Making Referrals

What you need to know

Thank you for choosing us for the needs of your patients who are Medicare beneficiaries. Since Medicare requires that the prescribing practitioner's records contain documentation of medical necessity, we would like to provide you with some important information.

Bilevel/RAD

Chronic respiratory failure consequent to COPD:

Hospital setting

Bilevel with or without a backup rate

- Diagnosis of acute on chronic respiratory failure due to COPD
- Physician's note indicates need for bilevel device and without it there will be rapid clinical deterioration
- Patient requires a RAD within the 24-hour period prior to hospital discharge
- The treating clinician determines that the patient is at risk of rapid symptom exacerbation or rise in $PaCO_2$ after discharge

Non-hospital setting

Bilevel without a backup rate

- Initial evaluation of patient within 12 months prior to starting Bilevel/RAD therapy$PaCO_2 \geq 52$ mm Hg by ABG while awake and breathing prescribed FiO_2.
- Sleep apnea must not be the predominant cause of the elevated CO_2

Bilevel with a backup rate

- $PaCO_2 \geq 52$ mm Hg by ABG while awake and breathing prescribed FiO_2

- Sleep apnea must not be the predominant cause of the elevated CO_2
- One of the following characteristics should also be noted in the patient's record
  - Stable COPD should also be noted in the patient's record
  - Hypercapnia present for at least two weeks post-hospitalization after resolution of an exacerbation of COPD requiring acute non-invasive ventilation using a RAD device

Restrictive thoracic and neuromuscular disorders:

Bilevel with or without a backup rate

- Initial evaluation of patient within 12 months prior to starting Bilevel/RAD therapy$PaCO_2 \geq 52$ mm Hg by ABG while awake and breathing

A. There is documentation in the beneficiary's medical record of a neuromuscular disease or a severe thoracic cage abnormality

B. One of the following:
   1. An arterial blood gas $PaCO_2$, done while awake and breathing the beneficiary's prescribed FiO_2 is greater than or equal to 45 mm Hg
   2. Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for greater than or equal to five minutes of nocturnal recording time done while breathing the beneficiary's prescribed recommended FiO_2. Minimum recording time of two hours

3. For a neuromuscular disease (only), either:
   – Maximal inspiratory pressure is less than 60 cm H_2O, or
   – Forced vital capacity is less than 50% predicted

C. Chronic obstructive pulmonary disease does not contribute significantly to the beneficiary's pulmonary limitation

Central sleep apnea or complex sleep apnea:

Bilevel with or without a backup rate

A complete facility-based, attended PSG is performed documenting the following:

A. The diagnosis of central sleep apnea or complex sleep apnea
B. Significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the beneficiary's prescribed liter flow

Hypoventilation syndrome:

Bilevel without a backup rate

Criteria A is met in addition to either criteria B or C:

A. An initial arterial blood gas $PaCO_2$, done while awake and breathing the beneficiary's prescribed liter flow, is greater than or equal to 45 mm Hg and spirometry shows an FEV1/FVC greater than or equal to 70%

EITHER

B. An arterial blood gas $PaCO_2$, done during sleep or

immediately upon awakening, and breathing the beneficiary's prescribed liter flow, shows the beneficiary's $PaCO_2$ worsened greater than or equal to 7 mm Hg compared to the original result

C. While using E0470, a facility-based PSG demonstrates oxygen saturation less than or equal to 88% for greater than or equal to a cumulative five minutes of nocturnal recording time. Minimum recording time of two hours. Additionally, it must be determined that obstructive upper airway events are not the predominant cause of issue

Bilevel with a backup rate

Criteria A is met, and either criterion B or C are met:

A. A covered E0470 device is being used. And spirometry shows an FEV1/FVC greater than or equal to 70%

EITHER

B. An arterial blood gas $PaCO_2$, done during sleep or immediately upon awakening, and breathing the beneficiary's prescribed liter flow, shows the beneficiary's $PaCO_2$ worsened greater than or equal to 7 mm Hg compared to the original result

C. While using E0470, a facility-based PSG demonstrates oxygen saturation less than or equal to 88% for greater than or equal to a cumulative five minutes of nocturnal recording time. Minimum recording time of two hours. Additionally, it must be determined that obstructive upper airway events are not the predominant cause of issue

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33800

Enteral nutrition

Please include chart notes with the following information:

The patient has a permanent (at least three months) impairment due to:

- Non-function or disease of the structures that normally permit food to reach the small bowel; or
- A disease of the small bowel which impairs digestion and absorption of an oral diet
- The patient requires tube feedings to maintain weight and strength commensurate with the patient's overall health status. Adequate nutrition is **not** possible through dietary adjustment and/or oral supplements
- The nutrition is being provided via a tube in the stomach or small intestine (the beneficiary is not drinking the nutrient)
- Practitioner's signature on the medical records must meet CMS signature requirements

Claims for enteral nutrition pumps:

