CERTIFICATION OF MEDICAL NECESSITY FOR CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE (CPAP)

Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____	
Members Name:	**Members Medicaid Number (Do Not List Mother's ID):**
Patient DOB ____/____/____ **Sex** ______ **HT.** ______ **(in) WT.** ______ **(lbs.)**	
Suppliers Name: Professional Medical HHC	**Suppliers Address and Telephone Number:** 4855 Memorial Drive Stone Mountain, GA 30083 404-292-9190
Suppliers NPI Number: 1942287131	
Physicians Name:	**Physicians Address and Telephone Number:**
Physicians NPI Number:	
HCPCS Code(s)	
Place of Service	

A copy of the polysomnography must be attached.

Primary Diagnosis________________________________ ICD-10 Diagnosis Code______________

☐ Obstructive sleep -apnea (ICD-10 Diagnosis Code CM G47.33)

Secondary Diagnoses supporting medical necessity:________________________________

ICD 10 Diagnosis Code(s)______________ Length of Need ______________________

Related Signs and Symptoms:

☐ nocturnal hypoxemia (greater than 5% sleep time is below 85% oxygen saturation or oxygen saturation falls less than 75%)

☐ Cor pulmonale (altered structure and/or impaired function of the right ventricle that results from pulmonary hypertension that is associated with diseases of the lung)

☐ Ventricular arrhythmias ☐ Daytime hyper somnolence (Epworth sleepiness score > 10) ☐ Hypertension

Polysomnography:

Length of sleep study ___________hours Apnea Index ____________ Apnea/Hypopnea Index ____________

Is surgery an alternative? ☐ Yes ☐ No Is the member cooperative and motivated? ☐ Yes ☐ No

I certify that the continuous pressure airway (CPAP) device requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature ____ Date_____/_____/_____

Additionally, the respiratory therapist or certified sleep technologist responsible for instruction and fitting of the mask must sign and date below, and the license or certification number must be listed.

Signature of RT/CST ____ Date _____/_____/_____

Certification or License #____________________________ Expiration Date _____/_____/_____

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.

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