कार्यालय जानन OFFICE MEMORANDUM

विषय : सीएचएसएस नामांकित वन्यजीवों के आवासीय उपयोग हेतु सीपीएपी/बीआईपीएपी/ऑक्सीजन कंसेंट्रेटर के प्रावधान के संबंध में।


इस विभाग में सीजीएचएस नियमों और अंतरराष्ट्रीय विभाग के सीएचएसएस के अनुसार सीएचएसएस नामांकित वन्यजीवों के आवासीय उपयोग हेतु सीपीएपी/बीआईपीएपी/ऑक्सीजन कंसेंट्रेटर के प्रावधान के लिए संदर्भ प्राप्त हुए हैं।

Reference has been received in the Department for provision of CPAP, BIPAP, Oxygen Concentrator etc. for domiciliary use to CHSS beneficiaries on line with CGHS Rules and DOS CHSS.

2. इस विभाग में और विभाग की सीएचएसएस समिक्षा समिति द्वारा भी इस विषय की जाँच की गई है। इस समिति की सिकारियों के आधार पर और सीजीएचएस के तहत नामांकित वन्यजीवों के लिए स्वास्थ्य एवं परिवार कल्याण मंत्रालय द्वारा विभिन्न तित्तियों और मानदंडों पर विचार करके विभाग सीएचएसएस नामांकित वन्यजीवों द्वारा ऑक्सीजन कंसेंट्रेटर/बीआईपीएपी/सीपीएपी आदि की खरीद करने और निरन्तरिक्षित शरीर को पूरा करने पर ऐसी मार्गों की कीमत की प्रतिपूर्ति करने हेतु अनुमति देने के लिए सहमत हुआ है।

The matter has been examined in the Department and also by the CHSS Review Committee in the Department. Based on the recommendations of the Committee and considering the guidelines/criteria provided by the Ministry of Health and Family Welfare for beneficiaries under CGHS, the Department has agreed to grant permission to purchase
Oxygen Concentrator/BIPAP/CPAP, etc. by CHSS beneficiaries and reimburse the cost of such machines subject to fulfilling the following:

(i) खरीद हेतु अनुमति केवल विभागीय स्तर पर दी जाएगी। संबंधित केंद्र और यूनिट द्वारा शरीर को पूरा करने वाले मामलों पर विचार और अनुमोदन हेतु पूर्व में स्थानीय की सिफारिश किए जाएं।

Permission for purchase to be given only at the Department level. Cases fulfilling the conditions may be recommended by the respective Centre/Unit to DAE for consideration and approval;

(ii) लाभार्थी का अनुरोध ह्या कार्यलय जापन के साथ जुड़े निर्धारित प्रप्त क्र. III/III (प्रतियों संलग्न) में उपचार करने वाला डॉक्टर की सिफारिशों सहित संबंधित केंद्र/यूनिट में किया जाएगा। उपचार करने वाला डॉक्टर प्रप्त के संबंधित कॉलम भरने से पहले निर्धारित दिशा-निदेशों को सावधानीपूर्वक पढ़ेंगे। प्रप्त में दर्शाया गए सभी पैरामीटर के वाल्ट्सबिक वैल्यू को अन्तिम रूप से प्रबल बनाए और बेसिक जो रिपोर्ट अवश्य संलग्न की जाएगी।

The request of the beneficiary should be made to the respective Centre/Unit along with the recommendations of the treating physician in the prescribed Form No. III/III to this OM (copies enclosed). The treating physician should carefully read the laid down guidelines before filling up the respective columns of the Form. Actual value of all the parameters mentioned in Form should invariably be entered and complete basic investigation reports must be attached:

a. रीजी द की हालत स्थिर होने और सम एंएस का शक्तिक लेने समय ती गयी आर्टरियल ब्लड गैस रिपोर्ट (ऑस्मीयन कंसेंट्रेटर एवं बॉई-लेवल वेंटिलेटरी सम्प्लायर सिस्टम)

Arterial blood gas report taken while the patient is in stable condition and is breathing room air (in case of oxygen concentrator and bi-level ventilator supplier system).

b. सिपीएपी एवं बॉई-लेवल सिपीएपी की सिफारिश की हालत में डिटेल्ड इज-लेवल लेवल-1 पालिसोमनोग्राफी रिपोर्ट (सभी ट्रेसिंग एवं टेबल सहित)

Detailed in-lab level-1 polysomnography report (including all the tracings and tables) in case of recommendation of CPAP and Bi-level CPAP.

