Oxygen Therapy

Standard Written Order (SWO)

Prism Health Care Services, Inc.
1337 Basswood Road
Schaumburg, IL 60173-4536
Phone: 847-310-4730 *3
Fax: 872-469-1673

Order Date: _____

Patient Name: _____ **Home Phone:** _____

Date of Birth: _____ **Cell Phone:** _____

Diagnosis: 1 _____ 2 _____ 3 _____

Duration: ☐ Lifetime (99) or Other _____ months

Indicate prescribed liter flow, method of administration, and usage:

O2 @ _____ **LPM** _____ **via** _____

(indicate liter flow)	*(select usage)*	*(select method)*
	_____hours/day	Nasal Cannula
	continuous	O2 Mask- Indicate Oxygen Mask style
	Nocturnal use only	PAP mask
		Trach Collar or Adapter

Check one of the following selections:

☐ **Nocturnal Use Only**

Oxygen Concentrator - stationary unit (E1390) with Backup Tank System
A portable system is not covered when oxygen is prescribed for Nocturnal use.

☐ **Concentrator and Portable Oxygen Tank System with OCD Evaluation**

Oxygen Concentrator - stationary unit (E1390), Tanks and Regulator (E0431 & E0443)
Patient must be mobile within the home in order to qualify for a portable oxygen system.

OCD - Clinically indicated for oxygen liter flow from 1 - 3.
Evaluation of my patient by a Respiratory Therapist to qualify for the OCD. Respiratory Therapist may titrate patient prescribed oxygen setting to achieve an SpO2 of ≥ 90% at rest and during exercise /activities of daily living. I authorize patient be set up on the appropriate OCD of choice or qualification, which may include, oxymizer conserving pendant, conserving regulator, or portable oxygen concentrator.

Initial delivery of the portable system is a standard regulator with E-tanks. If the patient meets the OCD liter flow criteria, an evaluation will be scheduled with a Respiratory Therapist. Portable Oxygen Concentrators are only available on a private pay basis.

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, OXYGEN SATURATION TESTING, AND CLINICAL NOTES, i.e. doctors, progress, nurses, occupational therapy, and physical therapy notes. The notes must include diagnosis and the need for the equipment. Also, it is required that the date of this form is the same or after the date on the Clinical Notes, Face to Face, and testing.

The following Medicare guidelines and must be met for the home oxygen therapy to be covered and deemed reasonable and medically necessary.

1. The treating physician has ordered and evaluated the results of a qualifying blood gas study performed at the time of need; AND
2. The beneficiary's blood gas study meets the criteria stated below; AND
3. The qualifying blood gas study was performed by a treating practitioner or by a qualified provider or supplier of laboratory services; AND
4. The provision of oxygen equipment in the home setting will improve the beneficiary's condition.

Group I criteria include any of the following: ***(For more coverage criteria, please review the Medicare Policy at https://www.cgsmedicare.com/jc/coverage/lcdinfo.html)***

1. An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake) while breathing room air; or,
2. An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during sleep for a beneficiary who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake. In this instance, oxygen and oxygen equipment is only reasonable and necessary during sleep; or,
3. A decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent from baseline saturation, taken during sleep and associated with symptoms of hypoxemia such as impairment of cognitive processes and nocturnal restlessness or insomnia (not all inclusive). In this instance, oxygen and oxygen equipment is only reasonable and necessary during sleep; or,
4. An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a beneficiary who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this instance, portable oxygen and oxygen equipment is only reasonable and necessary while awake and during exercise.

Physician Name: _____ **NPI:** _____

Physician Signature: _____ **Date :** _____

Physician Phone: _____ **Fax:** _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.