GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATION OF MEDICAL NECESSITY FOR BLOOD PRESSURE MONITOR

<table>
<tr><td colspan="3">Certification Type/ Date: Initial ___/___/___ Revised ___/___/___</td></tr>
<tr><td colspan="2">Member's Name:</td><td>Member's Medicaid Number:</td></tr>
<tr><td colspan="3">Patient DOB ___/___/___ Sex ____ Height ____ (in) Wt. ____ (lbs) Upper Arm Circumference ____ (in)</td></tr>
<tr><td colspan="2">Supplier's Name:</td><td rowspan="2">Supplier's Address, Telephone, Email:</td></tr>
<tr><td colspan="2">Supplier's NPI Number:</td></tr>
<tr><td colspan="2">Physician's Name:</td><td rowspan="2">Physician's Address, Telephone, Email:</td></tr>
<tr><td colspan="2">Physician's NPI Number:</td></tr>
<tr><td>HCPCS Code(s):</td><td colspan="2"></td></tr>
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Blood Presssure Monitors are only covered for Members with an HTN-related Diagnosis Code. The at-home use Blood Pressure Monitor should be covered once in five (5) years, and every 2 years for the cuff. The wrist-style is only covered for an upper arm circumference over 50 cm, or other documented inability to use the standard type. The Blood Pressure Monitor must be a validated BP device pursuant to www.validatebp.org, or listed on the U.S. Blood Pressure Validated Devisce Listing (VDL™).

A validated home Blood Pressure Monitor may be deemed a medically necessary alternative to ambulatory blood pressure monitoring to confirm the diagnosis of hypertension and manage the treatment to improve control in persons age 18 years of age and older who have elevated blood pressure readings in the office (greater than 140 systolic or 90 diastolic) and the following criteria are met:

1. The blood pressure cuff is prescribed by a physician; and,
2. Arm devices only without a documented exception; and,
3. Correct cuff size assessed and provided by the vendor; and,
4. Only one blood pressure cuff considered medically necessary per five (5) years.

Validated blood pressure monitors are deemed to be medically necessary for Members receiving hemodialysis or peritoneal dialysis in the home, or for Members diagnosed with gestational-hypertension or pregnancy-induced hypertension. (Note that a monitor for a pregnancy-related indication is not to be routinely replaced every five years.)

Primary Diagnosis: _____

ICD-10 Diagnosis Code: _____

Secondary Diagnoses supporting medical necessity: _____

Secondary ICD-10 Diagnoses Codes: _____

Indicate the latest 3 BP readings of the Member	Date: ___/___/___	Date: ___/___/___	Date: ___/___/___
	Reading:	Reading:	Reading:
How frequently does the BP need to be monitored?			

I certify that the Blood Pressure Monitor requested is medically necessary for this Member, and that I have had a face-to-face evaluation with this Member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring or prescribing medical services.

Date of face-to-face evaluation ___/___/___ (Must have occurred within 180 days prior to the order date.)

Physician's Signature: _____ Date: ___/___/___

Stamps are not an acceptable form of authentication for the date or signature on a Certificate of Medical Necessity or prescription/ written order submitted to Georgia Medicaid.

To be completed by DME Provider or Pharmacy:

Brand and Model of BP Monitor.	
Is BP Monitor validated?	
Cuff size:	

I certify that the Blood Pressure Monitor dispensed is a validated BP device pursuant to www.validatebp.org, or listed on the U.S. Blood Pressure Validated Devisce Listing (VDL™). I further certify that this entity is enrolled with Georgia Medicaid for the purpose of ordering, referring or dispensing DME.

Authorized Signature: _____ Date: ___/___/___

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