Medicare Oxygen Resource

Completing CMN Documents: Guidelines for Accuracy

Please call us with any questions
<Local branch name>
<Branch phone number>

CMN Cover Letter

For your reference, the cover letter includes the information provided to Apria at the time of referral.

Highlighted items are color coded to match the CMN example shown on the back.

APRIA HEALTHCARE®

APRIA HEALTHCARE INC
26220 ENTERPRISE CT
LAKE FOREST, CA 92630

INITIAL OXYGEN COVER LETTER

Physician's Fax #: 949-639-2001

Date: 07/21/2012
RE: RICHARD THOMPSON
HICN: 123456789A
DOB: 5/26/1935

Services	
E1390	OXYGEN CONCENTRATOR
E0431	PORTABLE GASEOUS OXYGEN SYSTEM; RENTAL

JOHN DOE
111 ENTERPRISE WAY BUILDING 5
LAKE FOREST, CA 92630

Dear Physician:

Below you will find the information that we confirmed from your order on 07/15/2012. The Medicare coverage guidelines require that a Certificate of Medical Necessity (CMS-484) form be included with all claims submitted to the Medicare Carrier. Under OBRA'90 regulations, we are prohibited from completing portions of this CMS-484 on your behalf. The information below is for confirmation purposes only and should not be used for the completion of the enclosed form. Information for the completion of the CMS-484 should be obtained from your own files.

As you know, correct information regarding the patient needs to be inserted into the attached blank CMS-484. In particular, if there are any changes in the order, the changes should be reflected on the attached blank form. **Any changes or corrections made on the attached CMN must also contain your initials and the date (MM/DD/YY) that you or your staff completed the change.**

QUESTIONS WE REVIEWED:	ANSWERS WERE PROVIDED BY: ANNE SMITH, RESP THERAPY
Diagnosis of Patient? 496. CPR. AIRWAY OBSTRUCT NEC	<<-------
Estimated Length of Need? 1 - 99 (99 = Lifetime)	99
Enter result(s) of most recent test(s) taken ON OR BEFORE the certification date in Section A: a) ARTERIAL BLOOD GAS PO2? b) OXYGEN SATURATION TEST? c) What is the date of most recent TEST?	a) b) 85.0% c) 07/01/2012
Was the above TEST 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
What were the condition(s) of the above TEST(s)? 1 = At Rest, 2 = Exercise, 3 = Sleep	1
If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, choose D.	YES
Enter highest oxygen flow rate ordered for patient in LPM, if less than 1, enter an 'X'.	002
If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM: a) ARTERIAL BLOOD GAS PO2 b) OXYGEN SATURATION TEST c) What is the date of most recent TEST?	a) b) c)
Does the patient have dependent edema due to congestive heart failure?	NO
Does 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?	NO
Does the patient have a hematocrit greater than 56%?	NO

Please complete ALL sections of the attached CMS-484, per CMS instructions, sign, date (MM/DD/YY), and either fax back to 800-878-5955, or return in the enclosed self-addressed, stamped envelope.
Please feel free to call (949) 639-2000, or fax to aforementioned fax#, should you have any questions. Thank you.

*CT99 - 0063255 - 21 - M

Diagnosis code and description.

Estimated length of need.

Results from the ABG PO_2 or saturation test. The test date should correspond with the applicable qualified test.

Test mode: Chronic/Inpatient/Other.

Test condition: Rest/Exercise/Sleep.

Patient mobile in home? When not ordering portable oxygen, D applies. Otherwise, the question is Yes or No.

Highest oxygen flow rate in Liters per Minute (LPM).

Information for Group II patients (if PO_2 = 56-59 mm Hg or O_2 sat = 89%).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0534

DME 484.03

CERTIFICATE OF MEDICAL NECESSITY
CMS-484 — OXYGEN

SECTION A Certification Type/Date: INITIAL 07/15/12 REVISED ___/___/___ RECERTIFICATION ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

RICHARD THOMPSON AAJ354
123 TULIP DRIVE
LAKE FOREST, CA 92630
(555) 276 - 7889 HICN 123456789A

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER
APRIA HEALTHCARE INC *CT99 - 0063255 - 21
26220 ENTERPRISE CT
LAKE FORST, CA 92630
(949) 639 - 2000 NSC or NPI # 1C1234560001

PLACE OF SERVICE 12

HCPCS CODE
E1390
E0431

PT DOB 05 / 26 / 35 Sex M (M/F)

NAME and ADDRESS of FACILITY
if applicable (see reverse)

PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN
JOHN DOE
111 ENTERPRISE WAY
BUILDING 5 LAKE FOREST, CA 92630
(949) 639 - 2000 UPIN or NPI # 1GRES000

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 1–9. (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 PO2 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 b)_____% 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 PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
	ANSWER QUESTIONS 7-9 **ONLY** IF PO2 = 56–59 OR OXYGEN SATURATION = 89 IN QUESTION 1
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: _____

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.) 002 LPM AT REST 24.00 Hrs/Day

HCPCS	DESCRIPTION	SUBMIT CHARGE	MCR ALLOWABLE
E1390	OXYGEN CONCENTRATOR	$760.48	$176.06
E0431	PORTABLE GASEOUS OXYGEN SYSTEM; RENTAL	$305.76	29.43

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.

Form CMS-484 (09/05)

Medicare Certificate of Medical Necessity

Highlighted items are color coded to match the cover letter information.

Please note: Section B of the CMN cannot be completed by Apria Healthcare.

Must be a cumulative, numerical LON (lifetime = 99).

Must contain at least one diagnosis code.

Results of the ABG PO_2 or saturation test.

Test date should correspond with applicable qualifying test and must be within 30 days of the certification/ therapy start date or two days from hospital discharge.

Ensure LPM in these two sections are the same.

For Group I patients, 7, 8 and 9 may be left blank. For Group II patients, 7, 8 and 9 must be answered.

If someone other than the physician completed the CMN, need name, title and employer.*

The physician's signature must correspond with the physician's information in Section A.

The physician must fill in the date. Staff cannot fill in the date on behalf of the physician.*

*No corresponding item on CMN cover letter.

Reminders

- Please remember that ALL cross-outs and/or overwrites MUST be initialed and dated by the physician. Do not use correction fluid or tape.
- Different color pens used to complete CMN may be construed by Medicare auditors as unauthorized corrections.
- Signature/date stamps are not allowed.
- Electronic signatures should be accompanied by a statement indicating that the signature was applied electronically (i.e., electronically signed by, authenticated by, digitally signed by, validated by, etc.).