Form Approved
OMB No. OMB 0938-0679

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 ☐ N	1. 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 ☐ N	9. Is there a report documenting that the patient used PAP ≥ 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)