DME 04.04B

## CERTIFICATE OF MEDICAL NECESSITY CMS-846 — PNEUMATIC COMPRESSION DEVICES

SECTION A Certification Type/Date: INITIAL/ REVISED/ RECERTIFICATION//			
		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER	
() HICN		() NSC or NPI #	
PLACE OF SERVICE	HCPCS CODE	PT DOB/ Sex (M/F) Ht(in) Wt(lbs.)	
NAME and ADDRESS of FACILITY	TIOI OS COBE	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable	
if applicable (see reverse)		NPI NUMBER or UPIN	
		() UPIN or NPI #	
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.			
EST. LENGTH OF NEED (# OF MONTHS	S): 1-99 <i>(99=LIFETIME)</i>	DIAGNOSIS CODES (ICD-9):	
ANSWERS ANSWER QUESTIONS 1–5 FOR PNEUMATIC COMPRESSION DEVICES (Circle Y for Yes, N for No, Unless Otherwise Noted)			
Y N 1. Does the patient have chronic venous insufficiency with venous stasis ulcers?			
Y N 2. If the patient has venous stasis ulcers, have you seen the patient regularly over the past six months and treated the ulcers with a compression bandage system or compression garment?			
Y N 3. Has the patient had radical cancer surgery or radiation for cancer that interrupted normal lymphatic drainage of the extremity?			
Y N 4. Does the pat	4. Does the patient have a malignant tumor with obstruction of the lymphatic drainage of an extremity?		
Y N 5. Has the patient had lymphedema since childhood or adolescence?			
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):  NAME: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/	

## INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR PNEUMATIC COMPRESSION DEVICES (CMS-846)

**SECTION A:** (May be completed by the supplier)

CERTIFICATION 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 TYPE/DATE:

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 Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number

INFORMATION: (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER 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 INFORMATION:

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, 1Cxxxxxxxxxx)

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:

PHYSICIAN NAME, ADDRESS:

Indicate the PHYSICIAN'S name and complete mailing address.

**PHYSICIAN** Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National INFORMATION:

Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number.

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

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:

AND DATE:

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

Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered

allowance for each item(s), options, accessories, supplies and drugs, if applicable.

**SECTION D:** (To be completed by the physician)

**PHYSICIAN** The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the

ATTESTATION: answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in

are medically necessary for this patient. 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 0938-0679. 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.