Order for Respiratory Assist Device for the Diagnosis of Severe COPD

Patient Name *(print)*_____

Physician Name *(print)*_____

Date of this order _____ / _____ / _____

I attest:

This patient is diagnosed as having severe COPD as evidenced by elevated $PaCO_2$ of _____ mm Hg taken on _____ / _____ / _____.

must be 52 mm Hg or greater to qualify

I am ordering a respiratory assist device for this diagnosis.

Obstructive sleep apnea, and treatment with CPAP, has been considered and ruled out as a cause of the severe COPD.

I am ordering:

- Respiratory assist device, bi-level pressure capability, <u>without backup rate feature</u>, procedure code *HCPC E0470*,
- Inspiratory Pressure of _____ and Expiratory Pressure of _____,
- all tubing, masks, and filters as necessary and;
- overnight oximetry.

Insurance will not cover a device with a backup rate upon initial discharge.

Insurance requires an overnight pulse oximetry to fully qualify the patient.

Length of need = ____ months (99 months = lifetime)

Physician

Signature X_____ **Date** _____