(iii) चूँकि वो मशीनें जीवन रक्षक उपस्थित होती हैं और इनकी अधिकतम लाइफ पॉच वर्ष है, इसलिए सीएपएसस के तहत पूर्व में उपलब्ध करायी गयी मशीन की अनुपयुक्तता/अनुपयोगिता के संबंध में सर्विस इंजीनियर द्वारा सर्विस फॉर्म की शर्त पर इन्हें बदला जा सकता है। इसे बदलने के लिए अनुमति देने हेतु पुरानी मशीन
As these machines are lifesaving devices and have a maximum life of five years, these will be allowed to be replaced again after a period of five years subject to a certificate by the service engineer regarding the un-serviceability/condemnation of the earlier machine provided under CHSS. For approving a replacement, the old machine is required to be deposited back to the recommending Centre/Unit. If the old machine is not returned back, no request for replacement will be considered.

The beneficiary has also to submit an affidavit to the effect that he has not claimed reimbursement of the cost of the machine in the last five years (copy of the format for the affidavit is enclosed).

The maximum ceiling limit for reimbursement will be as following:

a. オキシジェンコンスタント Oxygent Concentrator - ₹Rs. 60,000/-
b. サピーCPAP - ₹Rs. 50,000/-
c. バイレベル CPAP - ₹Rs. 80,000/-
d. バイレベル ベンチレーター システム Bi-level Ventilatory System - ₹Rs.1,20,000/-

The above ceiling limits include cost of maintenance with spare parts for a period of five years. No requests for reimbursement of cost of maintenance/parts will be entertained.

Details of the machine such as its model no., make, etc., for which reimbursement of cost of has been approved, should be entered in the
medical record/service records for necessary follow-up by the designated hospital/dispensary or by the Administration.

3. इसे सशक्त प्राधिकारी के अनुमोदन से जारी किया जाता है।
This issues with the approval of competent authority.

(राकेश गर्ग Rakesh Garg)
निदेशक (आईआरएंडडब्ल्यू) Director (IR&W)

सभी सीएचएसएस नियंत्रण प्राधिकारी All CHSS Administering Authorities
SHAPTH PATR AFFIDAVIT

(Notarized Affidavit for CPAP/Bi-level CPAP/Bi-level Ventilatory System/Oxygen Concentrator Machine)

I, Sh./Smt/Kum. __________________________ S/D/W/H/o. __________________________ a serving/pensioner CHSS beneficiary, CHSS No. __________________________ R/o. __________________________ attached with the CHSS dispensary __________________________ do solemnly affirm and declare that:

The CPAP/Bi-level CPAP/Bi-level Ventilatory System/Oxygen Concentrator machine has been advised by Dr. __________________________ Hospital __________________________ on dated __________________________ in respect of __________________________.

I undertake to return CPAP/Bi-level CPAP/Bi-level Ventilatory System/Oxygen Concentrator machine in good condition to CHSS dispensary __________________________ (to which I am attached) after its utility is over.

Further, in the unfortunate event of my death, anytime after acquiring the machine, it shall be the responsibility of my immediate family members to return the machine to the dispensary/hospital issuing the same.

The responsibility for maintenance and upkeep of the machine will lie with me. I shall not claim expenditure incurred, if any on upkeep and maintenance of the machine.
I will submit the claim at ceiling prescribed by DAE for its CHSS beneficiaries and the remaining amount, if any, will be borne by me.

