

# ArmsCare Inc.

Hospital Equipment and Services in Your Home  
1-888-545-4949 or 724-545-3200

## Home Oxygen/Respiratory

**Fax to: 724-543-2718**

### **Referral Information:**

Date \_\_\_\_\_ Time \_\_\_\_\_ Facility \_\_\_\_\_

Facility Contact Person: \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

### **Patient Information:**

Patient Name \_\_\_\_\_ Diagnosis \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone \_\_\_\_\_ Emergency Contact Phone \_\_\_\_\_

SSN# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Special Instructions/Education \_\_\_\_\_

### **Insurance Information:**

Primary Insurance \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

|  |   |
|--|---|
| <b>Prescription:</b><br>Oxygen (Please fax O2 Sats/ABGs)<br><input type="checkbox"/> Concentrator<br><input type="checkbox"/> Liquid<br><input type="checkbox"/> Portable<br><input type="checkbox"/> Gaseous<br><input type="checkbox"/> Other _____  | Test Results: <b>Test Date</b> _____<br><input type="checkbox"/> Rest <input type="checkbox"/> Exercise <input type="checkbox"/> Nocturnal<br><input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen @ _____ lpm<br>SpO2 _____ % or PaO2 _____<br><input type="checkbox"/> RDI _____<br><input type="checkbox"/> Low sat _____ |
| Use Oxygen at _____ liters/minute _____ Hours per day <input type="checkbox"/> Mask <input type="checkbox"/> Nasal Cannula   |   |
| <b>Sleep Equipment (please fax sleep study)</b><br><input type="checkbox"/> CPAP @ _____ cmH2O<br><input type="checkbox"/> BiPAP @ _____ IPAP _____ EPAP _____<br>Back-up Rate (BIPAP S/T) _____<br><input type="checkbox"/> Humidifier _____ Cool _____ Heated<br><input type="checkbox"/> Oxygen Bled in @ _____ LPM<br><input type="checkbox"/> Mask, size if available _____ | <b>Other HME Equipment</b><br><input type="checkbox"/> Nebulizer<br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> Other _____  |
| Physician Name: _____ Phone: _____<br>Address: _____ Fax: _____<br>_____<br>Physician NPI # _____  |   |

**Serving Armstrong and surrounding Counties**

# CERTIFICATE OF MEDICAL NECESSITY CMS-484 — OXYGEN

**DME 484.03**

|  |   |  |
|--|---|--|
| <b>SECTION A</b> Certification Type/Date: INITIAL ___/___/___    REVISED ___/___/___    RECERTIFICATION ___/___/___  |   |  |
| PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER<br><br>( ___ ) ___ - ___ HICN _____  |   | SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER<br><br>( ___ ) ___ - ___ NSC or NPI # _____ |
| PLACE OF SERVICE _____   | HCPCS CODE _____  | PT DOB ___/___/___    Sex ___ (M/F)  |
| NAME and ADDRESS of FACILITY<br><i>if applicable (see reverse)</i><br><br>_____<br>_____<br>_____  |   | PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN<br><br>( ___ ) ___ - ___ UPIN or NPI # _____            |
| <b>SECTION B</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 1-9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)  |  |
| a) _____ mm Hg<br>b) _____ %<br>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 <sub>2</sub> and/or (b) oxygen saturation test; (c) date of test.  |  |
| 1    2    3  | 2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?                             |  |
| 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  |  |
| Y    N    D  | 4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.   |  |
| _____ LPM  | 5. 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<br>b) _____ %<br>c) ___/___/___   | 6. 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 <sub>2</sub> and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c). |  |
| <b>ANSWER QUESTIONS 7-9 ONLY IF PO<sub>2</sub> = 56-59 OR OXYGEN SATURATION = 89 IN QUESTION 1</b>   |   |  |
| Y    N   | 7. Does the patient have dependent edema due to congestive heart failure?   |  |
| Y    N   | 8. 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   | 9. 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: _____   |   |  |
| <b>SECTION C</b> 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.)  |   |  |
| <b>SECTION D</b> 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 ___/___/___   |

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# INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN (CMS-484)

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**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 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 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) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxx)

**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. 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.

**PHYSICIAN INFORMATION:** Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)

**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 practitioner.)**

**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 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 4 codes).

**QUESTION SECTION:** This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, or "D" for does not apply.

**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(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, 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's 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.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0534. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

**DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.**