



Provider Manual

Pharmacy | DME

Mid-Atlantic Region
2023

For more information, please visit:
<https://onehome.health/for-providers/>

Phone: 1-833-523-2609 | Fax: 1-855-475-5614

Table of Contents

Physician Welcome	3
Hours and Contacts.....	4
Overview.....	5
Scope of Services.....	6
Intake/Admission.....	7
Pharmacy Services	8
Pharmacy Criteria	9-11
Contact Physician/Information Request.....	12
Non-Routine DME Items	13
Covered and Frequently Utilized Equipment.....	14-16
Medicare Covered and Non-Covered Services.....	17-22
CPAP Ordering Information.....	23
CPAP Order Requirements	24
Physician Office and Patient Acknowledgment Form	25
Home Infusion Request Form.....	26
Equipment Information/Reference Guide	27-28
Ostomy Guide.....	29-30
Urological Supply Guide.....	31
FAQ's.....	32
Provider Supply & Order Forms.....	33-41

Dear Provider,

We would like to take this opportunity to introduce you to onehome, your Home Healthcare Provider for Durable Medical Equipment and Infusion Pharmacy.

We are presenting this package to provide you with information regarding our referral process, scope of services provided, ordering requirements and guides, and our commitment to you and our healthcare partners.

We look forward to working with you and your staff in the provision of excellent patient and customer care!

Sincerely,

onehome

Hours of Operation

MONDAY THRU FRIDAY: 8:00 AM – 9:00 PM EST

AFTER HOURS (MONDAY THRU FRIDAY): 9:00 PM –
8:00 AM EST

SATURDAY AND SUNDAY: 9:00 AM – 5:00 PM EST

AFTER HOURS (SATURDAY AND SUNDAY): 5:00
PM – 9:00 AM EST

Contact Numbers

Phone: 1-833-523-2609 | Fax: 1-855-475-5614

onehome's DME and Pharmacy Solution Offers:

- A full range of high-quality and extensive durable medical equipment and infusion services fulfilled directly to your patients homes
- A single point of contact and accountability for all durable medical equipment and infusion services.
- A patient focused process to ensure high quality outcomes from initial order entry through fulfillment to reporting
- Improved service that eliminates duplicity through a streamlined process
- Work flows that allow the fulfillment center or network provider to focus on the delivery of service or care
- Integration of functional areas prior to the physician's order being received at one of our fulfillment centers or network providers
- Care management, pro-active utilization management and guideline driven principles that enhance quality and care continuity
- Real time visibility and transparency of referral orders and the patient care journey through our online portal.
- Knowledge and understanding of health plans and patient needs that create ownership and accountability

Scope of Services: Adults

Durable Medical Equipment	Home Infusion/Specialty Pharmacy
✓ Rehabilitation Equipment	✓ Antibiotic, Antiviral, Antifungal therapy
✓ Respiratory Equipment and Services	✓ Anti-hemophilia Factor
✓ Bariatric Equipment	✓ Anti-tumore Necrosis Factor
✓ Consumable Medical Supplies	✓ Catheter Care
✓ Decubitis Care Equipment	✓ Chemotherapy
✓ Customized Rehabilitation Equipment	✓ Enteral Nutrition
✓ Soft Good Supplies (Ostomy, Colostomy, Urological)	✓ Enzyme Replacement Therapy
✓ Sleep Therapy Equipment	✓ Growth Hormone Therapy
	✓ Hematopoietic Hormone Therapy
	✓ Hydration
	✓ Immunoglobulin Therapy
	✓ Infusion and Injectable Therapy
	✓ Inotropic/Cardiac Therapy
	✓ Interferon
	✓ Pain Management
	✓ Pumps
	✓ Total Parenteral Nutrition

Intake/Admission Process

Our intake team will accept all patient referrals/orders via an online portal, e-script or fax server.

Once a case is assessed by our intake team, and we verify the insurance, your patient's case will be staffed, processed and fulfilled. Equipment will be delivered according to patient and medical necessity needs, and the order time frame will be established according to service standards set forth within our contract.

- Our representatives will contact your office and patients to obtain all personal, demographic, and medical history information.
- Our team will notify you of any missing information or that which needs clarification.
- Our team will contact you when services requested are not covered according to our contract, Medicare, and/or Health Plan Guidelines.
- The onehome team is available 24/7 for questions, concerns, needs, and support of your home healthcare patients.

Infusion and Specialty Pharmacy Services

Scope of Service:

- Anti-Infectives (Antibiotics, Antifungals, and Antivirals).
- Total Parenteral Nutrition (TPN)
- Inotropics
- Pain Management
- Pharmacokinetics Based Dosing
- Lab Monitoring
- Chemotherapy
- Hydration
- Injectables
- Enteral Nutrition
- Anticoagulation
- IVIG/SCIG Therapies
- Anti-Emetics
- Tocolytics
- Hormone Therapies
- Cath Care
- Enzyme Replacement Therapies
- Anti-Tumor Necrosis Factor
- Growth Hormones
- Specialty Infusion and Injectable Medications Used to Treat Disease Management Therapies Such As:
 - ✓ Rheumatoid Arthritis
 - ✓ Hepatitis C
 - ✓ Multiple Sclerosis
 - ✓ Hemophilia
 - ✓ Crohn's Disease/Ulcerative Colitis
 - ✓ Inflammatory Skin Conditions
 - ✓ Sickle Cell Anemia
- Infusion pumps

Note: Therapies provided are dependent upon contractual terms. Please ask your provider services representative for Health Plan Specifics.

Necessary Information Needed for a Clinical Pharmacist to Process a New Referral

- **A COMPLETE order is necessary regardless of place of service:**

- Patient's Name
- Ordering MD with signature
- Date
 - Medication Name, Dose, Frequency, Route of Administration, and duration
 - e.g. Vancomycin 1 gm IV every 12 hours for 6 weeks.
 - Open ended orders accepted
- Verbal orders should state the name of the person that took the order along with date and time
- If patient is discharged from a facility the order or referral should state "Home Health Care."

