DRAFT

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

[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

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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 Describe:_____

*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

ICD-10	Description

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:_____

_____

Medications (Status: N=New, C=Current, M=Modified, D=Discontinued)

RxNorm	Description	Dose	Frequency	Route	Status

Other medications

Allergies (Include RxNorm if known)

RxNorm	Description	RxNorm	Description

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:_____

Breast:	___masses/tumors, ___tenderness, ___discharge, ___gynecomastia, ___other:_____
Pulmonary:	___cough, ___shortness of breath, ___pain, ___wheezing, ___hemoptysis, ___sputum production, _____history of obstructive sleep apnea ___other:_____
Cardiac:	___chest pain, ___palpitations, ___orthopnea, ___murmur, ___syncope ___other:_____
Vascular:	___edema, ___claudication, ___varicose veins, ___thrombophlebitis, ___ulcers ___other:_____
Gastrointestinal:	___swallowing problems, ___abdominal pain, ___constipation, ___diarrhea, ___incontinence, ___nausea, ___vomiting, ___ulcers, _____melena, _____rectal bleeding, ___jaundice, ____heartburn, ___hematemesis ___other:_____
Renal:	___dysuria, ___frequency, _____urgency, ___hesitation, ___flank pain, ___hematuria, ___incontinence, ____nocturia, ___polyuria, ___other:_____
Musculoskeletal:	___pain, ___swelling, ____stiffness, ____limitation of range of motion, ____arthritis ___gout, ___cramps, ____myalgia, ___fasciculation, ____atrophy, ____fracture, ___deformity, _____weakness, ___other:_____
Neurologic:	___seizures, ___poor memory, ____poor concentration, ____numbness / tingling, ___pins and needles sensation, ___hyperpathia, _____dysesthesia, ____weakness, ___paralysis, ___tremors, ___involuntary movements, ____unstable gait, ___fall, ___vertigo, ___headache, ____stroke, ___speech disorders ___other:_____
Psychiatric:	___hallucinations, _____delusions, ____anxiety, ____nervous breakdown, ___mood changes ___other:_____
Hematology:	___anemia, ____bruising, ____bleeding disorders (conditional) ___other:_____
Endocrine:	___heat or cold intolerance, ____diabetes, ____lipid disorders, ____goiter ___other:_____
Other:_____ _____	

Physical examination:

Vital signs: T=_____P=_____R=_____BP=_____/_____Height=_____Weight=_____

O2 Sat:_____ (RA at Rest) O2 Sat:_____ (with supplemental O2 at _____LPM)

Neck circumference:_____ cm Body mass index (BMI)_____

General appearance:_____

_____

Head and neck:_____

_____

Chest / lungs:_____

_____

Cardiovascular:_____

_____

Abdominal:_____

_____

Musculoskeletal / extremities (including gait exam):_____

_____

Neurological:_____

_____

Psychiatric:_____

_____

Visual Exam:_____

_____

Test Results (e.g. pulmonary function, pulse oximetry): _____

_____

_____

_____

Other:_____

_____

_____

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: _____