Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: POSITIVE AIRWAY PRESSURE DEVICES

Identifying Information [This section may be completed by the provider.]

Individual	**Prescriber**	**Provider**
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Address*	Telephone number	
	*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)	Date of evaluation	Previous PA number

Results of the sleep study:

Diagnosis component

☐ An AHI of at least 15

☐ An AHI of at least 5 coupled with documented evidence of any of the following conditions:

☐ Excessive sleepiness during waking hours ☐ Mood disorder ☐ Ischemic heart disease

☐ Insomnia ☐ Impaired cognition ☐ Hypertension ☐ History of stroke

Titration component, without supplemental oxygen

☐ A decrease in the number of airway obstructions per hour with any of the following indications of effectiveness:

☐ An absolute increase in oxygen saturation to at least 89%

☐ A relative increase in oxygen saturation of at least 15%

☐ Other clinical improvement _____

Titration component, with supplemental oxygen

☐ A decrease in the number of airway obstructions per hour with any of the following indications of effectiveness:

☐ An absolute increase in oxygen saturation to at least 89%

☐ A relative increase in oxygen saturation of at least 15%

☐ Other clinical improvement _____

Specification of a variable or bilevel positive airway pressure device:

☐ A positive airway pressure device that produces a single pressure level has been tried and found to be ineffective.

☐ Evidence gathered during the sleep study or during a one-week trial period indicates that a variable or bilevel positive airway pressure device is effective.

Estimated length of need: ○ _____ months ○ Indefinite/perpetual ☐

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.