Ohio Department of Medicaid

# CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
# IPPV OR APAP IN LIEU OF A VOLUME VENTILATOR

**Certification Type:** ☐ **Initial** ☐ **Revised** ☐ **Recertification**

***Instructions: The Certificate of Medical Necessity (CMN) must be used for approved ventilators 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 billing# |
|---|---|
| | |

| Street address | City/State/Zip | Date of birth |
|---|---|---|
| | | |

List other respiratory equipment in use

**Section A—Must be completed by prescriber**

Diagnosis(es) Include ICD-9 code and description

| Date of last examination by prescriber (must be within 30 days prior to first date of service) | Consumer has permanent tracheostomy ☐ Yes ☐ No |
|---|---|
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Medical history (attach hospital discharge summary, if applicable)

| ☐ APAP or ☐ IPPV device is required for ventilatory support/only effective alternative to a volume ventilator | Length of need ☐ Short term, # of months ☐ Chronic/permanent |
|---|---|
| | |

| Ventilatory support requirements<br>☐ Continuous ☐ Nocturnal only<br>☐ Other, explain: | Ventilator settings/parameters<br>O2 setting |
|---|---|
| | |

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's signature | Date | Ohio Medicaid Legacy #<br>NPI # |
|---|---|---|
| | | |

**Section B—Must be completed by Licensed Respiratory Care Professional (LRCP)**

Complete this section if the ventilator was dispensed prior to submitting prior authorization request

| **Licensed respiratory care professional services**<br>Date placed on ventilator<br>☐ Yes ☐ No Home evaluation prior to hospital discharge?<br>☐ Yes ☐ No Home set up?<br>☐ Yes ☐ No In-home training provided to care givers?<br>If "yes", check all that apply:<br>☐ Ventilator operation<br>☐ Tracheostomy care<br>☐ Cleaning/sterilizing technique | Home visits first week<br>☐ 5-7 ☐ 3-4 ☐ 1-2<br>Home visits after the first week (at least monthly)<br>Dates: 1)<br>2)<br>3)<br>4)<br>5)<br>6)<br>Is the consumer being weaned? ☐ Yes ☐ No |
|---|---|
| | |

LRCP name *(PRINTED)*

***I certify that I am the respiratory therapist 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.***

| LRCP signature | Date | License # |
|---|---|---|
| | | |