SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: ______________________________ **Medicaid # (10 digits):** ______________________________

(2) DOB ____/___/______ **Sex:** ___ **HT:** _______**(in)** **WT**______ **Date of service:** _____/____/______________________

(3) Provider's name: ______________________ **Provider's DME #:** ______________**NPI #:**____________________

(4) Street address: ____________________**City:** __________**State:**____ **Zip:** ________**Local telephone #:** ____________

(5) Provider's signature: ______________________________**Date:** ______________________________

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT:

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SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD) _________ **(Descriptions):** ____

_________ ____

_________ ____

(8) 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, 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
XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXXX	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"**

IF PO2 = 56-60 OR OXYGEN SATURATION = < 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.

Y N 7	7. Does the patient have dependent edema due to congestive heart failure?
Y N D	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 D	9. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION C QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: ______________________________ TITLE: ______________________ EMPLOYER: ______________________

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: ______________________________

(10) Please indicate the Prescription date: ____

(11) Duration of need (maximum of 12 months): ____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME ________________________ PHYSICIAN'S NPI # ______________________________

PHYSICIAN'S SIGNATURE ________________________ DATE___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME # and NPI #.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician.** **Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).**
QUESTION SECTION:	**This section is used to gather clinical information to help Medicaid 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 question of Section B, he/she must print his/her name, give his/her professional title and name of his/her employer where indicated. If the physician is answering the question, this space may be left blank.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 90 days of the date of treating /ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**