**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 <u>this request</u> 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? (<u>Not</u> 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 <u>and</u> 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 <u>while on 4 LPM</u>

    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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