- **Ordering Physician(s):**

- If the patient is being discharged from hospital, we need to get the name of the ordering MD if it is other than the hospitalist. If patient is on LMWH (Low Molecular Weight Heparin), Cardiologist or the Hospitalist order is acceptable. If multiple physicians are ordering, please list all.
- For a SNF patient, it should either be the facility MD and/or ordering MD (if it is a specialist).
- If patient is at home PCP info is required.
- Phone Number, Fax and NPI should be included for physicians

- **Access Type:**

- Order Referral to indicate: PICC, Port-A-Cath, Midline, Peripheral, IM Sub-Q, Peg-Tube.
- Because there are certain drugs that can only be given via central line and not peripherally a pharmacist may confer with the physician as needed.
- If patient has a central line, CVP is not an option, we will need the correct one number of lumens. Very important for multiple medication orders.
- Please notate IM or Sub-Q and feeding tube for enterals.

- **Diabetic Status:**

- Very important to determine the type of diluent to be used to dispense medication.

- **Height and Weight**

- Used to dose or verify ordered medication dose. Note that many of the medication doses are

based on weight. Most Chemotherapies are based on BSA (Body Surface Area), so height is needed.

- Also Ht. and Wt. is used to calculate CrCl (Creatinine Clearance), which is a way to evaluate renal function.

- **Allergies and First Dose:**

- Before an order is processed, a pharmacist should know what the patient's allergies are to be sure, ordered medication will not result in any harm to patient. If patient has no drug allergies NKDA (No Known Drug Allergies) it does not mean that a patient will not react to medication.
- If patient is allergic to a drug class i.e. Penicillin, and a drug belonging to the Penicillin class is prescribed, a proper documentation needs to be conducted to indicate that either patient has been on the medication before, started therapy already, or that MD is aware of allergy and approved the use of ordered medication.
- If patient has received the ordered medication, we need to know when and where therapy started (i.e. first dose at hospital on 08/01).

- **Diagnosis:**

- We need to obtain the right diagnosis for what is being ordered. This is extremely important for the clinical pharmacist to evaluate the appropriateness of the therapy and to make necessary adjustments based on labs if applicable.
 - Example: A patient is on Vancomycin to treat Osteomyelitis; however, diagnosis documented is Cellulitis. Pharmacist get a trough result of 10, thinks it is therapeutic for Cellulitis and does not make a dose adjustment. However, for Osteomyelitis 10 is sub therapeutic (15-20 is the range), so by getting the wrong diagnosis, we are misleading the pharmacist not to adjust the dose and risking patient to an amputation extended therapy, readmission, etc.

- **Ancillary Providers:**

- Nursing Agency taking care of patient
- SNF (if patient is a resident of one). Please provide Room #

- **Shipping Address:**

- We need to know where the medication is going to be delivered
- If medication is to be delivered to a Dr's. Office or a clinic, accurate address, hours of operation and contact person receiving the medication is required.

- **Insurance (Payor Information):**

- Pharmacy cannot process an order without an insurance company or payor.

- **DOB:**

- To properly evaluate the appropriateness of therapy and its clinical monitoring.

- **Shipping Address:**

- We need to know where the medication is going to be delivered
- If medication is to be delivered to a Dr's. Office or a clinic, accurate address, hours of operation and contact person receiving the medication is required.

- **Contact Information / Emergency Contact:**

Please note below. very important:

- **Last Dose Given:**

- For patients discharged from a hospital, we need to know when the last dose was given to ensure timely delivery for next dose.

- **Medication Profile:**

- This include all active meds, vitamins, over the counter and supplements patient is taking.

We encourage patient/family teaching, along with training and patient independence.



onehome
3351 Executive Way
Miramar, FL 33025

<Provider First and Last Name>
<Provider Address1>
<Provider Address2>
<Provider City>, < Provider State> < Provider Zip>
<Provider Fax>

Notice of Request for Information

Date: 02/28/2022

Dear <Provider First and Last Name>,

This communication is in response to your request for an authorization of service(s) by onehome for:

Member Name: <Member.Firstname> <Member.Lastname>
Member Number: <SubscriberID>

The service(s)/item(s) requested is (are):

Date Request Received	Service Code(s)	Services Requested Descriptions below may have been shortened.	Unit(s) Requested and Unit Type

We are unable to process your request due to the following missing information:

- Member Demographics (Name, DOB, Address)
- Health Plan Information (for new Member)
- Requesting Entity (Hospital, LTAC, IRF, SNF, HHA, Physician, etc.)
- Requesting Provider Information (Address, Phone number, NPI)
- Rendering Provider Information (if a specific rendering Provider is being requested)
- Diagnosis Code(s) (ICD-10) related to authorization request
- Service(s) Requested

Please re-submit the request with the missing information listed above so that we may enter your request. onehome is a subsidiary of Humana.

Please contact us if you have any questions. Thank you.