Medical record must contain documentation to justify the need for a pump:

- Gravity feeding is not satisfactory if due to reflux/aspiration; or severe diarrhea; or
- Dumping syndrome; or
- Administration rate less than 100 mL/hour; or
- Blood glucose fluctuations; or
- Circulatory overload; or
- Gastrostomy/jejunostomy tube used for feeding

High-Frequency Chest Wall Oscillation (HFCWO)

Bronchiectasis:

- Completed and signed Standard Written Order
- CT scan (within the last ten years) confirming bronchiectasis

AND

- Daily productive cough for at least six continuous months

OR

- Three or more exacerbations requiring antibiotic therapy

AND

- Documentation in chart notes of other standard treatment(s) which attempted to mobilize secretions, clearly indicating that these devices/technique failed

Other qualifying diagnosis for respiratory, cystic fibrosis, and neuromuscular conditions:

- Completed and signed Standard Written Order
- Qualifying diagnosis
- Chart notes to support diagnosis within six months prior to Standard Written Order*

*Time frame can vary by payor.

Nebulizers and nebulized respiratory medications

Please include chart notes with the following information:

- Documentation of medical need for nebulizer and equipment within three months
- Documentation of medical need for nebulized medications within 12 months
- Pulmonary diagnosis
- Prescribed respiratory medication listed in progress note
- Practitioner's signature on the medical records must meet CMS signature requirements

Respiratory medications provided by Reliant Pharmacy.

Oxygen

Initial chart notes should include the following:

- Prescription details (liter flow, method of administration, etc.)
- Patient status at the time of need for oxygen therapy (inpatient vs. outpatient)
- If inpatient, admission date and discharge date
- Date the provider is evaluating the test results. If portability, document that the patient is mobile in the home
- Reason patient is expected to improve with oxygen therapy

If groups I or II:

- Test date (for inpatient, must be performed within two days of discharge. For outpatient, because of the undefined restriction in the LCD, no more than three months; ask for a free text explanation after 30 days)
- Test type (Pulse Oximetry or ABG)
- Test condition

  Standard, non-OSA related:
  - Rest, continuous oxygen
  - Exercise, continuous and/or portable oxygen
  - Overnight, nocturnal oxygen

  OSA-related
  - Overnight, titration on optimal RAD pressure settings
- Test results
  - Qualifying test result if <89% or >59 mm Hg

Group II criteria include all of the following:

A. An arterial PO_2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89%; and,

B. Any of the following:
   1. Dependent edema suggesting congestive heart failure; or,
   2. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or,
   3. Erythrocythemia with a hematocrit greater than 56%

Group III criteria include the following:

- Diagnosis of cluster headaches
- Non-qualifying testing: Arterial PO_2 greater than 59 mm Hg or an oxygen saturation greater than 89%
- Re-evaluation for continued need

Positive Airway Pressure (PAP) devices

Please include chart notes with the following information:

- Initial clinical evaluation and documentation of signs and symptoms of OSA OR the need for a sleep study. Must be noted prior to the sleep study but no more than 12 months prior
- Planned course of treatment
- Other therapeutic interventions
- Results of qualifying PSG or report
- Practitioner's signature on the medical records must meet CMS signature requirements

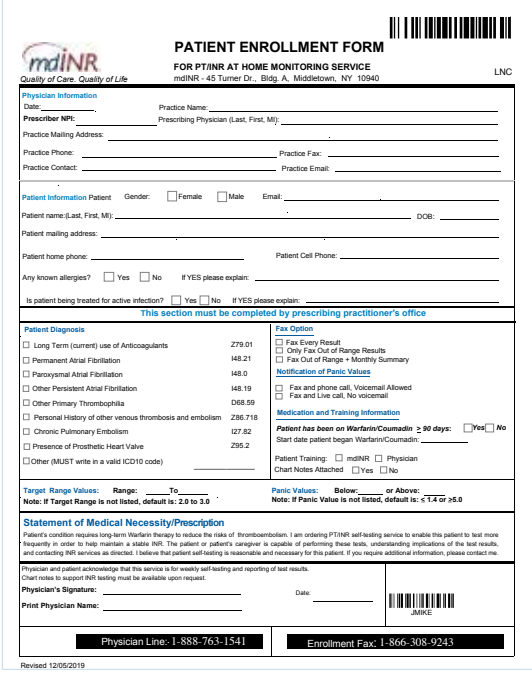
After three months of therapy:

- In-person follow-up evaluation
- Diagnosis of OSA
- Compliant use of PAP
- Patient is benefiting from therapy

PT/INR home testing

The order should include:

- Physician name
- Physician NPI
- Patient name
- Diagnosis
- Documented anticoagulant use for three months or greater
- Physician signature
- Signature date



mdINR
Quality of Care. Quality of Life

PATIENT ENROLLMENT FORM

FOR PT/INR AT HOME MONITORING SERVICE
mdINR - 45 Turner Dr., Bldg. A, Middletown, NY 10940

