Program Memorandum
Carriers

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-00-08 **Date: FEBRUARY 2000**

CHANGE REQUEST 1082

SUBJECT: Instruction for Usage of the Revised Oxygen Certificate of Medical Necessity Form 484.2 (dated 11/99)-----ACTION

The Office of Management and Budget has approved use of the revision of the Oxygen Certificate of Medical Necessity (CMN). The changes to the CMN are the disclosure statement on the back page under the instructions, a word change to the instructions and the date of the form. The changes to the CMN are as follows:

The disclosure statement now states that the estimate for the time required to complete this information has changed from 15 minutes to 10 minutes. The other change to the disclosure statement is to the address for suggestions which now reads, "HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503." All verbiage to the instructions on the back page has been changed from "ordering" physician to "treating" physician. The date of the form, which indicates a revision without substantive changes, has been changed from 5/97 to 11/99.

You may continue to accept the CMN dated 5/97 with claims received on or before September 30, 2000. The revised form is required for claims received by the DMERCs on October 1, 2000 or after.

The *effective date* for this Program Memorandum (PM) is April 1, 2000.

The *implementation date* for this PM is October 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2001.

If you have any questions, contact Karen Daily at (410) 786-0189.

ATTACHMENT

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY

DMERC 484.2

OXYGEN

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION __/___/__

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____		(__ __ __) __ __ __ - __ __ __ __ NSC # _____
PLACE OF SERVICE _____	HCPCS CODE	**PT DOB ___/___/___; Sex ___ (M/F) ; HT.____(in.) ; WT.____(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See Reverse)	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (__ __ __) __ __ __ - __ __ __ __ UPIN # _____

SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | **DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ANSWERS	ANSWER QUESTIONS 1-10. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
a) _____ mm Hg b) _____% c) ___/___/___	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO_2 and/or (b) oxygen saturation test. Enter date of test (c).
Y N	2. Was the test in Question 1 performed **EITHER** with the patient in a chronic stable state as an outpatient **OR** within two days prior to discharge from an inpatient facility to home?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7). Print/type name and address below: NAME: ADDRESS:
Y N D	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.
_____ LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "**X**".
a) _____ mm Hg b) _____% c) ___/___/___	7. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO_2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
IF PO_2 = 56–59 OR OXYGEN SATURATION = 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.	
Y N D	8. Does the patient have dependent edema due to congestive heart failure?
Y N D	9. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N D	10. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge and **(3)** Medicare Fee Schedule Allowance for each item, accessory and option. *(See instructions on back.)*

SECTION D Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.