Sincerely,

onehome
1-855-475-5614

Non-Routine Items: Medical Necessity Documentation Needed

- POC's (Portable Oxygen Concentrators)/ or Extra Battery
- Custom Power Wheelchairs
- Manual Custom Wheelchairs
- Air Fluidized Beds
- Bone Growth Stimulators
- Specific Brand Names that may be outside of our formulary / normally stocked items.
- Over Bed Table
- Bath Bench
- Transfer Bench
- Bathmats
- Elevated Toilets
- Covered items exceeding Medicare/Medicaid Allowable.
- Non DME/HCPC Items (case by case)

Covered and Frequently Utilized Equipment



**Quad Cane
E0105**



**Standard Cane
E0100**



**Walker
E0135**



**Walker with Wheels
E0143**



**Alternating
Pressure Pad
E0181**



**3 Wheel Rollator
E0143**



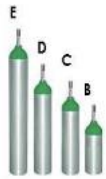
**4 Wheel Rollator
E0143/
E0156**



**3 in 1 Commode
E0163**



**Oxygen
Concentrator
E1390**



Name	Diameter (in.)	Height (in.)	Capacity (liters)	Weight (lb.)**
B or M-6	3.21	11.6	164	2.2
C or M-9	4.38	10.7	255	3.7
D or M-15	4.38	16.5	425	5.3
E or M-24	4.38	34.9	680	7.9

**Portable Tanks (B and
E's)
E0431**



**Liquid Oxygen
with Portable
E0434/E0439**



**Portable Concentrator
E1392**



**Standard
Wheelchair
K0001**



**Electric
Wheelchair
K0823**



**Scooter
K0800**



**Egg Crate Mattress
E0199**



**LIGHT WEIGHT W/C
K0003**



**Heavy Duty
K0006**



**ULTRA LIGHT
WEIGHT W/C
K0005**



**EXTRA HEAVY
DUTY W/C
K0007**



**COMPANION W/C
E1038**



**LOW AIR-LOSS MATTRESS
E0277**



**NEBULIZER
E0570**



**CRUTCHES
E0114**



**FOREARM CRUTCHES
E0110**



**HOYER LIFT (HYDAULIC)
E0630**



**HOYER LIFT (ELECTRIC)
E0635**



**FOAM
E2601**



**GEL CUSHION
E0110**



**GEL OVERLAY
E0185**



**CPAP
E0601**



**CPAP FULL FACE MASK
A7030**



**CPAP NASAL MASK
A7034**



**CPAP NASAL PILLOWS
A7029**



**SEMI-ELECTRIC
HOSPITAL
E0260**



**BI-PAP
E0470**



**Genadyne Woundyac
E2402**



**BI-PAP with Back-up
E0471**

Additional Frequently ordered items

Humidifier	E0562
CPAP Tubing	A7037
CPAP Filter	A7038
Water Chamber	A4604
Tens Unit	E0720
Nasal Cannula	A4615
Heavy Duty Hospital Bed (42 in)	E0303

Medicare Covered and Non-Covered Services

Durable Medical Equipment and Supplies Quick Reference Guide

Some items do not fall strictly under the definition of DME, and are considered to be “supplies.” This list contains both DME items and supplies.

Covered items may be subject to medical necessity review and contract limitations. In addition, some items may require SLR (Second Level Review). Please refer to the NCD and LCD for all covered and non-covered items. Please click on www.cms.gov for NCD or LCD

Description	Code	Policy
Ambulation Aids		
Canes	E0100	Covered, if condition impairs
Crutches	E0110, E0111, E0112, E0113, E0114, E0116, E0117, E0118	Covered Not covered
Quad	E0105	Covered
Walkers	E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149	Covered, if condition impairs ambulation
Bathtub, Bathroom Equipment, Etc.		
Bath Chair	E0240, E0245	Not covered
Bathroom Grab Bars	E0241, E0243, E0242, E0246	Not covered
Bathtub Lifts	E0625	Not covered
Bathtub Rails	E0241, E0242	Not covered
Bathtub Seats	E0240, E0245	Not covered
Toilet Seat	E1399	Not covered
Century Bed Bath	E0235, E1399	Not covered
Cheney Safety Bath Lift	E0625, E1399	Not covered
Eaton E-Z Bath	E0245	Not covered
Raised Toilet Seat	E0244	Not covered
Bathtub, Bathroom Equipment, Etc.		
Tub	E1399	Not covered
Mecalift (patient lift, bathroom or toilet)	E0625	Not covered
Mobile Monomatic Sanitation System	E1399	Not covered
Bath Chair	E1399	Not covered
Raised Toilet Seats	E0244	Not covered

Sauna Bath	E1310	Not covered
Bed Bath	E1399, A9270	Not covered
Sitz Bath	E0160, E0161, E0162	Not covered
Toilet Safety Rails	E0243	Not covered
Toilet Seat Erector	E0244	Not covered
Toilet Seats	E0244	Not covered
Transfer tub rail attachment	E0246	Not covered
Tub chair, stool or bench	E0245	Not covered
Beds, Bed Equipment, Mattresses		
Air Pressure Mattress	E0197	Covered
Alternating Pressure Pads and	E0181, E0182	Covered
Bed Cradles	E0280	Covered
Bed Elevator	E0315	Not covered
Bed Lifter	E0315	Not covered
Bed Pads	A4554	Not covered
Bed Pans	E0275, E0276	Covered if patient is bed confined
Bed Side rails	E0310	Covered, as part of an approved hospital bed
Bed boards	E0273	Not covered
Beds-Lounge (power or manual)	E1399	Not covered
Beds-Oscillating	E0270	Not covered
Clinitron Beds and Similar Air Fluidized Beds	E0194	Not covered
Disposable sheets and bags	A9270	Not covered
Beds, Bed Equipment, Mattresses continued....		
Footboard	E1399	Covered
Hospital bed, institutional type	E0270	Not covered
Bed board	E0273	Not covered
Alternating Pressure Pad	E0185	Covered
Hospital Beds, electric	E0265, E0266	Not covered
Hospital Beds, general	E0250, E0251, E0255, E0256, E0260	Covered
Powered air flotation bed	E0193	Covered
Synthetic sheepskin pad	E0188, E0189	Covered
Lattoflex Spring-base bed	E1399	Not covered
Mattress, inner spring or foam	E0271	Covered as part of an approved hospital bed
Gel pressure pad for mattress	E0185	Covered
Ortho-Prone Bed	E1399	Not covered
Oscillating Bed	E0270	Not covered
Over bed Tables	E0274	Not covered
Powered Air-flotation Bed	E0193	Covered

