



REVISITING QUALIFICATIONS FOR HOME OXYGEN

by *Kenneth A. Wyka, MS, RRT, FAARC*

Every now and then, it's a good idea to revisit and look at something we all tend to take for granted. In home care, this would be the Centers for Medicare and Medicaid Services (CMS) qualifications for home oxygen therapy. You know, the need for an O₂ saturation < 88% to qualify for home oxygen. But, before I go further, a bit of good news for the home care industry and Medicare beneficiaries regarding oxygen in the home setting.

On July 15, 2008, President Bush vetoed HR 6331 which had previously passed both House and Senate by significant margins. Before any response could be mounted by the AARC, the home care industry, RTs in general and patients; Congress overturned the veto on the very same day. Yes, both House and Senate. Key elements in this piece of legislation included a reimbursement mechanism for pulmonary rehabilitation, a delay in the implementation of the national competitive bidding initiative and an end to patient ownership of their long term oxygen therapy (LTOT) equipment after 36 months.

This equipment will still have a capped rental after this 36 month period, but home care providers (HCPs) will receive a fee every 6 months to maintain and service the equipment they have in each patient's home. What happens regarding providing portable O₂ is still up in the air but at least Medicare beneficiaries won't have to be concerned about owning and maintaining their home oxygen units. The capped rental provision will take effect beginning January 1, 2009. For patients and the home care industry alike, it was a tough battle but in the end, we can all say we won one.

With that put aside, qualifications for home oxygen are basically the same except for a few areas that require attention and need to be reviewed. Everyone is familiar with the primary diagnoses that qualify patients for home O₂. They include COPD, diffuse interstitial lung disease, bronchiectasis, cystic fibrosis and pulmonary neoplasm (primary or metastatic). Hypoxia-related conditions that may improve with oxygen therapy are pulmonary hypertension, recurring CHF due to cor pulmonale, erythrocytosis or polycythemia (Hct > 56%), cognitive impairment, nocturnal restlessness and morning headache. Non-covered conditions include angina pectoris, dyspnea without cor pulmonale or evidence of hypoxemia, severe peripheral vascular disease resulting

in desaturation in the extremities and terminal illness that does not affect the lungs.

To qualify, patients need to demonstrate a specified degree of hypoxemia. For Group I patients this means an O₂ saturation < 88% or an arterial pO₂ < 55 torr. For Group II patients, this is an O₂ saturation of 89% or an arterial pO₂ between 56-59 torr as long as they also have a secondary diagnosis of either pedal edema, polycythemia, a history of CHF or "p pulmonale" (an elevated p wave > 3 mm in lead II, III or AVF that is associated with cor pulmonale). Group II patients must also be retested within 61 to 90 days after institution of oxygen therapy. Patients with an O₂ saturation > 90% or an arterial pO₂ > 60 torr usually do not qualify, even with exhaustive physician or healthcare provider documentation. Qualifying tests must be done within 48 hours of discharge from an acute care facility or within 30 days if the patient is stable and was tested as an outpatient at either a provider's office or clinic. Also, saturations from overnight pulse oximetry only qualify the patient for nocturnal oxygen; not for any portables. This is another situation that requires attention and proper documentation. When delivering a pulse oximeter for nocturnal testing, the HCP is not allowed to coach the patient in any way regarding the testing procedure or use of the equipment. Home care companies simply deliver and pick-up the oximeter and download the data. The IDTF prepares the report and sends it to the prescribing healthcare provider. It is only after the report is sent that the HCP is notified regarding the results.

As for portable oxygen, there are qualifications that sometimes slip through the cracks but RTs

continued on next page

For patients and the home care industry alike, it was a tough battle but in the end, we can all say we won one.



"I may be going to prison. Other than that, it's business as usual."

need to be aware of. First, a portable system must complement a stationary system and must be prescribed for use within the home setting with a prescribed exercise regiment or level of physical activity. Portable O₂ is not intended as a convenience for shopping, visiting family or making healthcare provider office visits. Home care companies do not make the rules or write the regulations but they must abide by them.

To qualify for a portable system, an oxygen saturation must be taken at rest and on room air followed by an ambulatory saturation on room air and then a recovery saturation with the patient on oxygen. All of the above saturations must be documented on the prescription along with the route of O₂ administration, prescribed liter flow, frequency of use (hours per day or minutes per hour if applicable and please note that prn is not acceptable), duration of need (number of months) and patient diagnosis. This recovery saturation appears to be one area that healthcare providers are not documenting on a regular basis and should. While home care companies are now allowed to offer overnight pulse oximetry as long as an independent testing facility (IDTF) is utilized, the evaluation for portable oxygen can only be conducted by personnel not affiliated with any home care company.

Another area of concern pertaining to portable oxygen is evaluating and dispensing oxygen conserving devices (OCDs). Depending on state law, the script for this type of service may need to indicate that the evaluation be conducted using pulse oximetry. While pulse oximetry is implied as the evaluation mode, in some states it must be specified. Some companies indiscriminately set-up their patients on a conserving device without any evaluation. This is not a good idea and is not safe patient practice. Patients need assessment regarding their ability to tolerate an OCD plus handle and maintain the equipment.

The type of oxygen system should also be noted on the prescription. This is usually overlooked by the physician or healthcare provider and constitutes another one of those gray areas when it comes to prescribing home oxygen. In most cases, an oxygen concentrator is usually implied unless a liquid oxygen system or cylinder oxygen is specifically requested. Another area pertaining to patient qualification is when patients need liter flows > 4 LPM. In this particular case, the patient needs to be placed on 4 LPM of oxygen and a saturation documented. The rationale here is to demonstrate that 4 liters of oxygen is not sufficient and that the patient does, in fact, require higher liter flows.

While qualifications for home oxygen are basically the same with little change over the past few years, there are those areas pertaining to nocturnal oxygen, portable systems and higher liter flows that HCPs need to pay more attention to. It is also recommended that they communicate this information to their referral sources. With a greater understanding of what is required on the oxygen prescription, insurance reimbursement to HCPs will be less problematic, there will be less confusion overall and this will ultimately result in more efficient and effective patient care in the home environment.

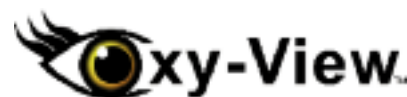
Ken Wyka RRT is a veteran therapist, author and lecturer. He is also a clinical specialist for the Home Therapy Equipment Corporation of Clifton Park, NY



Join us May 14-16, 2009 in Orlando
for the 9th Annual Focus Conference
at Disney's Coronado Springs Resort

Oxygen Therapy For The 21st Century.

by



Innovative
eyewear for
patients requiring
continuous
supplemental
oxygen.



Call today to find out more about
Oxy-View oxygen therapy eyewear.
877-699-8439

Oxy-View, Inc.
109 Inverness Drive East, Englewood, Colorado 80112
P. 877-699-8439 www.oxyview.com F. 303-790-4588

CIRCLE READER ACTION CARD # 24



**Transtracheal Systems the world
leader in SCOOP Transtracheal Oxygen
Therapy since 1986.**

Scientifically validated in medical literature.

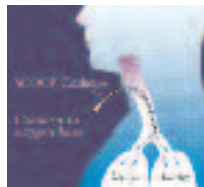
Thousands of satisfied patients, RT's,
and physicians.

Cost effective, revenue enhancing
program for hospital RT department.



Complete line of accessories to optimize the T₂O₂
experience.

On-site in-service available.



What are you waiting for?
Get the SCOOP!

For more information call: 800-527-2667
ext. 202 or e-mail drscoop@tto2.com

CIRCLE READER ACTION CARD # 25