British Columbia
Home Oxygen Program
Medical Criteria
2012

Prepared by:

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Dear Healthcare Professional,

The five British Columbia health authorities operate and manage their Home Oxygen Programs (HOP) independently and use common medical eligibility criteria to subsidize medically appropriate home oxygen therapy in accordance to current professional practice guidelines and the best available evidence.

The Medical Consultants and Managers of the HOPs have reviewed and updated the existing provincial medical criteria based on the guidelines of the Canadian Thoracic Society, Cochrane Review, and other resources. The revised HOP medical criteria will be in effect April 2, 2012 throughout BC, and will be reviewed at a later date.

Current HOP clients with Vancouver Coastal will be "grandfathered", however, clients will have the option to be reviewed under the previous criteria or the new criteria during follow up assessments.

In this package you will find the new medical criteria and a copy of the new application form. Please discard any previous revisions of the home oxygen application forms.

Electronic copies of the application form and guidelines are available upon request in pdf and Word. Please contact our office at 604.301.3814 for details.

Respectfully,

Dan Sandberg
Coordinator
Home Oxygen Program
Vancouver Coastal Health

Dr John Fleetham
Respirologist
HOP Medical Consultant

BC Home Oxygen Program Medical Eligibility (April 2, 2012)

Statement:

All HOP applicants are expected to seek and be compliant with optimal medical or adjunctive treatment prior to use of oxygen therapy.

The safe use of oxygen at all times is vital.

Physicians discharging clients from acute care must provide evidence of co-morbid disease. However, if not available at discharge, time-limited funding for oxygen may be provided to allow more time for submission of evidence of co-morbid disease.

Oxygen flow rates titrated to achieve SpO_2 > 90% must be provided with the application.

1. Resting Oxygen:

Client must be breathing room air and seated at rest for at least 10 minutes prior to taking ABG or beginning to monitor oximetry.

A. $PaO_2 \leq 55$ mmHg on room air. Or $SpO_2 < 88\%$ sustained continuously for 6 minutes.

-OR-

B. $PaO_2 \leq 60$ mmHg, with evidence of one of the following co-morbid diseases.

- **i.** Heart Failure
- **ii.** Pulmonary hypertension

Information to support the co-morbid diseases is required (e.g. consultation note, discharge summary, spirometry, echocardiogram, etc).

2. Ambulatory oxygen:

If the client is unable to walk 1 minute or more, ambulatory oxygen will not be useful and will not be funded. Oxygen therapy for ambulation is intended to encourage activity outside of the home and for those clients who qualify for funding in Section 1.

Acute care inpatient portable oxygen applications: Long-term ambulatory oxygen therapy criteria takes precedence over short-term ambulatory oxygen therapy criteria. Acute care may perform a short-term ambulatory study prior to client's discharge and must show the following *short-term ambulatory oxygen therapy criteria:*

SpO2 < 88% sustained continuously for one minute while breathing room air.

Outpatient portable oxygen applications (e.g. Pulmonary Function Labs): Clients must show the following *long-term ambulatory oxygen therapy criteria:*

i. SpO2 < 88% sustained continuously for a minimum of one minute while breathing room air and a measured improvement within a 6-minute walk test as tolerated on oxygen compared to room air showing the distance traveled increases by at least 25% and at least 30 meters (100 feet).

-OR-

ii. SpO_2 < 80% with ambulation for a minimum of one minute.

3. Nocturnal Oxygen:

In absence of co-morbidities (as mentioned in 1B), daytime desaturation must be present at rest or with ambulation according to Sections 1 or 2 for nocturnal oxygen therapy to be funded. Information to support the co-morbid diseases, if present, is required (e.g. consultation note, discharge summary, spirometry, echocardiogram, etc).

Sleep disordered breathing (i.e. sleep apnea) will only be treated with supplemental oxygen if the nocturnal criteria are met despite optimal CPAP treatment.

