

**Certificate of Medical Necessity (CMN) for: Continuous Positive Airway Pressure**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Requesting Provider: \_\_\_\_\_

Pt. Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

1. Does the patient have a diagnosis of Obstructive Sleep Apnea by polysomnogram? Y      N

2. Enter the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI).

3. Is the Obstructive Sleep Apnea suspected to be causing Dysrhythmia(s)? Y      N

4. What additional clinical diagnoses does this patient have? (Circle)

- a. Excessive daytime sleepiness
- b. Impaired cognition
- c. Mood disorders
- d. Insomnia
- e. Hypertension
- f. Ischemic heart disease
- g. History of stroke

5. Results of CPAP Trial (at Optimum CPAP Pressure)

a. Enter the AHI or RDI at optimum CPAP

\_\_\_\_\_ %

b. During the Trial, what was the Lowest Oxygen Saturation?

\_\_\_\_\_

c. Did CPAP correct the Dysrhythmia(s)?

Y      N      D

6. Does the patient have clinically significant Congestive Heart Failure? Y      N

Contact Name: \_\_\_\_\_

Phone : \_\_\_\_\_

\_\_\_\_\_  
Physician Signature (Stamps are not acceptable)

\_\_\_\_\_  
Date

Key - (Y)es, (N)o, (D)oes not apply

**Requested Information:**

1. Typed office note with pertinent information.
2. All sleep study documentation