Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: APNEA MONITORS

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.

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

Mark all items that apply.

Diagnosis code(s)	Other equipment in use

- ☐ Occurrence of at least one apparent life-threatening event (ALTE) requiring mouth-to-mouth resuscitation or vigorous stimulation
- ☐ Need for active medical management of apnea of prematurity
- ☐ Occurrence of sudden infant death syndrome (SIDS) in a sibling
- ☐ Need for home oxygen therapy or ventilatory support (either invasive or non-invasive) and associated technology-dependence
- ☐ Tracheotomy and associated technology-dependence
- ☐ Abnormal pneumogram at discharge from a medical facility
- ☐ Severe gastroesophageal reflux and associated apnea
- ☐ Severe upper airway abnormality (e.g., achondroplasia, Pierre Robin syndrome)
- ☐ Another disorder necessitating close cardiorespiratory monitoring (Specify) _____
- ☐ The appropriate caregivers are capable of being trained to use the monitor properly.

Certification for Additional Rental or Purchase [This section may be transcribed by the provider.]

Mark all items that apply.

☐ Rental: Requested dates from __/__/____ to __/__/____ ☐ Purchase
Prior dates from __/__/____ to __/__/____

Prior PA number

- ☐ The individual has a need for continued home monitoring.
- ☐ The child is technology-dependent.
  (Attach documentation that the equipment or service on which the child is dependent — not the apnea monitor itself — is still necessary and is still being used.)
- ☐ The child is not technology-dependent.
  - ☐ Single apnea episode: Date ___/___/_____ Length _____
  - ☐ Multiple apnea episodes: Number _____ Average length _____
  - ☐ Single bradycardia episode: Date ___/___/_____ Length _____ Heart rate _____
  - ☐ Multiple bradycardia episodes: Average length _____ Average heart rate _____
  - ☐ Recent emergency department visit or ☐ Recent hospital admission for an ALTE: Date ___/___/_____

  (Attach supporting documentation.)
- ☐ The child had a sibling who died of SIDS. Sibling's birth date ___/___/_____ and death date ___/___/_____

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.