

Use of this template is voluntary / optional

Home Oxygen Therapy

Laboratory Test Results Template Guidance

Purpose

This template is designed to assist a clinician in documenting pertinent and essential information regarding “Home Oxygen Therapy Laboratory Test Results” to meet requirements for Medicare beneficiary coverage for home oxygen therapy. This template is available to the clinician and can be kept on file with the patient’s medical record or can be used to develop a laboratory test results template for use with the system containing the patient’s electronic medical record.

Patient eligibility

Eligibility for coverage of home oxygen therapy under Medicare requires the ordering physician or allowed Non-Physician Practitioner (NPP)¹ to complete a Certificate of Medical Necessity (CMN), OBM Form CMS-484, to establish that coverage criteria are met. This helps to ensure the oxygen equipment and services to be provided are consistent with the physician’s prescription and supported in the patient’s medical record.

Completing the “Home Oxygen Therapy Laboratory Test Results Template” does not guarantee eligibility and coverage but does provide guidance in support of home oxygen therapy equipment and services ordered and billed to Medicare. This template may be used with the “Home Oxygen Therapy Order Template” and “Home Oxygen F2F Encounter Template”.

Oxygen testing timing requirements

For arterial blood gas measurement or oximetry – O₂ saturation

- Initial Certification Testing: (See Appendix A for “Covered Blood Gas Values”)
 - Within 2 days prior to dismissal from an acute inpatient hospitalization when ordering home oxygen therapy for a patient who is transitioning to a different level of care
 - Within 30 days prior to the start of home oxygen therapy.
- Retesting for Recertification:
 - Group I Criteria – Within or by the end of the 12 month after the start of home oxygen therapy – Initial Certification Date
 - Group II Criteria – Between the 61st and 90th day from the start of home oxygen therapy - Initial Certification Date
 - Group III Criteria – this includes beneficiaries with arterial PO₂ levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent. For these beneficiaries, there is a rebuttable presumption of non-coverage.

¹ A Medicare allowed NPP as defined is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861 (aa) (5) of the Social Security Act) who is working in accordance with State law.

Who can complete the Home Oxygen Therapy Laboratory Test Results Template?

- Physician / NPP who performed the test, or a
- Medicare allowed provider or supplier of oxygen laboratory testing services.

Note: If the laboratory test results template is used:

1) CDEs in black Calibri are required

2) CDEs in *burnt orange Italics Calibri* are required if the condition is met

3) CDEs in *blue Times New Roman* are recommended but not required

Version R4.0

Appendix A -- Covered Blood Gas Values

For Initial Certifications, the patient's blood gas study (either an arterial blood gas or an oximetry test) values meet all requirements for one of the following criteria:

Group I criteria: (Must meet one or more of the following test results.)

- Patient tested at rest (awake) on room air:
 - Arterial oxygen saturation is at or below 88%; or
 - Arterial partial pressure of oxygen (PO₂) is at or below 55 mm Hg; or
- Patient tested during sleep on room air: (See Appendix A)
 - Arterial PO₂ < 55 mm Hg or an arterial oxygen saturation < 88 percent; taken during sleep;
 - For a patient who demonstrated arterial PO₂ > 56 mmHg while awake, or arterial O₂ saturation > 89% while awake, or
 - A greater than normal decrease in O₂ level during sleep (a decrease in arterial PO₂ > 10 mm Hg, or decrease in arterial O₂ saturation > 5% from baseline saturation).
 - More than 5% for at least 5 minutes, and
 - Associated with symptoms or signs consistent or attributed to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia), **or**
- Patient tested during exercise on room air:
- Patient demonstrates an arterial PO₂ > 56 mm Hg or arterial O₂ saturation > 89%, during the day at rest; and
- Demonstrates a decrease with exercise in arterial PO₂ < 55 mm Hg or an arterial oxygen saturation < 88 percent; and
- Documented evidence of improvement of hypoxemia during exercise with application of supplemental oxygen.

Group II Criteria:

- Coverage is available, (except for patients with variable factors affecting blood gas values as listed below), for patients whose arterial PO₂ is 56-59 mm Hg or whose arterial blood oxygen saturation is 89% at rest while awake, during sleep for at least 5 minutes in total, or during exercise provided there is evidence of:
 - Dependent edema suggesting congestive heart failure;
 - 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 AVFL; or
 - Erythrocythemia with a hematocrit greater than 56%.

Group III criteria (NOT COVERED):

- Arterial oxygen saturation at or above 90 percent; or
- Arterial PO₂ at or above 60 mm Hg.

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Home Oxygen Therapy Laboratory Test Results Template
Patient information: Last name: _____ First name: _____ MI: _____ DOB (MM/DD/YYYY): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other Medicare ID: _____
Provider (physician/NPP) who is performing the face-to-face evaluation: Last name: _____ First name: _____ MI: _____ Suffix: _____ NPI: _____ Date of face-to-face evaluation (MM/DD/YYYY): _____
Date of testing (MM/DD/YYYY): _____
Person or entity performing testing (e.g. IDTF): Laboratory: _____ NPI: _____ Name of Tester: _____ Tester Credentials: _____
Was the patient receiving oxygen while the test was being performed? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If Yes: Flow rate: ____/____ (LPM/Oxygen %)</i> <i>Means of oxygen delivery: <input type="checkbox"/> Nasal cannula <input type="checkbox"/> Non-rebreather <input type="checkbox"/> Ventilator</i> <i><input type="checkbox"/> Mask <input type="checkbox"/> Other _____</i>
One or more of the following tests/studies is required
<i>Arterial Blood Gas (at rest): PH: _____ PaCO₂: ____ mmHg O₂ Sat: _____%</i> <i>HCO₃: _____ mmol/L Hematocrit: _____ % PaO₂: _____ mmHg</i>
<i>Pulse oximetry at rest/awake on room air: O₂ Sat: _____%</i>
Exercise O₂ test: <i>Oxygen saturation results at rest without oxygen: O₂ Sat: _____%</i> <i>Oxygen saturation results during exercise without oxygen: O₂ Sat: _____%</i> <i>Oxygen saturation results during exercise with oxygen applied: O₂ Sat: _____%</i> <i>Flow Rate: ____/____ (LPM/oxygen %)</i>
<i>Overnight oximetry results (while asleep and on room air): O₂ Sat: _____%</i> <i>(lowest value with total aggregate duration of no less than five (5) minutes during testing)</i>
Signature, name, date completed and NPI Signature: _____ Name (Printed): _____ Date (MM/DD/YYYY): _____ NPI _____