SpO_2 must be < 88% for > 30% of a minimum 4 hour nocturnal oximetry study while breathing room air.

4. Palliative:

Palliative clients must have hypoxemia according to Sections 1, 2, or 3 to be funded.

5. Substance Abuse:

Known illicit drug users (e.g. crack, heroin, cocaine, etc) or excessive alcohol users may not be eligible for funding. Clients involved with active rehabilitation may be considered.

6. Smoking:

Smokers who do not comply with safety instructions will be at risk of having oxygen funding discontinued immediately and Doctor notified.

References:

Baird, Marianne, *Alberta Aids to Independent Living Respiratory Policies and Procedures,* Government of Alberta, Revision August 23, 2011, retrieved from http://www.seniors.alberta.ca/aadl/av/manual/PDF/48_manual_r.pdf

Celli, BR, MacNee. W, et al., "Standards for the diagnosis and treatment of patients with COPD:a summary of the ATS/ERS position paper," *European Respiratory Journal*, 2004; 23: 932–946.

Collop N, "Sleep and sleep disorders in chronic obstructive pulmonary disease," *International Review Of Thoracic Diseases* 2010; Vol. 80 (1): 78-86.

----------, et al., "Clinical guidelines for the use of unattended portable monitors in the diagnosis of obstructive sleep apnea in adult patients," *Journal of Clinical Sleep Medicine*, 2007 Dec 15;3(7): 737-47.

Cranston, J, et al., "Domiciliary oxygen for chronic obstructive pulmonary disease," EBM Reviews - *Cochrane Database of Systematic Reviews* 1, 2009.

Epstein LJ, et al., "Clinical guideline for the evaluation, management and long-term care of obstructive sleep apnea in adults," Adult Obstructive Sleep Apnea Task Force of the American Academy of Sleep Medicine, *Journal of Clinical Sleep Medicine*, 2009 Jun 15;5(3): 263-76.

Fleetham, J, et al., "Canadian Thoracic Society 2011 guideline update: Diagnosis and treatment of sleep disordered breathing," 2006 Oct; Vol. 13 (7): 387-92.

McDonald CF, "Adult domiciliary oxygen therapy. Position statement of the Thoracic Society of Australia and New Zealand," *The Medical Journal of Australia*, 2005 Jun 20; Vol. 182 (12): 621-6.

Medical Research Working Party, "Long Term Domiciliary Oxygen therapy in Chronic Hypoxic Cor Pulmonale Complicating Chronic Bronchitis and Emphysema," *The Lancet*, 1981; March 28, 1981: 681-686.

Morgenthaler TI, et al., "Practice parameters for the medical therapy of obstructive sleep apnea," Standards of Practice Committee, American Academy of Sleep Medicine. *Sleep* 2006 Aug 1; 29(8):1031-5.

Nocturnal Oxygen Therapy Trial Group, "Continuous or nocturnal oxygen therapy in hypoxemic chronic obstructive lung disease: a clinical trial," *Annals of Internal Medicine*, 1980 Sep; Vol. 93 (3): 391-8.

Non Insured Health Benefits, "Provider Guide for Medical Supplies and Equipment (MS & E) Benefits," May 2011, retrieved from http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_medequip/2009-prov-fourn-guide/index-eng.php#_3.4

O'Donnell, DE, et al., "The Canadian Thoracic Society Recommendations for management of chronic obstructive pulmonary disease – 2007 update," *Canadian Respiratory Journal*, 2007; 14 (Suppl B): 5B-32B.

Ontario, Ministry of Health and Long Term Care, *Home Oxygen Program (HOP) Administration Manual*, Assistive Devices Program, April 2010.

Randerath WJ, "Treatment options in Cheyne-Stokes respiration," *Therapeutic Advances in Respiratory Disease*. 2010 Dec; Vol. 4 (6): 341-51.

Weitzenblum E, "Sleep and chronic obstructive pulmonary disease," *Sleep Medicine Reviews* 2004 Aug; Vol. 8 (4): 281-94.