Use of this template is voluntary / optional

Ventilator

Progress Note Template Guidance

Purpose

This template is designed to assist a clinician in completing a progress note documenting an in-person visit or encounter for a ventilator and accessories to meet requirements for Medicare eligibility and coverage. The clinician can keep the completed template on file within the patient’s medical record or it can be used to develop an in-person visit or encounter progress note for use with the system containing the patient’s electronic medical record.

Patient eligibility for coverage of a ventilator under Medicare

Eligibility for coverage of a ventilator and accessories under Medicare requires a physician or qualified Non-Physician Practitioner (NPP)\(^1\) to establish that coverage criteria are met. This helps to ensure the ventilator and accessories provided are consistent with the physician’s prescription and supported in the patient’s medical record.

Indications for use of a ventilator is divided into three categories:

- Neuromuscular diseases;
- Thoracic restrictive diseases;
- Chronic respiratory failure consequent to chronic obstructive pulmonary disease

Initial coverage -- first three (3) months of therapy

Medical record must document:

The beneficiary has one (1) of the disorders listed above which is of sufficient intensity to require the ventilator and meets all coverage criteria.

Continued coverage

Medical records support that the beneficiary is benefitting from consistent use of the device.

Beneficiaries entering Medicare

- There must be documentation of the following:
  - A qualifying diagnosis confirming that the beneficiary met criteria for use of a ventilator and accessories prior to Fee-for-Service (FFS) Medicare enrollment, that meets the current coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of a replacement device and/or accessory; and

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\(^1\) A Medicare allowed NPP is defined as 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.
There must be an in-person physician/NPP clinical evaluation/progress note following enrollment in FFS Medicare that confirms the following:

- The beneficiary has the qualifying medical condition for the applicable scenario;
  - Neuromuscular diseases;
  - Thoracic restrictive diseases;
  - Chronic respiratory failure consequent to chronic obstructive pulmonary disease, and
- Any testing performed, date of the testing used for qualification and results; and
- The beneficiary has a medical need for the device; and
- The beneficiary is benefitting from the treatment.

Other guidance

A copy of the in-person physician/NPP clinical evaluation/progress note documentation needs to be received by the supplier on or after the date of the order and before submission of a claim for a ventilator and accessories.

Completing the Ventilator Progress Note Template does not guarantee eligibility and coverage, but does provide an area within the patient’s medical record that is readily identifiable and available in support of the need for a ventilator and accessories ordered and billed to Medicare. This template may be used in conjunction with the Ventilator Order Template.

Who can complete this progress note template?

A physician or allowed NPP who performs an in-person encounter:

Note: If this 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 R1.0a
## Ventilator Progress Note Template

**Patient information:**
- **Last name:**
- **First name:**
- **MI:**
- **DOB (MM/DD/YYYY):**
- **Gender:** M F Other
- **Medicare ID:**

**Provider (physician/NPP) who performed the in-person evaluation if different from the signing provider:**
- **Last name:**
- **First name:**
- **MI:**
- **Suffix:**
- **NPI:**

**Date of encounter (MM/DD/YYYY):**

**Is this an evaluation of the patient’s need for a ventilator?**
- **Yes**
- **No**

**If Yes, is this ___ an initial evaluation or ___ a re-evaluation?**

**If re-evaluation, is there evidence of continued use of the ventilator and accessories?**
- **Yes**
- **No**

**If No, purpose of the encounter:**

**Patient Diagnoses related to need for a ventilator (full description to support diagnosis must appear in the Review of Systems and/or Physical Exam section):**
- Neuromuscular disease
- Thoracic Restrictive disease
- Chronic respiratory failure consequent to COPD

**Other Diagnoses**

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Description</th>
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**For continued coverage:**

**Demonstrated benefit from continued use?**
- **Yes**
- **No**

**Describe:**

**Chief complaint / history of present illness and associated signs / symptoms:**

**Related past medical / surgical history:**

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**Use of this template is voluntary / optional**
### Medications (Status: N=New, C=Current, M=Modified, D=Discontinued)

<table>
<thead>
<tr>
<th>RxNorm</th>
<th>Description</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Status</th>
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**Other medications**

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<thead>
<tr>
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### Allergies (Include RxNorm if known)

<table>
<thead>
<tr>
<th>RxNorm</th>
<th>Description</th>
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<th>Description</th>
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### Review of systems (Significant as per history of present problem and need for a ventilator):

**General:**

- weight gain
- weight loss
- sleeping problems
- fatigue
- fever
- chills
- night sweats / diaphoresis
- other:

**Skin:**

- pressure ulcers
- rashes
- changes in nails/hair
- eczema
- pruritus
- other:

**Lymphatic:**

- swollen glands/masses:
- in the neck
- axilla
- groin
- other:

**Head:**

- fainting
- dizziness
- headaches
- other:

**Eyes:**

- diplopia
- glasses/contact lenses
- redness/discharge
- blurred vision
- glaucoma
- cataracts
- other:

**Ears:**

- tinnitus
- discharge
- hearing loss
- other:

