State of California Health and Human Services Agency Department of Health Care Services

Certificate of Medical Necessity for a Power Operated Vehicle (POV) AKA Scooter, Standard or Bariatric

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 scooter. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information may 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	Clinician Address
Last _____	Street _____
First _____	City _____
Phone _____	State _____
License Number _____	Zip Code _____

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	Patient Address
Last _____	Street _____
First _____	City _____
Phone _____	State _____
Date of Birth _____	Zip Code _____
Medi-Cal Number _____	

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—POV Requested:

a) Standard HCPCS Code(s) _____ b) Custom/Bariatric Code(s) _____

c) Replacing existing equipment? ☐ Yes ☐ No Date of Purchase: _____
Make/Model/Serial #: _____ Explain "Yes" Answer: _____

d) Attach repair cost 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 (use attachments):

j) Is this beneficiary able to safely operate the requested equipment? ☐ Yes ☐ No

SECTION 4—Diagnosis Information:

Diagnoses: _____

Date of onset: _____

SECTION 5—Pertinent History:

History of pressure sores: _____

None at 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 ☐ Edema
☐ Amputee Level: _____ ☐ Left ☐ Right ☐ Cast ☐ Ataxia

Comments: _____ Height: _____ Weight: _____

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—Transportation:

To/from medical appointments? ☐ Yes Local Community? ☐ Yes ☐ No

SECTION 9A—Activity Level:

Number of hours per day using the POV: _____
Distances the beneficiary pushes/drives daily: _____
Beneficiary will use the POV: ☐ At home ☐ Outside ☐ For physician visits
☐ Job related activities ☐ School ☐ Social Activities ☐ SNF
☐ ICD/DD
Beneficiary is unable to propel manual wheelchair:
☐ At Home ☐ In the community

SECTION 9B—Ambulation:

Beneficiary is independently ambulatory: ☐ Yes ☐ No
Beneficiary is unable to walk: ☐ Yes ☐ No
Beneficiary ambulation is 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

SECTION 10 —Narrative description of the POV and cost and justification for higher cost:

This beneficiary was evaluated for a Manufacturer/Model(s): _____ and was unable to use it in home and/or community for mobility.
Other justifications for this requested "high-end" POV:

Manufacturer: _____	Model: _____
Provider Name: _____	Provider Street: _____
Provider City: _____ Provider State: ___ Provider Zip Code: _____	

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:

Name: _____ Title: _____ (OT, PT, RESNA, etc.) Signature: _____ Date: _____	DME Provider Name: _____ Signature:

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: _____ Date: _____