Medical Management & Policy
Fax Number: 412-544-2921

Certificate of Medical Necessity (CMN) for Support Surfaces

Date: ____/_____/_____ **Requesting Provider: _____**

Pt. Name: _____ **I.D. Number: _____**

Group II	**Alternating Pressure Mattress E0277**
Group III	**Air Fluidized Beds E0194**

1. Is the patient's physician going to supervise use of this device (for treatment and prevention of decubiti), and reevaluate progress monthly?	Y	N	D
2. Is the patient bedridden or chair bound as a result of severely limited mobility?	Y	N	D
3. Does the patient have significant co-existing pulmonary or cardiac disease? If yes – diagnosis. _____	Y	N	D
4. Has a conservative treatment program been tried without success? (Including freq. repositioning, optimal wound care, nutrition, etc.)	Y	N	D
5. Was a comprehensive assessment performed after failure of conservative treatment?	Y	N	D
6. Are <u>open</u>, moist or wet dressings used in the treatment of the patient?	Y	N	D
7. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of this device?	Y	N	D

8. Over the past months, the patient's ulcer(s) have in general: (please circle)
   1) Improved 2) Remained the same 3) Worsened

9. Provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress or bed.
   If the patient is highly susceptible to decubitus ulcers, but currently has no ulcer present, place a "9" under ulcer #1.
   What condition puts patient at risk? _____

	Ulcer #1	Ulcer #2	Ulcer #3
Stage:			
Max. Length (cm)			
Max. Width (cm)			

For Air Fluidized bed, has home been assessed for adequate structural support (bed weighs 1600 pounds) and for electrical system capacity to handle safely?	Y	N
For Alternating Pressure mattress, has appropriate Group I (pressure reducing foam or gel) support surface been tried and failed before request for Group II?	Y	N
Has patient had recent (60 days) myocutaneous flap or skin graft? If yes – what anatomic area? _____	Y	N

Estimated Length of Need (in months): _____(99 = Permanent)

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.