I have enclosed a complete sleep lab report/ABG report and proforma duly filled up by treating specialist.

I shall not use the aforesaid machine for any other purpose except treatment of ____________.

I, the undersigned, do hereby declare that, I have not purchased any CPAP/Bi-level CPAP/Bi-level Ventilatory System/Oxygen Concentrator machine, in the past five years at Government expenses:

1. Name
2. CHSS No.
3. CHSS Dispensary to which attached
4. Validity of CHSS Card
5. Address of Applicant/Mobile

Date: __________________________
Signature of the Applicant
Certificate of Medical Necessity to be issued to CHSS Beneficiaries being prescribed Bi-level Continuous Positive Airway Pressure (Bi-Level CPAP/Bi-Level Ventilatory Support System)

(To be filled by the treating physician)

Certification Type : Initial/Revised

1. Patient Name

2. Age of Patient

3. Physician Name

4. Address of physician

5. Telephone No. of Physician

6. (a) Brief history and physical findings

(b) Co-morbidity (if any)

(c) Whether accompanied by symptoms of

- Excessive daytime sleepiness : Yes / No
- Snoring : Yes / No
- Impaired cognition : Yes / No
- Documented cardiovascular disease like Hypertension, ischemic heart disease or Stroke (specify if Yes) : Yes / No

7. Laboratory data (specify date against each parameter)

   Hematocrit

   ECG

   Blood Sugar (wherever necessary)

   Lipid Profile (wherever necessary)

   Arterial blood gases :

   Date

   pH
   paO₂
   paCO₂
   HCO₃⁻
HCO₃s
BE
O₂sat

(Note: The Arterial blood gas values should include those during chronic, stable state (atleast 3 months after an acute exacerbation) of the disease e.g. in a case of COPD, the ABG value during acute exacerbation generally demonstrates moderate to severe hypercapnia which may normalize during stable state and therefore may not be an indication for long term NIPPV)

X-ray Chest

Echocardiography (wherever necessary)

Pulmonary function tests

Thyroid function tests

Ear, nose & throat examination

Others(specify)

8. Diagnostic nocturnal polysomnography (NPSG) data: Only whole night polysomnography (Level-1) including channels for sleep, breathing, pulse oxymetry, leg EMG, ECG, snoring will be accepted for consideration of BI-LEVEL CPAP/BI-LEVEL ventilator support system.

(a) Date of sleep study
(b) Address of sleep-laboratory / facility
(c) Duration of diagnostic NPSG study (in hours)
(d) Parameters studied during polysomnography

- Electro-encephalogram
- Electro-oculogram
- Electro-myogram
- Oro-nasal airflow
- Chest & Abdominal wall effort
- Body position
- Snore microphone
- Electro-cardiography
- Oxyhemoglobin saturation

Yes / No

(e) Average number of obstructive events per hours of recorded sleep (in case of standard as well as split NPSG)

(i) Obstructive apnoea*
(ii) Hypopnea**
(iii) Flow limitations***
(iv) RERA****

(f) Respiratory Distress Index (RDI)
9. Date of CAP titration study

10. CPAP pressure (in cm H₂O) prescribed (to abolish obstructive apnoeas, hypopneas, RERAs and snoring in all sleep positions and sleep stages):

11. Supplemental oxygen (flow rate or FIO₂):

12. Final Diagnosis

I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I have carefully gone through the note for prescribers before filling up this proforma.

Date: ____________________________
(Full name, Signature & Address of Physician)

Note for prescribers (For diagnostic as well as for titration):

Only whole night manually validated Level-1 polysomnography including channels for sleep, breathing, pulse oximetry, leg EMG, ECG, snoring and CPAP titration will be accepted for consideration of CPAP/BiPAP. Screening studies such as Level III, Level IV (Cardio pulmonary sleep studies) shall not be acceptable. Auto titrated CPAP studies shall also not be acceptable.

*Apeas: Absence of airflow on the nasal cannula and <10% baseline fluctuations on the thermistor signal, lasting for >10s.

**Hypopneas American Academy of Sleep Medicine (AASM) hypopneas: As proposed by the AASM Task Force (10), these events include both flow Hypopneas and any flow limitation event associated with 3% desaturation or associated with an AASM arousal.

***Flow limitation events: Any series of two or more breaths (lasting >10s) that had a flattened or non-sinusoidal appearance on the inspiratory nasal cannula flow signal and ended abruptly with a return to breaths with sinusoidal shape.

****RERA (respiratory effort-related arousal): is defined as an event characterized by increasing respiratory effort for ≥10 seconds leading to arousal from sleep but which does not fulfill the criteria for hypopnoea or apnoea. A RERA is detected with, nocturnal esophageal catheter pressure measurement, which demonstrates a pattern of progressive negative esophageal pressures terminated in a change in pressure to a less negative pressure level associated with an arousal.

Upper airway resistance syndrome(UARS): is an abnormal breathing pattern during sleep that is associated with isolated daytime sleepiness not explained by any other cause, including the obstructive sleep apnoea /hypopnea syndrome. Essential features include(a) the clinical complaint of excessive daytime sleepiness: (b) an elevated EEG arousal index (more than ten
per hour of sleep) with arousals related to increased respiratory efforts as measured by continuous nocturnal monitoring of esophageal pressures; (c) a normal RDI of less than 5 events per hour of sleep. Supportive features include (a) the clinical complaint of snoring (b) an increase in snoring intensity prior to EEG arousals and (c) clinical improvement with a short term trial of nasal CPAP therapy.

**Split-Night Study NPSG:** Patients with a RDI of >40 events per hour during the first 2 hours of a diagnostic NPSG receive split-night study NPSG, of which the final portion of the NPSG is used to titrate CPAP; split-night study may be considered for patients with RDI of 20-40 events per hour, based on clinical observations, such as the occurrence of obstructive respiratory events with a prolonged duration or associated with severe oxygen desaturation; a minimum of 3 hours of sleep is preferred to adequately titrate CPAP after this treatment is initiated; split-night studies require the recording and analysis of the same parameters as a standard diagnostic NPSG; on occasion, an additional full-night CPAP titration NPSG may be required if the split-night study did not allow for the abolishment of the vast majority of obstructive respiratory events or prescribed CPAP treatment does no control clinical symptoms.

**BI-LEVEL CPAP is indicated in the following conditions:**

Bi-level CPAP is a device used mainly for severe cases of OSA.

Bi-level CPAP (with IPAP 4-22 cm water and EPAP 4-22 cm water)

I. When CPAP pressure requirement is greater than 16 cm.

II. Oral leaks become uncontrollable at sub-therapeutic pressure after trying humidifier, chin strap & positive pressure therapy.

III. Pressure of central apneas due to too high pressures

IV. When patient cannot tolerate CPAP after ensuring the problem is not due to oral leaks, dryness, nasal congestion, interface problem or claustrophobia.

V. Patients with persistent hypoxia and/or hypercapnia after treatment with CPAP.

**BI-LEVEL Ventilatory support system is indicated in the following conditions:**

Bi-level CPAP (with IPAP 4-30 cm water and EPAP 4-30 cm water)

(I) Restrictive Thoracic Disease: (e.g. sequelae of polio, spinal cord injury, neuropathies, myopathies and dystrophies, amyotrophic lateral sclerosis, chest wall deformities and kyphoscoliosis, post thoracoplasty for TB) with symptoms (such as fatigue, dyspnea, morning headaches etc.) and one of the following: (a) PaCO₂ ≥45 mmHg on room air or PaCO₂≥52 mmHg, done while awake and breathing the patient’s usual FiO₂; (b) sleep oximetry demonstrating oxygen saturation ≤88% for at least 5 continuous minutes done while breathing the patient’s usual FiO₂; (c) for progressive neuromuscular disease (only) maximal inspiratory pressure is ≤60 cm H₂O or forced vital capacity is <50% predicted and chronic obstructive pulmonary disease does not contribute significantly to the patient’s pulmonary limitation.