**Nose:**

- epistaxis
- sinus infections
- discharge
- polyps
- other:

**Oral:**

- dysphagia
- hoarseness
- teeth/dentures
- other:

**Neck:**

- lumps
- pain on movement
- other:
<table>
<thead>
<tr>
<th>System</th>
<th>Symptoms</th>
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<tbody>
<tr>
<td><strong>Breast</strong></td>
<td>____ masses/tumors, ____ tenderness, ____ discharge, ____ gynecomastia,</td>
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<tr>
<td></td>
<td>____ other:</td>
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<tr>
<td><strong>Pulmonary</strong></td>
<td>____ cough, ____ shortness of breath, ____ pain, ____ wheezing, ____ hemoptysis,</td>
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<tr>
<td></td>
<td>____ sputum production, ____ history of obstructive sleep apnea</td>
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<td></td>
<td>____ other:</td>
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<tr>
<td><strong>Cardiac</strong></td>
<td>____ chest pain, ____ palpitations, ____ orthopnea, ____ murmur, ____ syncope</td>
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<td>____ other:</td>
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<tr>
<td><strong>Vascular</strong></td>
<td>____ edema, ____ claudication, ____ varicose veins, ____ thrombophlebitis,</td>
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<tr>
<td></td>
<td>____ ulcers</td>
</tr>
<tr>
<td></td>
<td>____ other:</td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td>____ swallowing problems, ____ abdominal pain, ____ constipation, ____ diarrhea,</td>
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<tr>
<td></td>
<td>____ incontinence, ____ nausea, ____ vomiting, ____ ulcers, ____ melena, ____ rectal bleeding,</td>
</tr>
<tr>
<td></td>
<td>____ jaundice, ____ heartburn, ____ hematemesis</td>
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<td></td>
<td>____ other:</td>
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<tr>
<td><strong>Renal</strong></td>
<td>____ dysuria, ____ frequency, ____ urgency, ____ hesitation, ____ flank pain,</td>
</tr>
<tr>
<td></td>
<td>____ hematuria, ____ incontinence, ____ nocturia, ____ polyuria, ____ other:</td>
</tr>
<tr>
<td><strong>Musculoskeletal</strong></td>
<td>____ pain, ____ swelling, ____ stiffness, ____ limitation of range of motion,</td>
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<tr>
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<td>____ arthritis, ____ gout, ____ cramps, ____ myalgia, ____ fasciculation, ____ atrophy, ____ fracture,</td>
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<tr>
<td></td>
<td>____ deformity, ____ weakness, ____ other:</td>
</tr>
<tr>
<td><strong>Neurologic</strong></td>
<td>____ seizures, ____ poor memory, ____ poor concentration, ____ numbness / tingling,</td>
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<tr>
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<td>____ pins and needles sensation, ____ hyperpathia, ____ dysesthesia, ____ weakness,</td>
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<td>____ paralysis, ____ tremors, ____ involuntary movements, ____ unstable gait, ____ fall,</td>
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<td>____ vertigo, ____ headache, ____ stroke, ____ speech disorders ____ other:</td>
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<tr>
<td><strong>Psychiatric</strong></td>
<td>____ hallucinations, ____ delusions, ____ anxiety, ____ nervous breakdown,</td>
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<td>____ mood changes ____ other:</td>
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<tr>
<td><strong>Hematology</strong></td>
<td>____ anemia, ____ bruising, ____ bleeding disorders (conditional) ____ other:</td>
</tr>
<tr>
<td><strong>Endocrine</strong></td>
<td>____ heat or cold intolerance, ____ diabetes, ____ lipid disorders, ____ goiter</td>
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<td>____ other:</td>
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<tr>
<td><strong>Other</strong></td>
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</table>
**Physical examination:**

<table>
<thead>
<tr>
<th>Vital signs: T= _____ P= _____ R= _____ BP= _____ / _____ Height= _____ Weight= _____</th>
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<tbody>
<tr>
<td>O2 Sat: _____ (RA at Rest)</td>
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<tr>
<td>Neck circumference: _____ cm</td>
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**General appearance:**

**Head and neck:**

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<thead>
<tr>
<th>Chest / lungs:</th>
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**Cardiovascular:**

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<tr>
<th>Abdominal:</th>
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**Musculoskeletal / extremities (including gait exam):**

<table>
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<tr>
<th>Neurological:</th>
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<tr>
<th>Psychiatric:</th>
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<tr>
<th>Visual Exam:</th>
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<table>
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<tr>
<th>Test Results (e.g. pulmonary function, pulse oximetry):</th>
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<tr>
<th>Other:</th>
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</table>
### Physician/NPP assessment / summary:

- 
- 
- 

### Treatment plan:

- 
- 
- 

### Orders:

- Medications:
  - 
  - 

- Supplies:
  - 
  - 

### Investigations / diagnostic testing:

- 
- 
- 

### Consults:

- 
- 
- 

### Other:

- 
- 

### Signature, Name, Date and NPI of physician or allowed NPP

- Signature:
- Name (Printed):
- Date (MM/DD/YYYY):
- NPI: