

CERTIFICATE OF MEDICAL NECESSITY FOR A MOTORIZED WHEELCHAIR, CUSTOM OR STANDARD

The DME provider must complete all applicable areas not completed by the clinician or therapist.

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for a motorized wheelchair. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information will result in a deferral, denial or delay in payment of the claim.

REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

SECTION 1—Clinician's Information:

Clinician Name (Print)	Last	First	Phone Number () - () - () ()	License Number
Address		Street	City	State ZIP

Clinician's description of the patient's current functional status and need for the requested equipment: _____

SECTION 2—Patient's Information: New Rx (For Rx Renewal, please also complete 2A below)

Patient Name (Print)	Last	First	Date of Birth () - () - () ()	Medi-Cal Number
Address		Street	City	State ZIP

Date of last face-to-face visit with the beneficiary: _____

Is this beneficiary expected to be institutionalized within the next 10 months? Yes ☐ No ☐ Explain "Yes" answer: _____

Equipment required for:

- ☐ Less than 10 months (code the TAR for a rental)
- ☐ More than 10 months (code the TAR for a purchase)

SECTION 2A—For Renewal

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

SECTION 3—Motorized Wheelchair Requested:

- | | |
|--|--|
| a) Standard HCPCS Code(s): _____ | b) Custom HCPCS Code(s): _____ |
| c) Replacing existing equipment? ☐ Yes ☐ No Model/Serial # _____ If yes, explain why: _____ | |
| d) Attach repair estimate if replacement with similar equipment is requested. | |
| e) Other DME the beneficiary has: _____ | f) Current wheelchair: _____ |
| g) How many hours per day of usage: _____ | h) Accessories requested and why (use attachments): _____ |
| i) Custom features requested and why: _____ | j) Have they tried the chair? ☐ Yes ☐ No |

SECTION 4—Diagnoses Information:

Diagnoses: _____

Date of onset: _____

SECTION 5—Pertinent History:

Pressure Sores Present: ☐ Yes ☐ No

Beneficiary has a history of pressure sores: ☐ Yes ☐ No

Beneficiary lacks protective sensation and is at risk for developing sores: ☐ Yes ☐ No

Beneficiary's protective sensation is intact: ☐ Yes ☐ No

If sores are present, location and stage: _____

SECTION 6—Pertinent Exam Findings:

Upper Extremity:	Weakness ☐	Paralysis ☐	Contractures ☐
Comments: _____			
Lower Extremity:	Weakness ☐	Paralysis ☐	Contractures ☐
	Amputee ☐ Level: _____	Left ☐ Right ☐	Edema ☐
Comments: _____		Cast ☐	Ataxia ☐
		HT: _____	WT: _____

Sitting posture/Deformity: _____ Cognitive status: _____

Requires wheelchair supervision: ☐ Yes ☐ No Vision: Impaired ☐ Normal ☐

SECTION 7—Living Environment:House/condominium ☐ Apartment ☐ Stairs ☐ Elevator ☐ Ramp ☐ Hills ☐ SNF ☐ ICF/DD ☐ B&C ☐Doorway widths and home layout for adequate wheelchair use indoors verified except: Bathroom ☐ Bedroom ☐ Kitchen ☐ Other:Living Assistance: Lives Alone ☐ With Other Person(s) ☐ Alone Most of the Day ☐ Alone at Night ☐Attendant Care: ☐ Live in attendant or _____ Hours/day ☐ Homemaker _____ Hours _____

Transportation:

To/from medical appointments? ☐ Yes Local Community? ☐ Yes ☐ No Beneficiary drives from the wheelchair? ☐ Yes ☐ No

Tie-down system: _____

Public Transportation: _____

SECTION 8—Activity Level:

Number of hours per day in the wheelchair: _____ Distances the beneficiary pushes/drives daily: _____

Beneficiary will use the wheelchair: At home ☐ Outside ☐ For physician visits ☐ Job related activities ☐ School ☐Social Activities ☐ SNF ☐ ICD/DD ☐Who will propel this chair? ☐ Beneficiary Other: _____Beneficiary can independently propel a manual wheelchair: ☐ Yes ☐ No At Home ☐ In the community ☐Beneficiary can disassemble this type of manual wheelchair and independently transfer self and chair to a motor vehicle: ☐ Yes ☐ NoBeneficiary is unable to effectively propel any manual wheelchair: ☐ Yes ☐ No**SECTION 9—Ambulation:**Beneficiary is independently ambulatory: ☐ Yes ☐ No Beneficiary is unable to walk: ☐ Yes ☐ No

Beneficiary ambulation is non-functional and limited by: _____

Beneficiary's ambulation ability is expected to change: ☐ Yes ☐ No Explain "Yes" Answer: _____Beneficiary is scheduled for additional lower extremity medical/surgical intervention(s). ☐ Yes ☐ No Explain "Yes" Answer: _____**SECTION 10—Motorized Wheelchair Base and Accessories:**1. Does the beneficiary require and use the wheelchair to move around in their place of residence? ☐ Yes ☐ No2. Does the beneficiary have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or need to rest in a recumbent position two or more times during the day? ☐ Yes ☐ No3. The beneficiary has a cast, brace or musculoskeletal condition, which prevents 90 degrees of flexion of the knee, or does the beneficiary have significant edema of the lower extremities? ☐ Yes ☐ No

4. How many hours a day is this beneficiary expected to spend in this wheelchair? _____ (Round to nearest hour)

5. Does the beneficiary have a need for arm height different than those available using non-adjustable arms? ☐ Yes ☐ No6. Does the beneficiary have severe weakness of the upper extremities due to a neurological, muscular, or cardiopulmonary disease/condition that precludes the use of a manual wheelchair? ☐ Yes ☐ No7. Is this beneficiary able to safely operate the requested equipment? ☐ Yes ☐ No**SECTION 11—Narrative description of the wheelchair and cost and justification for higher cost frames, second wheelchair, tilt recline:**

Manufacturer: _____

Model: _____

Provider Name: _____

Provider Location: _____

SECTION 12—DME provider/Therapist attestation and signature/date:*By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.*

Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print): _____

Name: _____
(Please print)Title: _____
(OT, PT, RESNA, etc.)DME Provider Name: _____
(Please print) _____
(Use Ink - A signature stamp is not acceptable)

Date: _____

 _____
(Use Ink - A signature stamp is not acceptable)

Date: _____

SECTION 13—Clinician attestation and signature/date:*I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.*

Clinician's Signature: _____



(Use Ink - A signature stamp is not acceptable)

Date: _____