

## **Further Recommendations for Prescribing and Supplying Long-Term Oxygen Therapy. 1987**

### **Recommendation 1:**

For the purposes of LTOT, the definition of the term “ambulation” should be expanded to include all activities requiring mobility beyond the delivery range of a stationary oxygen source (up to 50 feet of oxygen tubing).

### **Recommendation 2:**

The medical standard for LTOT should be continuous administration (24 h/day) with ambulatory capability.

### **Recommendation 3:**

Exceptions to continuous administration with ambulatory capability (e.g. a portable oxygen source) should be specified and would be expected to include (1) patients who are not capable or desirous of activity beyond the delivery range of a stationary oxygen source; (2) patients requiring oxygen only during sleep; (3) patients requiring oxygen only during ambulation; (4) patients who prove to be noncompliant with prescribed therapy and in whom it is demonstrated repeatedly that the portable oxygen source is not being used.

### **Recommendation 4:**

Initial documentation of the medical necessity for LTOT should consist of an arterial blood gas measurement performed when the patient is stable and receiving optimal medical management and analyzed by a duly approved laboratory (e.g. American Thoracic Society, College of American Pathologists, Joint Committee on Accreditation of Healthcare Organizations, etc).

Oximetry is recognized as an appropriate and acceptable methodology for documenting hypoxemia during activity and sleep. It is also an acceptable follow-up methodology for evaluating and monitoring LTOT. The need for continued use of LTOT should be verified on an annual basis by the patient's physician.

### **Recommendation 5:**

The physician should prescribe the oxygen source (such as compressed gas, liquid oxygen, or concentrators) and must also prescribe the delivery device (such as continuous nasal cannula, transtacheal administration, reservoir nasal cannulas, pulse-dose oxygen administration and demand valve) based on the most appropriate therapeutic regimen for each individual patient. The liter flow to correct hypoxemia must be specified by the physician.

**Recommendation 6:**

Once a hospitalized patient is identified as needing home oxygen therapy, transfer to the home setting should include, but not limited to (1) whether the patient should be given oxygen en route from hospital to home (to be determined by the physician), and (2) adequate instruction and familiarization of the patient (and his/her family) with the oxygen equipment prior to discharge and upon arrival home.

**Recommendation 7:**

Equipment maintenance is best handled by close adherence to the manufacturer's recommendations for each specific item of equipment. Therefore, it is important that (1) manufacturers always provide, coincident with the market introduction of any new equipment, comprehensive maintenance and repair instructions appropriate to the nature and anticipated level of field service of the equipment, and (2) such instructions to be kept up to date as design modifications are made.

**Recommendation 8:**

Clinical evaluation should include regular assessments of patient compliance with prescribed therapy, potential complications, potential hazards, and the need for continued education. Patients receiving LTOT share responsibility with the prescribing physicians for remaining in communication with their physician or designate in order to assure continued appropriate care for their condition.

**Recommendation 9:**

For patients receiving LTOT, routine measurement of their arterial blood gasses or oxygen saturation in the home environment is not necessary; however, such measurements may be useful in-patients found to be clinically unstable. Furthermore, the physician continues to have the responsibility of documenting the efficiency and safety of the LTOT in correcting the patient's hypoxemia and its clinical consequences after the initiation of home oxygen therapy.

**Recommendation 10:**

The development of quality assurance standards for continuing medical management of the home oxygen patient is beyond the scope of the current committee. It is recommended, however, that a conference of appropriate healthcare providers (physicians, respiratory care practitioners, respiratory nurses, durable medical equipment (DME) providers, etc) should develop a set of guidelines for appropriate medical follow-up.

**Recommendation 11:**

In view of the need for education of physicians concerning the indications, means of administration and complications of LTOT, it is recommended that the appropriate professional societies set up continuing medical education courses leading to certification in long-term oxygen treatment. The certification should only be awarded after competence is shown by an objective evaluation and should be for a defined period of time. The necessary continuing medical education and certification should be made available to all practicing physicians who seek certification of competence in LTOT.

**Recommendation 12:**

Reimbursement must be based on: (1) patient's continuous oxygen flow requirements regardless of the oxygen source or delivery device employed; (2) whether or not the patient is ambulatory in accordance with recommendations 1 through 3; (3) the technological and professional components necessary to meet the therapeutic requirements.