LINCARE

Respiratory Solutions

A comprehensive approach to the provision of home respiratory medication therapy that includes:

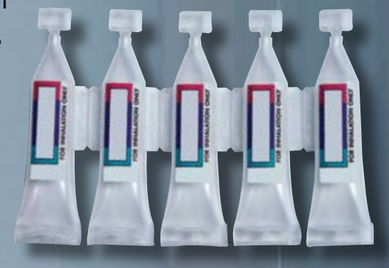
- Clinical education in the home
- Compliance monitoring
- Customized equipment to fit any patient's needs
- Medicare and other payers billed directly

Reliant Pharmacy Service

Providing respiratory medications

Reliant Pharmacy will provide overnight delivery of the following medications, which are covered by Medicare when used with a prescribed nebulizer:

- Albuterol
- Ipratropium
- Albuterol 2.5mg/Ipratropium .5mg in a 3ml commercial vial
- Levalbuterol
- Budesonide



L-05-02 (03/07)

care check

Provided by Lincare

A clinical service designed to meet the needs of early stage COPD patients

Lincare's Standard of Care for Your Respiratory Patients

Components:

- Home visits by licensed Clinical Specialists
- Education on disease process, prescribed therapies and equipment management
- Respiratory assessment
- Follow-up reporting

Benefits:

- Improved patient compliance through patient education
- Improved quality of life
- Clinical feedback in a timely manner

For more information contact your local LINCARE center

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

Form Approved
OMB No. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY
CMS-484 — OXYGEN

DME 484.03

SECTION A **Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___**

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER		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)
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable 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): _____ 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.)

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 ____/____/____

Form CMS-484 (09/05) EF 08/2006

Length of need <99 months - retesting required for renewal

1. PO_2 or saturation from test results and test date

2. Testing conditions

3. Patient condition at testing

4. Portable

5. Liter flow

6. If greater than 4 LPM

7-9. If applicable

List the ICD code number that represents the primary reason for ordering this item

Hand Written Physician Signature and Date

LINCARE®

Medicare Guidelines for Oxygen Reimbursement

Group I criteria include any of the following:

1) An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88% taken at rest (awake)

   OR

2) An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, for at least 5 minutes (cumulative) taken during sleep for a patient who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake

   OR

3) An arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken during exercise for a patient who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

Group II criteria include the presence of (a) an arterial PO_2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89% at rest (awake), during sleep for at least 5 minutes (cumulative), or during exercise (as described under Group I criteria) and (b) any of the following:

1) Dependent edema suggesting congestive heart failure

   OR

2) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater then 3 mm in standard leads II, III or AVF)

   OR

3) Erthrocythemia with a hematocrit greater than 56%.

CMS, Medical Coverage Issues Manual, 60-4, Home Use of Oxygen

LINCARE®
Patient Information