

CERTIFICATE OF MEDICAL NECESSITY

DME 03.03

CMS-10269: POSITIVE AIRWAY PRESSURE (PAP) DEVICES FOR OBSTRUCTIVE SLEEP APNEA

SECTION A: Certification Type/Date: INITIAL ____/____/____ RECERTIFICATION ____/____/____

PATIENT NAME, ADDRESS, TELEPHONE and HICN

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #

(____) ____ - ____ HICN ____

(____) ____ - ____ NSC or NPI # ____

PLACE OF SERVICE ____

HCPCS CODE ____

PT DOB ____/____/____; Sex ____ (M/F); HT. ____ (in.); WT. ____ (lbs.)

NAME and ADDRESS of FACILITY if applicable
(See Reverse)

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S NSC or NPI #: ____

PHYSICIAN'S TELEPHONE #: (____) ____ - ____

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 1-7 FOR INITIAL EVALUATION

ANSWER QUESTIONS 8-10 FOR FOLLOW-UP EVALUATION (RECERTIFICATION)

(Check Y for Yes, N for No, D for Does Not Apply)

☐ Y ☐ N1. Is the device being ordered for the treatment of obstructive sleep apnea (ICD-9 diagnosis code 327.23)?
If YES, continue to Questions 2-5; If NO, Proceed to Section D

____/____/____

2. Enter date of initial face-to-face evaluation

____/____/____

3. Enter date of sleep test (If test spans multiple days, enter date of first day of test)

☐ Y ☐ N

4. Was the patient's sleep test conducted in a facility-based lab?

5. What is the patient's Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI)?

☐ Y ☐ N

6. Does the patient have documented evidence of at least one of the following? Excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease or history of stroke.

☐ Y ☐ N ☐ D

7. If a bilevel device is ordered, has a CPAP device been tried and found ineffective?

____/____/____

8. Enter date of follow-up face-to-face evaluation.

☐ Y ☐ N9. Is there a report documenting that the patient used PAP \geq 4 hours per night on at least 70% of nights in a 30 consecutive day period?☐ Y ☐ N

10. Did the patient demonstrate improvement in symptoms of obstructive sleep apnea with the use of PAP?

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 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 ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)