Powered Pressure-reducing mattress (alternating pressure or low air loss)	E0277	Covered
Select-A-Rest	E1399	Not covered
Powered pressure reducing mattress, with pump	E0181, E0182	Covered
Surgi-Bed	E1399, A9270	Not covered
Trapeze Bar	E0910	Covered
Vasculating Bed	E1399	Not covered
Water and Pressure Pads and Mattresses	E0185	Covered

Breast Related Supplies

Breast Pump	E0602, E0603, E0604	Not covered
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Environmental Control Items

Air Cleaners	A9270, E1399	Not covered
Air Conditioner	A9270, E1399	Not covered
Air Purifier	A9270, E1399	Not covered
Dehumidifiers (room or central system)	E1399	Not covered
Electric Air Cleaner	E1399	Not covered
Electric Air Filter	E1399	Covered, if part of covered equipment (i.e.O2)
Electrostatic Machine	E1399	Not covered
Environmental Control Items	A9270, E1399	Not covered
Fomentation Device	E0238	Not covered
Heating and Cooling Plants	A9270, E1399	Not covered
Heating Pads	E0210, E0215	Not covered
Humidifier (central or room)	A9270, E1399	Not covered
Micronaire Environmental	A9270, E1399	Not covered
Pollen Extractor	A9270, E1399	Not covered
Portable Room Heaters	A9270, E1399	Not covered
Vaporizers	E0605	Not covered

Exercise Equipment and Supplies

Bicycle Ergometer	E1399, A9270	Not covered
Continuous Passive Motion (CPM) Device, Knee	E0935 E0935RR	Not covered (purchase) Covered following total knee arthroplasty (rental)
Continuous Passive Motion (CPM) Device, Other than Knee	E0936	Not covered
Posture Pump Spinal Trainer	E1399	Not covered, convenience item
Pronex (Pneumatic device for clavicle pain)	E1399	Not covered
Pulse Tachometer	99070, E1399	Not covered

Shoulder Pulley	E1399	Not covered
Theraband	99070, A9270, A9300	Not covered, over the counter item
Tilt Table	E1399	Not covered
Traction Equipment, standard	E0830, E0840, E0849, E0850, E0855, E0856	Covered
Training Balls	99070, E1399, A9300	Not covered
Weighted Quad Bood	99070, E1399, A9300	Not covered
Lifts		
Bathtub Lifts	E0625	Not covered
Bed Lifts	E0315	Not covered
Bed Elevator	E0315	Not covered
Safety Bath Lift	E0625	Not covered
Cushion Lift Power Seat	E1399, E0627, E0628, E0629, E2300, E2301	Covered (only the mechanism)
Electric Powered Recliner and Elevating Seat	E1399	Not covered
Elevator	E1399	Not covered
Elevator Chair (not a Stairway Chair)	E1399	Not covered
Hoyer Lift	E0630	Covered
Hydraulic Patient Lift	E0630	Covered
Patient Lifts (i.e., Hoyer)	E0630, E0635	Covered
Seat Lift	E1399	Not covered
Seat Lift Chair Mechanism	E0627, E0628, E0629	Covered (only the mechanism)
Stair glide	E1399	Not covered, see Elevator
Stairway Elevator	E1399	Not covered, see Elevator
Transfer Board or Device	E0705	Covered
Trans lift Chair	E1399	Not covered
Van Lift	E1399	Not covered
Wheel-O-Vator	E1399	Not covered
Respiratory Aids and Supplies		
Air Compressor without Nebulizer	E0565	Not covered, except for patients with a tracheostomy
Bi-PAP	E0470, E0471, E0472	Covered
Concentrator, Oxygen	E1390, E1391, E1392	Covered
C-PAP	E0601	Covered
Nebulizer, w/compressor	E0570	Covered

Face Mask (oxygen)	A4620	Covered
Face Mask (surgical)	A4928	Not covered
Flowmeter	E0440	Covered
LC-3 Oxygen System	E0425, E1399	Not covered
Masks (oxygen)	A4620	Covered
Nebulizer	E0570, E0575	Covered
Nebulizer (Mistogen)	E0585	Covered
Nebulizer w/compressor (i.e., Devilbiss Pulmo-Aide)	E0570	Covered
Nebulizer, Portable	E1399	Covered
Nebulizer, Ultrasonic only	E0575	Covered
Oximeter	E0445	Covered
Oxygen Humidifier	E0550, E0555, E0560, E0561, E0562	Covered
Oxygen Portable Systems	E0430, E0431, E0434, E0435	Covered
Oxygen Regulator	E1353	Covered
Oxygen System	E0424, E0425, E0439, E0440	Covered
Air Filter (for CPAP/BIPAP)	E1399, A7038, A7039	Covered
Postural Drainage Board	E0606	Covered
Suction Pump	E0600	Covered
Ventilators	E0450, E0460, E0461, E0463, E0464	Covered
Toilet Equipment		
Bed Pan	E0275, E0276	Covered, if bed confined
Toilet Seat	E1399, E0244	Not covered
Commodes	E0163, E0165, E0168, E0170, E0171	Covered, if the patient does not have access to regular toilet facilities because he/she is confined to: a single room, or a single level without a toilet, or a home where there is no toilet.
Raised Toilet Seat	E0244	Not covered
Toilet Trainer	E1399, 99070	Not covered
Wheelchairs/Chairs		

3 to 4-wheel scooter and other similar scooters	E1230	Covered
Feeder Seat	E1399	Not covered, convenience item
Rollabout Chairs and Mobile Geriatric Chair	E1031	Covered, if to be used in lieu of a wheelchair
Wheelchairs, Power Operated	Multiple	Covered
Wheelchairs, Standard	Multiple	Covered
Miscellaneous		
Blankets	A9270	Not covered
Catheters and Supplies	A4344, A4346, A4349, A4351, A4352, A4353, A4354, A4355	Covered
Colostomy Bags and Supplies	A4361, A4362, A4363, A4364, A4367, A4405, A4406	Covered
Pessary	A4561, A4562	Not Covered
Pleurx Pleural Catheter and Home Drainage Kit	A7042, A7043	Not Covered
Polarcare	E0218	Not covered, convenience item
Portable Infusion Pumps/Devices	E0781, E0782, A4305, A4306	Covered
Mobile Infusion Pump Ambulatory/Stationary	E0781	Covered
Warm-up Therapy system for wound care	E0217	Not covered
Wigs	A9282	Not covered
Wound Vac	E2402	Covered (Varies per health plan)

Dear Physician,

Below you will find a listing of the HCPCS codes and items that are routinely utilized by CPAP patients. Please ensure that you include all necessary item codes when sending your orders to onehome. It is imperative that you submit the authorization/request appropriately so therapy and equipment orders may be fulfilled in their entirety.