(II) Chronic Obstructive Pulmonary Disease (COPD) (e.g. chronic bronchitis, emphysema, bronchiectasis) with symptoms (such as fatigue, dyspnea, morning headache etc.) and one of the following: (a) PaCO₂>55mmHg while awake and breathing patient’s usual
FiO₂ (b)PaCO₂ of 50-54 mmHg and nocturnal desaturation of spO₂ ≤ 88% for 5 continuous minutes while receiving oxygen therapy ≥ 2 LPM; (c) PaCO₂ of 50-54 mmHg and hospitalization related to recurrent (≥2 in a 12 month period) episodes of hypercapneic respiratory failure; optimal management with bronchodilators, oxygen when indicated must have been ensured; obstructive sleep apnoea must have been excluded by polysomnography and there should preferably be evidence of sustained hypoventilation as shown by prolonged episodes of desaturation during sleep.

(iii) Nocturnal hypoventilation from additional disorders (alveolar hypoventilation: central alveolar hypoventilation, idiopathic central sleep apnoea, obesity hypoventilation syndrome, Cheyne-Stokes respiration, obstructive sleep apnoea combined with COPD and pulmonary hypertension or CHF i.e. overlap syndrome, radiation fibrosis or occupational exposure diseases; NPSG criteria for OSA not responsive to CPAP include (i) PSG criteria for mixed sleep apnoea not responsive to CPAP therapy (ii) central sleep apnoea; (iii) other forms of nocturnal hypoventilation.

**Indications for humidification**

(i) Positive Airway Pressure more than 12 cm water
(ii) Recurrent and intractable nasal stuffiness and blockage
(iii) Severe dryness of throat
Certificate of Medical Necessity to be issued to CHSS Beneficiaries being prescribed Continuous Positive Airway Pressure (CPAP) Device
(To be filed by the treating physician)

Certification Type : Initial/ Revised

1. Patient Name
2. Age of Patient
3. Physician Name
4. Address of Physician
5. Telephone No. of Physician
6. (a) Brief history and physical findings

(b) Co-morbidity (if any) e.g. COPD, diabetes mellitus etc.

(c) Whether accompanied by symptoms of
   - Excessive daytime sleepiness
   - Snoring
   - Impaired cognition
   - Documented cardiovascular disease like Hypertension, ischemic heart disease or Stroke (Specify if yes)

7. Laboratory data (specify date against each parameter):
   - Hematocrit
   - ECG
   - Blood sugar
   - Lipid Profile

Arterial blood gases:
   Date 1 2 3
   pH
   paO₂
   paCO₂
   HCO₃⁻
   HCO₃s
   BE
   O₂ sat
X-ray Chest

Echocardiography (wherever necessary)

Pulmonary function tests

Thyroid function test

Ear, nose & throat examination

Others (specify)

8. Diagnostic nocturnal polysomnography (NPSG) date: Only whole night polysomnography (Level-1) including channels for sleep, breathing, pulse oximetry, leg EMG, ECG, snoring will be accepted for consideration of CPAP/BIPAP.

   (a) Date of sleep study
   (b) Address of sleep-laboratory / facility
   (c) Duration of diagnostic NPSG study (in hours)
   (d) Parameters studied during polysomnography

     • Electro-encephalogram
     • Electro-oculogram
     • Electro-myogram
     • Oro-nasal airflow
     • Chest & Abdominal wall effort
     • Body position
     • Snore microphone
     • Electro-cardiogram
     • Oxyhemoglobin saturation

   (e) Average number of obstructive events per hours of recorded sleep (in case of standard as well as split NPSG)

      (i) Obstructive apnoea*
      (ii) Hypopnea**
      (iii) Flow Limitations***
      (iv) RERA****

   (f) Respiratory Distress Index (RDI)

9. Date of CPAP titration study

10. CPAP pressure (in cm H₂O) prescribed (to abolish obstructive apnoeas, hypopneas, REPAs and snoring in all sleep positions and sleep stages):
11. Supplemental oxygen (flow rate or FiO₂)

12. Final Diagnosis

I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I have carefully gone through the note for prescribers before filling up this proforma.