LNC

Physician Information
Date: _____ Practice Name: _____
Prescriber NPI: _____ Prescribing Physician (Last, First, MI): _____
Practice Mailing Address: _____
Practice Phone: _____ Practice Fax: _____
Practice Contact: _____ Practice Email: _____

Patient Information Patient Gender: ☐ Female ☐ Male Email: _____
Patient name:(Last, First, MI): _____ DOB: _____
Patient mailing address: _____
Patient home phone: _____ Patient Cell Phone: _____
Any known allergies? ☐ Yes ☐ No If YES please explain: _____
Is patient being treated for active infection? ☐ Yes ☐ No If YES please explain: _____

This section must be completed by prescribing practitioner's office

Patient Diagnosis

☐ Long Term (current) use of Anticoagulants	Z79.01
☐ Permanent Atrial Fibrillation	I48.21
☐ Paroxysmal Atrial Fibrillation	I48.0
☐ Other Persistent Atrial Fibrillation	I48.19
☐ Other Primary Thrombophilia	D68.59
☐ Personal History of other venous thrombosis and embolism	Z86.718
☐ Chronic Pulmonary Embolism	I27.82
☐ Presence of Prosthetic Heart Valve	Z95.2
☐ Other (MUST write in a valid ICD10 code)	_____

Fax Option
☐ Fax Every Result
☐ Only Fax Out of Range Results
☐ Fax Out of Range + Monthly Summary

Notification of Panic Values
☐ Fax and phone call, Voicemail Allowed
☐ Fax and Live call, No voicemail

Medication and Training Information
Patient has been on Warfarin/Coumadin ≥ 90 days: ☐ *Yes* ☐ *No*
Start date patient began Warfarin/Coumadin: _____
Patient Training: ☐ mdINR ☐ Physician
Chart Notes Attached ☐ Yes ☐ No

Target Range Values: **Range:** _____ **To** _____
Note: If Target Range is not listed, default is: 2.0 to 3.0

Panic Values: **Below:** _____ **or Above:** _____
Note: If Panic Value is not listed, default is: ≤ 1.4 or ≥6.0

Statement of Medical Necessity/Prescription
Patient's condition requires long-term Warfarin therapy to reduce the risks of thromboembolism. I am ordering PT/INR self-testing service to enable this patient to test more frequently in order to help maintain a stable INR. The patient or patient's caregiver is capable of performing these tests, understanding implications of the test results, and contacting INR services as directed. I believe that patient self-testing is reasonable and necessary for this patient. If you require additional information, please contact me.

Physician and patient acknowledge that this service is for weekly self-testing and reporting of test results.
Chart notes to support INR testing must be available upon request.
Physician's Signature: _____ Date: _____
Print Physician Name: _____
JMIKE

Physician Line: 1-888-763-1541 **Enrollment Fax: 1-866-308-9243**

Revised 12/05/2019

We look forward to taking care of your warfarin patient.

Service provided by mdINR.

mdINR

Ventilators

Restrictive thoracic and neuromuscular disorders:

- Initial evaluation of within 12 months prior to starting ventilator therapy
- Patient requires a ventilator, mechanical ventilator, or non-invasive mechanical ventilator due to the severity of covered diagnosis
- Ventilator is required to decrease work of breathing, improve pulmonary status and prevent the interruption of respiratory support, which could lead to serious harm, i.e., decline in health status, worsening condition, increase risk of CO_2 retention, and untimely readmissions
- If CPAP/RAD tried indicate why it is no longer effective

Chronic respiratory failure consequent to COPD:

Hospital discharge

- Diagnosis of acute on chronic respiratory failure due to COPD
- Patient requires a ventilator, mechanical ventilator, or non-invasive ventilator due to the severity of the covered diagnosis
- Patient's need exceeds the capabilities of a bilevel and requires use of a ventilator within 24-hour period prior to hospital discharge

- The patient's chart notes establish the patient is at risk for rapid symptom exacerbations or rise in $PaCO_2$ after discharge

Non-hospital discharge

- Diagnosis of chronic respiratory failure due to COPD
- Initial evaluation of patient within 12 months prior to starting ventilator therapy
- Patient requires a ventilator, mechanical ventilator, or non-invasive ventilator due to the severity of the covered diagnosis
- ABG $PaCO_2 \geq 52$ mm Hg during awake hours while breathing his/her prescribed FiO_2
- Chart note supports sleep apnea is not the predominant cause of the hypercapnia (Formal sleep testing is not required if, per the treating clinician, the patient does not experience sleep apnea as the predominant cause of the hypercapnia.)

https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&ncaid=315

Disclaimer: Information about the devices are being provided for your convenience only. Complete information about any device depicted should be obtained from the manufacturer. Please note that the devices depicted are examples of what may be available. The actual device provided may be different. Device availability and inventory levels are subject to change without notice. Devices may require a valid prescription.