**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.