Date:

(Full Name, Signature & Address of Physician)

Note for prescribers (For diagnostic as well as for titration):

Only whole night manually validated Level-1 polysomnography including channels for sleep, breathing, pulse oxymetry, leg EMG, ECG, snoring & CPAP titration will be accepted for consideration of CPAP/BiPAP. Screening studies as Level III, Level IV (Cardio pulmonary sleep studies) shall not be acceptable. Auto titrated CPAP studies shall also not be acceptable.

*Apneas: Absence of airflow on the nasal cannula and <10% baseline fluctuations on the thermistor signal, lasting for >10s

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Upper airway resistance syndrome (UARS): is an abnormal breathing pattern during sleep that is associated with isolated daytime sleepiness not explained by any other cause, including the obstructive sleep apnoea/hypopnoea syndrome. Essential features include (a) the clinical complaint of excessive daytime sleepiness, (b) an elevated EEG arousal index (more than ten per hour of sleep) with arousals related to increased respiratory efforts as measured by continuous nocturnal monitoring of esophageal pressures, (c) a normal RDI of less than 5 events per hour of sleep. Supportive features include (a) the clinical complaint of snoring, (b) an increase in snoring intensity prior to EEG arousal and (c) clinical improvement with a short term trial of nasal CPAP therapy.
Split-Night Study NPSG: Patients with a RDI of >40 events per hour during the first 2 hours of diagnostic NPSG receive a split-night study NPSG, of which the final portion of the NPSG is used to titrate CPAP; split-night study may be considered for patients with RDI of 20-40 events per hour, based on a clinical observations, such as the occurrence of obstructive respiratory events with a prolonged duration or associated with severe oxygen desaturation; a minimum of 3 hours of sleep is preferred to adequately titrate CPAP after this treatment is initiated; split-night studies require the recording and analysis of the same parameters as a standard diagnostic NPSG; on occasion, an additional full-night CPAP titration NPSG may be required if the split-night study did not allow for the abolishment of the vast majority of obstructive respiratory events or prescribed CPAP treatment does not control clinical symptoms.

CPAP treatment is indicated in the following situations:

The treatment of obstructive sleep apnea (OSA) in adults is considered medically necessary for patients who meet either of the following criteria on polysomnography:

1. Apnea Hypopnea Index (AHI) or a respiratory disturbance index (RDI) greater than or equal to 15 events per hour; or

2. AHI (or RDI) greater than or equal to 5, and less than 15 events per hour with documentation demonstrating any of the following symptoms:
   - Excessive daytime sleepiness, as documented by either a score of greater than 10 on the Epworth Sleepiness scale or inappropriate daytime napping, (e.g., during driving, conversation or eating) or sleepiness that interferes with daily activities; or
   - Impaired cognition or mood disorders; or
   - Hypertension; or
   - Ischemic heart disease or history of stroke; or
   - Cardiac arrhythmias, or
   - Pulmonary hypertension

The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of two hours of sleep recorded by polysomnography using actual recorded hours of sleep, (i.e. the AHI may not be extrapolated or projected.)

