Reset Form

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
APNEA MONITORS

Instructions: The Certificate of Medical Necessity (CMN) must be used for apnea monitors under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer	Medicaid Number — — — — — — — — — — — —

Street Address	City/State/Zip	Date of Birth

List other respiratory equipment in use	Prior Dates of Service

Section A - Must be completed by prescriber

Diagnosis(es) Include ICD-9 codes and description

The first 4 months of rental are covered without prior authorization. Check the appropriate **clinical indication(s)** listed below (check all that apply to the initial 4 month rental period):

- ☐ One or more apparent life-threatening events requiring mouth-to-mouth resuscitation or vigorous stimulation
- ☐ Symptomatic preterm infant (active medical management of apnea of prematurity)
- ☐ Sibling of one or more sudden infant death syndrome (SIDS) victims
- ☐ Infant required home oxygen therapy or invasive/non-invasive ventilatory support (technology dependent)
- ☐ Tracheotomized infant (technology dependent)
- ☐ Infant with abnormal pneumogram at discharge
- ☐ Infants with severe upper airway abnormalities (e.g., achondroplasia, Pierre-robin syndrome, etc.)
- ☐ Multiple birth SIDS survivor
- ☐ Severe gastroesophageal reflux associated with apnea
- ☐ Infants with other disorders that demonstrate a need for close cardiorespiratory monitoring to facilitate discharge. Specify:

Continued monitoring (check all that apply) Infant is ☐ Technology dependent ☐ Non-technology dependent

- ☐ Apnea episode: Date: _____/_____/_____ Length of episode: _____
- ☐ Multiple apnea episodes: Number: _____ Average length of episodes: _____
- ☐ Bradycardia episode: Date: _____/_____/_____ Heart rate: _____ Length of episode: _____
- ☐ Multiple bradycardia episodes: Average heart rate: _____ Average length of episode: _____
- ☐ Recent emergency room visit or ☐ Hospital admission, for ALTE Date of visit/admission: _____/_____/_____

Technology dependent infant:

- ☐ Infant is still in need of monitoring
- ☐ Equipment (other than apnea monitor) is still in use. Specify other technology/equipment:

SIDS Sibling	Date of Birth	Sibling Date of Death

Section B - Must be completed by the Provider of medical suppler services

Provider adheres to the requirements for use of home monitoring as recommended in the "Supplemental Statement on Home Monitoring - 1984" adopted by the Committee on Sudden Infant Death Syndrome of the Ohio Chapter of the American Academy of Pediatrics:, in accordance with rule 5101:3-10-09 of the OAC.

I certify that the information in Section C of this certificate of medical necessity is true. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider authorized representative *(PRINT name)*

Provider Authorized Representative Signature	Date

Section C - Prescriber Attestation and Signature/Date

Prescriber's Name *(PRINTED)*

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature	Date	Ohio Medicaid Provider #