

Medical Management & Policy

Fax Number 412-544-2921

Certificate of Medical Necessity (CMN) for Oxygen Therapy

Pt. Name: _____

I.D. Number: _____

1. Date of most recent assessment of patient's oxygen carrying capacity (ABG or % Sat): _____
(Must be within 30 days of this request and must be performed on room air)

Arterial Blood Gas PO2 _____ mm Hg Oxygen Saturation Test _____ % saturation

2. What is the patient's diagnosis that requires oxygen therapy?

3. Has it been established that disease is severe and will improve with this therapy? Y N

4. Have alternative treatment measures (to improve cardiopulmonary function) been considered/tried and have been documented as ineffective? Y N

5. Was patient in a chronic stable state at time ABG or saturation performed? (Not during an acute illness)? Y N

6. What were the test conditions:
_____ At rest and/or during activities of daily living (i.e. getting up and walking)
_____ During exercise (i.e. walking on a treadmill)
_____ During sleep (by automated sleep oximetry study)

Name of Physician/Provider performing test: _____
Cannot be a DME or Respiratory Equipment Provider per Medicare

Complete #7 below if in question 1 - PO2 >= 56-59 mm Hg or Oxygen Saturation >= 89%

- 7. Are there other conditions that would help qualify the patient for oxygen?
a. _____ Dependent edema due to Congestive Heart Failure
b. _____ Cor Pulmonale or Pulmonary Hypertension _____
(documented by what diagnostic testing)
c. _____ Hematocrit greater than 56%
d. _____ Other _____

PRESCRIPTION INFORMATION:

8. Patient is already on oxygen therapy _____ months _____ years

- 9. What type of equipment are you requesting for the patient?
a. _____ Stationary Only: For patients requiring O2 only at rest or sleep (comes with portable backup unit)
b. _____ Portable Only: Is patient mobile within the home? _____ Yes _____ No
c. _____ Both Stationary and Portable: For patients requiring O2 while at rest and when mobile

10. What is the highest flow (LPM) ordered for this patient?
a. _____ LPM (fill in amount)*
b. _____ Less than 1 LPM
*If an LPM of >4 is prescribed, enter recent test results taken while on 4 LPM

Date of test: _____ a) Arterial Blood Gas PO2 _____ mm HG on 4L O2
b) Oxygen Saturation Test _____ % on 4L O2

Contact Name: _____

Phone : _____

Physician Signature (Stamps are not acceptable)

Date

Key - (Y)es, (N)o, (D)oes not apply

Requested Information:

- 1. Typed office note with pertinent information.
2. Lab results if available