

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.