requirements completed in full and provided to our office in their entirety.

Home Oxygen Concentrator & Portable



- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description of items and related accessories:
    - "E1390 Home Oxygen Concentrator"
    - "E0431 Portable Oxygen Container"
  - ☐ Dosage or Liter Flow = (examples: "2LPM" or "3LPM")
  - ☐ Delivery = (examples: "continuous flow" or "pulse")
  - ☐ Route of delivery = (examples: "via nasal cannual", "via mask", "bled into CPAP", etc.)
  - ☐ Frequency of use = (examples: "use 24 hours a day", "use for exertion only", or "use while sleeping")
  - ☐ Duration / length of need = "99 months"
  - ☐ Physician name
  - ☐ Physician signature
  - ☐ Physician signature date
  - ☐ NPI on prescription that matches ordering physician's signature

Documentation to justify the need for the equipment MUST be in the medical records. Any documentation written on the Detailed Written Order is not accepted.

- Documentation within the medical records with examination notes from physician detailing **ALL** of the following:
  - ☐ The examination was completed:
    - In-person with patient & physician.
    - Within six (6) months of the order of oxygen.
  - ☐ Detailed information about the patient's medical condition and substantiate the need for oxygen by including:
    - Qualifying Diagnosis - Patient must have documentation of a severe lung disease or hypoxia-related symptoms expected to improve with oxygen therapy. Examples include (but are not limited to):
      - Diseases - COPD, diffuse interstitial lung disease (known or unknown etiology), cystic fibrosis, bronchiectasis, and widespread pulmonary neoplasm.
      - Symptoms - pulmonary hypertension, recurring congestive heart failure due to corpulmonale, erythrocytosis, impairment of cognitive process, nocturnal restlessness, and morning headache.
    - Duration of Condition – Patient must have a "chronic" condition (vs. "acute" condition) and notes must include:
      - Patient has a history of "_____" (specify condition) since "_____" (specify timetable).

- Clinical Course of Action & Prior Treatments:
  - Documentation must include one of the following:
    - Prior treated with "_____" (specify treatments including medications, pulmonary rehab, etc.)
    - Alternative treatment measures have been considered and deemed clinically ineffective.
- Functional limitations:
  - Patient is mobile within the home.
  - Patient's diagnosis of "_____" (specify condition) significantly impairs the ability to participate in one or more Activities of Daily Living in the home.
  - Disease progression now necessitates use of home oxygen therapy.
- Qualifying Saturation Test - Timeline – The Qualifying Saturation Test (arterial blood gas "ABG" test or pulse oximetry) must be completed either:
  - IP - Within two (2) days of discharge from an inpatient hospital stay OR
  - OP - Within thirty (30) days prior to Written Order with patient in a chronic stable state as an outpatient.

****IMPORTANT - Test performed in a qualified provider's office must be reviewed and signed by patient's physician or qualified provider****

- Qualifying Saturation Test - Results - Patient must be in a chronic stable state AND cannot use supplemental oxygen while being tested "at rest":
  - Resting - Patient on room air while at rest (awake) when tested:
    - Arterial oxygen saturation is at or below 88% or PO2 is at or below 55 mm Hg
  - Overnight ① - Tested while sleeping, the patient must have at least 5 minutes where:
    - Arterial oxygen saturation is at or below 88% or PO2 is at or below 55 mm Hg
    - A decrease in PO2 more than 10mm Hg or arterial oxygen saturation of 5%
  - Exertion - Patient arterial oxygen saturation is at or below 88% or PO2 is at or below 55 mm Hg during exercise requires evidence of:
    - Patient above 88% or 55%mm Hg while on room air
    - Patient is at or below 88% or 55mm Hg during exercise
    - Oxygen is provided during exercise and is documented to improve saturation levels

① IMPORTANT – Oxygen therapy for the diagnosis of OSA must be used in conjunction with a PAP machine AND requires the patient have an in-lab sleep study done with proof of titration with supplemental oxygen included

- Prognosis:
  - The oxygen will help patient complete ADLs.
  - Patient is willing and able to safely use the oxygen within the home.

Documentation to justify the need for the equipment MUST be in the medical records. Any documentation written on the Detailed Written Order is not accepted.

Our team of Customer Service Representatives is standing by to assist you and your patients

This document is not considered Medical Documentation in any way. It merely provides guidance on what is required with the patient's Medical Records

ABC Health Care • 28 Research Drive, Hampton, VA 23666 • Phone: (757) 826-2600 • Fax: (757) 826-9269 • www.abc-hc.com