CPAP

Item	Description	Qty
E0601	Cpap, Device	1
A7034	Cpap Nasal Mask	1
A7035	Cpap, Headgear/Each	1
A7037	Cpap Tubing, Long, each	1
A7038	Cpap Filter disposable/each	2
E1499	Cpap carrying case	1
A7027	Combination Oral/Nasal M	1
A7029	Repl Nasal Pillow Comb Mask	1

BiPap

Item	Description	Qty
E0470	Bipap S system	1
A7034	Bipap Nasal Mask	1
A7035	Bipap, Headgear/Each	1
A7037	Bipap Tubing, Long, each	1
A7038	Bipap Filter disposable/each	2
E1499	Bipap carrying case	1

C-PAP/Bi-PAP Order Requirements

NF Settings (cm H₂O) – Remember that the CPAP System requires only one pressure level for therapy, but the Bi-PAP System requires two different pressure levels for therapy.

OF Sleep Study

PF Prescription/Physician orders

QF If a Humidifier is needed the script must identify **heated or non-heated**

- HCPC code for Non-heated is E0561
- HCPC code for Heated humidifier E0562

RF Chin Strap (Optional) HCPC code A7036

SF If a full-face mask is needed HCPC code is A7030

TF The HCPCS for **a Bi-PAP ST with Back up Rate is E0471**

UF When ordering supplies must include the code for replacement of water chamber. A7046
Replacement water chamber for positive airway device.

VF Rx should suggest if nasal mask or nasal pillows.

NMF Rx should state “bleed into oxygen” when necessary.



Physician Office and Patient Acknowledgement Form

Please fax to: 1-855-475-5614

Patient Name: _____ Parent's Name: _____ DX: _____

(If Applicable)

Patient Date of Birth: _____ Insurance ID#: _____ Group# _____

Attestation:

I _____,
 (Office Personnel) (Position)

Certify that our above listed patient has been trained on the below referenced equipment.

X _____
 Office Staff Date

X _____
 Patient Signature/Guardian/Caregiver Date

Items Delivered	Qty
Compressor Nebulizer Serial #	
3-1 Commode	
Walker with Wheels	
Cane	
Quad Cane	
Crutches	
Walker	

PRESCRIPTION

For the use of the prescribing physician only.
 Physician deems dispensing of nebulizer medically necessary to expedite care.

PRESCRIBING PHYSICIAN SIGNATURE:

(Stamped Signature Not Accepted)

X _____

Location Name: _____

Telephone: _____

Location Address: _____

NPI: _____

City: _____

State: _____

Zip: _____

UPIN: _____



Please fax completed form along with Clinical Notes/PMH/Medication Record/Progress Notes/Labs/Tests/PICC Line Record to(onehome#)

Home Infusion Request Form

Date Requested: _____

Date of Service: _____

Patient Demographic Information

Patient Name:	Patient DOB:
Patient Phone:	Patient Address:
Patient Health Plan ID #	Group Number:

Physician Information

Ordering Physician:	NPI:
Contact Phone:	Contact Fax:
Primary Care Physician:	NPI:
Contact Phone:	Contact Fax:

Patient Medical Information

ICD 10 Diagnosis:	Height:	Weight:
Allergies:		
Diabetic: Yes <input type="checkbox"/> No <input type="checkbox"/>	First dose given: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Clinical Notes/PMH/Medication Record/Progress Notes/Labs/Tests/PICC line record attached <input type="checkbox"/>		
Access type:		

Medication Orders

Indicate medication name, dose, frequency, route, and length of therapy (duration)

Medication Name	Dose	Frequency	Route	Duration (Length of Therapy)

Ancillary orders – Home Health

SN Assess/Administer and/or teach self-administration where appropriate.

Other (please specify): _____

Skilled Nursing Facility Patients Only

SNF Name:	SNF Contact:
SNF Phone:	SNF Fax:

Physician Signature: _____ Date _____

<p>OXYGEN (Gas) Need script or orders to state:</p> <ul style="list-style-type: none"> • Concentrator LPM (liters per minute) • Nasal Cannula (N/C) Mask • Humidifier • Frequency (PRN/Continuous/At night) 	<p>All patients get a Concentrator which plugs into an outlet in the home. These patients also get tanks to take with them and move about in the home. Some patents require a Portable Oxygen Concentrator for travel, and they are small and need Medical Director Approval/Second, Level Review, Clinical Documentation and authorization.</p> <ul style="list-style-type: none"> • Saturation needs to be below 88% (Second Level Review if saturation not below 88%)
<p>Liquid Oxygen</p> <ul style="list-style-type: none"> • Different than gas (concentrator and tanks) and needs a prescription specifying LIQUID OXYGEN. 	<p>They are stationary units called RESERVOIRS and get filled weekly or depending on patients use. With the stationary Reservoir comes a portable, usually an H300/Helios or Marathon. Needs Medical Necessity Documentation and Review.</p>
<p>Foley Supplies</p> <ul style="list-style-type: none"> • Catheters (14FR-22FR) • Bags / Leg Bags • Lubricant • Gloves 	<p>Used for patients who are unable to pass urine on their own. Need to be catheterized, either continuously (foley or sporadically/intermittent (Self cath/Straight cath).</p>
<p>CPAP and BiPAP Continuous Positive Airway Pressure/Bi-level positive airway pressure)</p> <ul style="list-style-type: none"> • CPAP Mask: Small, Medium, Large (Masks are used for months at a time). Medicare limitations, 1 every 3 months. Need type. • Headgear, need size (Nasal Pillows/Full Mask) <p>Visit to be performed by a Respiratory Therapist. RT sets up and instructs on the machine and "FITS" the patient properly for the mask and necessary supplies.</p>	<p>CPAP's and BiPAP's used for those with Sleep Apnea. This is when patients stop breathing in their sleep. It causes unhealthy, disruptive sleep patterns and can even cause death. The machine forces air through the patient's airway at all times to ensure proper breathing, and better sleep.</p> <ul style="list-style-type: none"> • Doctor's orders must include settings, pressure, Script with Diagnosis, and Sleep Study. <p>IF OXYGEN BLEED IN: LPM a must or O2%.</p> <p>Patients are usually sent for a sleep study to assess their specific needs. We do need a copy of the sleep study.</p>

<p>Tracheostomy Care Adult/Pediatric/Neonatal</p> <ul style="list-style-type: none"> • Suction Catheters (6FR – 16FR) Trach Care Kits • Trach Tube Holders • Trach Mask Yankauers • 50 psi Compressor/Humidity • Large Nebulizer Bottles • Spare Trach Tube/ Inner Cannulas • O2 Adapter/O2 Connection Tubing 	<p>Used for patients who have had a tracheostomy/TRACH.</p> <p>A tracheostomy is the surgical construction of an opening in the trachea, usually by making an incision in the front of the neck, for the insertion of a catheter or tube to facilitate breathing.</p>
<p>Suction Pump: Adult</p> <ul style="list-style-type: none"> • Suction Catheters • Suction Tubing • Suction Canisters 	<p>Used for those with trachs or vent patients. Used to clear the airway. These are very important and are to be treated with urgency. Breathing can be blocked if patient is not suctioned.</p> <p>There are Portable and Stationary Units.</p>
<p>Nebulizers: Adult/Pediatric Neb Kit/Mask</p>	<p>Used frequently for patients who need breathing treatments either chronic or acute. Bronchitis, Asthma, etc. Need same day delivery. Also, in our consignment closets for easy patient access. (See consignment process/program info. Pg. 18-19)</p>
<p>Diabetic/Insulin Pumps and Supplies</p>	<p>Need to know items type and quantities needed. (i.e., Quick Set – MMTxxx, Reservoir type and quantities).</p>
<p>Continuos Passive Motion Device (CPM)</p>	<ul style="list-style-type: none"> • Utilized After lower extremity surgeries. • Need script to state settings. (i.e., 90 degrees flexion and 50 degrees knee extension. -60, -20)
<p>Power Operated Vehicles (POV) /Custom Equipment</p>	<p>Need prescriptions, physician face to face, CMN, Physical Therapy Assessment, Measurements, and Health Plan Approval. Submission Timeframe Critical</p>

Ostomy Guide/Standard Ostomy Items with Medicare Allowable

Please note that the Medicare allowable is indicated below. If patient requires additional supplies more than Medicare allowable, clinical documentation is required. Please attach to order.

Supplies	HCPC Codes	Item #'s/REF	Allowable for month
<u>Pouches for a 2-Piece system</u>			
Drainable 12 inch	A5063		20
Drainable 10 Inch	A0563		20
Drainable 6 Inch	A5063		20
Closed with Filter	A5054		20
Closed No Filter	A5054		20
Urostomy with flip flow valve	A5073		20
Other:			
<u>Water for 2-Piece System</u>			
Standard wear with flexible tape collar	A4414		20
Standard wear without tape collar	A4414		20
Extended wear with flexible tape collar	A4414		20
Extended wear without flexible tape collar	A4414		20
Extended wear with convexity	A4414		20
Other:			
<u>1 Piece System</u>			
1 Piece drainable pouch 12-inch	A5061		20
1 Piece drainable 6-inch	A5061		20
1 Piece closed pouch with filter	A5051		60
Stoma Cup	A5055		60
Misc Supplies	HCPC Codes	Item #'s/REF	Allowable for month
Paste 2 oz tube	A4364		
Comfortable Seal	A4385		
Convex Insert	A5093		
Deodorant 8 oz	A4395		
Belt	A4367		
Skin Barrier Wipes	A5120		
Adhesive Remover	A4456		

Beadside Drain Bag	A4357		
Tape, Waterproof or Non-Waterproof	A4450		
Gauze, non-sterile, urostomy only	A6402		
Foley Catheter	A4338		
Other:			

Urology Supply Guide

Please note that the Medicare allowable is indicated below. If patient requires additional supplies more than Medicare allowable, clinical documentation is required. Please attach to order.