Note: For the purposes of this recommendation, the terms apnea hypopnea index (AHI) and respiratory disturbance index (RDI) are interchangeable, although they may differ slightly in clinical use; an AHI/RDI greater than 30 is consistent with severe obstructive sleep apnea. In some cases, respiratory effort-related arousal (or RERAS) are included in the RDI value. These RERAS episodes represent EEG arousals associated with increased respiratory efforts but do not qualify as apneic or hypopneic episodes because of the absence of their defining airflow changes and/or levels of oxygen desaturation.
Certificate of Medical Necessity to be issued to CHSS Beneficiaries being prescribed long term Oxygen Therapy/Oxygen Concentrator
(To be filled by the treating physician)

Certificate Type: Initial/Revised

1. Patient Name
2. Age of Patient
3. Physician Name
4. Address of physician
5. Telephone No. of Physician
6. (a) Brief history and physical findings

(b) Co-morbidity (if any)

(c) Whether accompanied by symptoms of
- Excessive daytime sleepiness
- Snoring
- Impaired cognition
- Documented cardiovascular disease like Hypertension, ischemic heart disease or Stroke (specify if Yes)

7. Laboratory data (specify date against each parameter):
   Hematocrit
   ECG
   X-ray Chest
   Echocardiography (wherever necessary)
   Pulmonary function gases:
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(Note: The Arterial blood gas values should include those during chronic, stable state (at least 3 months after an acute exacerbation) of the disease e.g. in a case of COPD, the ABG value during acute exacerbation generally demonstrates moderate to severe hypoxemia and hypercapnia which may normalise during stable state and therefore may not be an indication for long term oxygen therapy)

8. Final Diagnosis

9. Recommended : Oxygen concentrator/portable oxygen cylinder/compressed oxygen cylinders)

(a) Flowrate  
(b) Nasal prongs/Cannula  
(c) Nasal mask  
(d) Number of hours per day

I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I have carefully gone through the note for prescribers before filling up this proforma.

Date :  
(Full Name, Signature & Address of Physician)

Note for prescribers (For diagnostic as well as for titration):
Home oxygen therapy is the home administration, of oxygen at concentrations greater than the ambient air with the intention of treating or preventing the symptoms and manifestations of hypoxic or non-hypoxic medical conditions that are known to clinically improve with oxygen.

Clinical Indications
Home oxygen therapy is considered medically necessary in the following circumstances:

1. Chronic Hypoxia (generally long-term use). The conditions with which this may be associated include, but are not limited to:
   - Chronic obstructive pulmonary disease  
   - Diffuse interstitial lung disease  
   - Bronchiectasis  
   - Widespread pulmonary neoplasm  
   - Pulmonary hypertension  
   - Recurring congestive heart failure due to chronic cor pulmonale
The following laboratory values, obtained while breathing ambient air, will be presumptive evidence for hypoxia:

**Adults:**
- Arterial partial pressure of oxygen (PaO2) less than or equal to 55mmHg or arterial oxygen saturation (SaO2) less than or equal to 88%.
- PaO2 levels between 56 and 59 or SaO2 89% in the presence of pulmonary hypertension, cor pulmonale, edema secondary to right heart failure, or erythrocytosis with hematocrit greater than 55%.

**Note:**

1. Patients who desaturate to an SaO2 less than or equal to 88% only during exercise and who demonstrate improvement in both the hypoxia and dyspnea and/or exercise capacity when using O2 are candidates for supplemental O2 during exercise only.

2. Patients who desaturate only during sleep to an SaO2 of less than or equal to 88% for more than 30% of the night or with evidence or otherwise unexplained pulmonary hypertension, cor pulmonale, edema secondary to right heart failure, or erythrocytosis with hematocrit, greater than 55%, and in whom obstructive sleep apnea (OSA) and other nocturnal apnea or hypoventilation syndromes have been ruled out or, if OSA present, have persistent desaturation despite correction of AHI (RDI) by CPAP, are candidates for nocturnal O2.

**Infants and children:**
- Arterial partial pressure of oxygen (PaO2) less than or equal to 60mmHg or arterial oxygen saturation (SaO2) less than or equal to 92%

**Note:**

Portable oxygen systems are considered medically necessary only when needed to complement the medical needs of an individual who requires a stationary system.