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 O_2
    b) Oxygen Saturation Test ______% on 4L O_2

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

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