Urology Supplies Requested	HCPC Codes	Allowable Per Month	Quantity Needed
Male External Cath Self Adhesice 28mm 31mm 33mm 35mm 40mm	A4349	35	
Intermittent Catheter (Each) Red Rub Plastic FR.	A4351	Up to 200	
Self-Cath (Changes per day) FR.	A4353	Up to 200	
Coude Tip Cath (Changes per day) FR.	A4352	Up to 200	
Foley Catheter Silicone Coated (each) 5cc 30cc FR.	A4338	2	
Foley Insertion Tray (Each) 10cc 30cc	A4310	2	
Lubricant	A4320	2	
Bedside Drainage Bag (Each) 2000cc	A4357	2	
Leg Bag (Each) Sm Md Lg	A4358	2	
Irrigation Tray Kit	A4320	2	
Adhesive Remover Wipes (Box)	A4456	2	
Skin Prep Wipes (Box)	A5120	2	
Other Supplies Requested			

Frequently Asked Questions

For Frequently Asked Questions Please Visit:

www.onehome.health/for-providers

Prior Authorization DME Request Form



Date Requested:

Date of Service:

<input type="checkbox"/> Standard Request	<input type="checkbox"/> Expedited Request I Certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Provider signature Required: _____ Date _____
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Patient Name:	Ordering Provider:
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Patient Health Plan ID #	Service Provider:
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Patient birthdate:	Contact Name:
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ICD 10 Diagnosis:	Contact Phone: _____ Fax: _____
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Height: ____ Feet ____ Inches Weight: ____ Lbs.	Complete only if ordering one of these items: Platform Walker: <input type="checkbox"/> Right <input type="checkbox"/> Left Air Cushion: Length: _____ Width: _____ # Valves: <input type="checkbox"/> Single <input type="checkbox"/> Double Profile: <input type="checkbox"/> High <input type="checkbox"/> Low CPM: Full Leg Height _____ Speed _____ Angular limits(degrees) _____ Lymphedema Pump: Extremity: <input type="checkbox"/> Full Arm <input type="checkbox"/> Full Leg <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
--	--

Check DME Type	
<input type="checkbox"/> Purchase	<input type="checkbox"/> Rental: Rental Start date: _____ Rental End date: _____

Other DME		
Equipment	HCPCS	Quantity

Please fax/email completed form along with Supporting Clinical to include Physician Order and Letter of Medical Necessity.

Physician Signature: _____ Date: _____

Prior Authorization PAP Device Request Form



<input type="checkbox"/> Standard Request	<input type="checkbox"/> Expedited Request I Certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Provider Signature: _____ Date: _____
Patient Name:	Ordering Provider:
Patient Health Insurance ID #	Service Provider:
Patient birthdate:	Contact Name:
ICD 10 Diagnosis:	Contact Phone: _____ Fax: _____
Height: ____ Feet ____ Inches Weight: ____ Lbs.	<input type="checkbox"/> E0470 BiPAP w/o B/U Rate
Estimated Length of time needed: _____	<input type="checkbox"/> E0471 BiPAP S/T w/ B/U Rate
<input type="checkbox"/> CPAP @ ____ cm H ₂ O	<input type="checkbox"/> E0562 Hum Heated
<input type="checkbox"/> Auto CPAP@ ____ Min ____Max cm H ₂ O	<input type="checkbox"/> E0601 CPAP/Auto CPAP Device
<input type="checkbox"/> BiPAP@ ____I/____E cm H ₂ O	<input type="checkbox"/> A7034 Nasal Pillows
<input type="checkbox"/> BiPAP S/T@ ____I/____E cm H ₂ O with ____BPM	<input type="checkbox"/> A7030 Full Face Mask
<input type="checkbox"/> O ₂ Bleed in @ ____LPM	<input type="checkbox"/> A7034 Nasal Mask
<input type="checkbox"/> VPAP Auto (RESMED)@ ____IPAP Max, ____EPAP Min	<input type="checkbox"/> A7036 Chin Strap
_____Pressure Support	<input type="checkbox"/> E0470 PiPAP Auto/VPAP Auto
<input type="checkbox"/> BiPAP Auto (Respironics)@ ____IPAP Max,	
EPEP Min _____PS Max, _____PS Min	
1. Is the device being ordered for treatment of obstructive Sleep Apnea?	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Date of Initial face to face eval	____/____/____
3. Enter date of sleep test	____/____/____
4. Was sleep test conducted in facility-based lab?	<input type="checkbox"/> Y <input type="checkbox"/> N
5. What is patients AHI or RDI?	_____
6. Does patient have at least one of the following: excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease or history of stroke?	<input type="checkbox"/> Y <input type="checkbox"/> N
7. If bilevel device is ordered, has CPAP device been tried and found ineffective?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D
RECERTIFICATION ONLY	
1. Enter date of follow up face to face eval	____/____/____
2. Is there a report documenting patients used PAP at least 4 hours per night on 70% of nights in 30 consecutive day period?	<input type="checkbox"/> Y <input type="checkbox"/> N

3. Did the patient demonstrate improvement in symptoms of OSA with use of PAP?

Y N

Please fax/email completed form along with Supporting Clinical to include Physician Order and Letter of Medical Necessity.

Please note: Prescription is valid for one year from signature date unless order changes.

Date Requested:

01/2022

Date of Service:

Physician Signature: _____ Date _____

Prior Authorization POV Request Form



Date Requested:

Date of Service:

<input type="checkbox"/> Standard Request	<input type="checkbox"/> Expedited Request I Certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Provider signature Required: _____ Date _____
Patient Name:	Ordering Provider:
Patient Health Plan ID #	Service Provider:
Patient birthdate:	Contact Name:
ICD 10 Diagnosis:	Contact Phone: _____ Fax: _____
Height: ____ Feet ____ Inches Weight: ____ Lbs.	Certification Date: __/__/____ <input type="checkbox"/> Initial <input type="checkbox"/> Revised Face-to-Face visit date: ____/____/____
A. Does the patient have a mobility limitation that prevents, significantly impairs, or substantially delays his/her ability to participate in one or more mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
B. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
C. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
D. The beneficiary is able to: <ul style="list-style-type: none"> <input type="checkbox"/> Safely transfer to and from a POV, and <input type="checkbox"/> Operate the tiller steering system, and <input type="checkbox"/> Maintain postural stability and position while operating the POV in the home. 	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
E. The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
F. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
G. The beneficiary's weight is less than or equal to the weight capacity of the POV that is provided and greater than or equal to	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA

95% of the weight capacity of the next lower weight class POV – i.e., a Heavy Duty POV is covered for a beneficiary weighing 285 – 450 pounds; a Very Heavy Duty POV is covered for a beneficiary weighing 428 – 600 pounds.	
H. Use of a POV will significantly improve the beneficiary’s ability to participate in MRADLs and the beneficiary will use it in the home. The beneficiary has not expressed an unwillingness to use a POV in the home.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
I.) The beneficiary has not expressed an unwillingness to use a POV in the home.	<input type="checkbox"/> Y <input type="checkbox"/> N

DME Equipment		
Equipment	HCPCS	Quantity

Please fax/email completed form along with Supporting Clinical to include pertinent mobility/ADL issues, Balance and stability concerns, pertinent global health concerns and any special or unique considerations.
Approval is based on provider attestation that the patient is physically unable to manage the mobility requirements with a manual w/c, that UE and LE mobility restrictions are supported by medical record documentation, PMD is medically necessary, and that CMS guidelines for the medical necessity of the POV have been applied, periodically reviewed and are documented consistently.

Physician Signature: _____ Date _____

Prior Authorization PWC Request Form



Date Requested:

Date of Service:

<input type="checkbox"/> Standard Request	<input type="checkbox"/> Expedited Request I certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Provider signature Required: _____ Date _____
Patient Name:	Ordering Provider:
Patient Health Plan ID #	Service Provider:
Patient Birthdate:	Contact Name:
ICD 10 Diagnosis:	Contact Phone: _____ Fax: _____
Height: ____ Feet ____ Inches Weight: ____ Lbs.	Certification Date: __/__/____ <input type="checkbox"/> Initial <input type="checkbox"/> Revised Face-to-Face visit date: ____/____/____
<p>A power wheelchair is covered if:</p> <ul style="list-style-type: none"> a. All of the basic coverage criteria (A-C) are met; and b. The beneficiary does not meet coverage criterion D, E, or F for a POV; and c. Either criterion J or K is met; and d. Criteria L, M, N, and O are met; and e. Any coverage criteria pertaining to the specific wheelchair type (See LCD L33789) are met. 	
A. Does the patient have a mobility limitation that prevents, significantly impairs, or substantially delays his/her ability to participate in one or more mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
B. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
C. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
D. The beneficiary is able to: <ul style="list-style-type: none"> ○ Safely transfer to and from a POV, and ○ Operate the tiller steering system, and ○ Maintain postural stability and position while operating the POV in the home. 	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA
E. The beneficiary's mental capabilities (e.g., cognition, judgment)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA

Prior Authorization Respiratory Devices Request Form

Date Requested:

Certification Date:

Initial

Revised Recertification

<input type="checkbox"/> Standard Request	<input type="checkbox"/> Expedited Request I Certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Provider signature: _____ Date: _____
Patient Name:	Ordering Provider:
Patient Health Insurance ID #	Face to Face Visit Date (within 30 days prior to initial Certification):
Patient birthdate:	Contact Name:
ICD 10 Diagnosis:	Contact Phone: _____ Fax: _____
Height: ____ Feet ____ Inches Weight: ____ Lbs. Length of time needed(#Months): _____ Oxygen/Portable Oxygen Concentrator: Oxygen Flow: <input type="checkbox"/> Continuous <input type="checkbox"/> Pulse Oxygen Route: _____ Hours of Use: _____ Apnea Monitor: Heart Rate High _____ Heart Rate Low _____ Apnea Delay: _____ Pediatric Oximeter: Heart rate: High _____ Low _____	<input type="checkbox"/> Oxygen Concentrator HCPCS: _____ <input type="checkbox"/> Portable Oxygen Concentrator HCPCS: _____ <input type="checkbox"/> Apnea Monitor HCPCS: _____ <input type="checkbox"/> Pediatric Oximeter HCPCS: _____ <input type="checkbox"/> Supplies HCPCS: _____ HCPCS: _____ HCPCS: _____ HCPCS: _____ HCPCS: _____ HCPCS: _____
Oxygen/Portable Oxygen Concentrator Medical Necessity Criteria (Group I Criteria-Recertification-12 months after initial certification)	
1.) Enter the results of recent test taken on or before the certification date listed above. A.) Arterial blood gas PO2 and/or B.) oxygen saturation test. C.) Date of test (most recent study obtained within 30 days prior to date of initial Certification).	A: _____ mmHg B: _____ % C: ____/____/____
2.) Was the test in Question 1 performed? A.) with the patient in a chronic stable state as an outpatient B.) within 2 days prior to discharge from inpatient facility to home, OR C.) under other circumstances?	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
3.) Check the one letter for the condition of the test in Q 1: A.) at rest; B.) during exercise; C.) during sleep	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
4.) If you are ordering portable oxygen, is patient mobile within the home and a qualifying blood gas study performed while awake?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A Qualifying Sat: awake(at rest) _____ During Exercise: _____
5.) Enter the highest oxygen flow rate ordered for this patient in liters per minute.	_____ LPM
6.) If greater than 4 LPM is prescribed, enter results of recent	A: _____ mmHg

test taken on 4 LPM. This may be an: A.) arterial blood gas PO2 and/or B.) oxygen saturation test with patient in a chronic stable state. C.) enter date of test	B: _____% C: ____/____/_____
Answer Questions 7-9 only if PO2 = 56-59 or oxygen saturation =89 in Question 1 (Group II Criteria-Recertification- 3 months after initial certification)	
7.) Does the patient have dependent edema due to congestive heart failure?	<input type="checkbox"/> Y <input type="checkbox"/> N
8.) Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an Echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?	<input type="checkbox"/> Y <input type="checkbox"/> N
9.) Does the patient have a hematocrit greater than 56%?	<input type="checkbox"/> Y <input type="checkbox"/> N
Please fax/email completed form along with Supporting Clinical Documentation to include Physician Order and Letter of Medical Necessity. Please note: Prescription is valid for one year from signature date unless order changes.	

Physician Signature: _____ Date_____