State of California - Health and Human Services Agency

Department of Health Services

# CERTIFICATE OF MEDICAL NECESSITY FOR A MANUAL WHEELCHAIR, STANDARD OR CUSTOM

***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 manual 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 | Phone Number ( ) | Date of Birth mm / dd / yy | 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—RX Renewal - Verification of continued medical necessity:

Manual Wheelchair Requested:

| a) Standard HCPCS Code(s) | b) Custom HCPCS Code(s) |
|---|---|
| c) Replacing existing equipment? ❒ Yes ❒ No Model/Serial #: | Explain "Yes" Answer: |
| 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 for other DME: | h) Accessories requested and why (use attachments): |
| i) Custom features requested and why (use attachments): | |

### SECTION 3—Diagnosis Information:

Diagnoses: _____

Date of onset: _____

### SECTION 4—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 5—Pertinent Exam Findings:

Upper Extremity: Weakness ❒ Paralysis ❒ Contractures ❒

Comments: _____

Lower Extremity: Weakness ❒ Paralysis ❒ Contractures ❒ Edema ❒

Amputee ❒ Level: Left ❒ Right ❒ Cast ❒ Ataxia ❒

Comments: _____ HT: _____ WT: _____

Sitting posture/Deformity: _____ Cognitive status: _____

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

**SECTION 6—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 7—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 ❒ No
Beneficiary is unable to effectively propel any manual wheelchair: ❒ Yes ❒ No

**SECTION 8—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 9—Wheelchair Base and Accessories:**

1. Does the beneficiary require and use the wheelchair to move around in their place of residence? ❒ Yes ❒ No
2. 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? ❒ Yes ❒ No
3. The beneficiary has a cast, brace or musculoskeletal condition, which prevents 90 degrees of flexion of the knee, or does the patient 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. Is this beneficiary able to adequately self-propel (without being pushed) in a standard weight manual wheelchair? ❒ Yes ❒ No
6. If the answer to question #5 were "No", would this beneficiary be able to adequately self-propel (without being pushed) in any type lightweight wheelchair? ❒ Yes ❒ No

**SECTION 10—Narrative description of the wheelchair and cost and justification for higher cost frames, second wheelchair tilt recline:**

Manufacturer: Model: Provider Name:
Provider Location:

**SECTION 11—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)*

**SECTION 12—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: _____