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

Certificate of Medical Necessity for All Durable Medical Equipment (DME)

(Except Wheelchairs and Scooters)

The 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 Durable Medical Equipment. 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—Equipment Requested:

a)

b) STANDARD: _____ BARIATRIC: _____
c) Replacing existing equipment? ☐ Yes ☐ No If yes, explain why: _____
d) Attach repair cost estimate if replacement with similar equipment is requested.
e) Other DME the beneficiary has: _____
f) How many hours per day of usage? _____
g) Accessories requested and why: _____
h) Custom features requested and why: _____
i) Other equipment currently in the home: ☐ Cane ☐ Walker ☐ Crutches ☐ Prosthesis ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Hospital Bed ☐ Oxygen ☐ POV (scooter) ☐ Other: _____
j) Patient currently using the following equipment: _____
k) When/How often: _____
l) State specific reason for accessories requested: _____

SECTION 4—Diagnosis Information:

Diagnoses: _____ Date of onset: _____
Prognosis: _____

SECTION 5—Pertinent History:

SECTION 6— Functional Status:

Beneficiary's height: _____ Beneficiary's weight: _____

a) Ambulation: ☐ Independent ☐ Walker/Cane ☐ Assisted ☐ Unassisted ☐ Unable ☐ Bed Confined ☐ Recent fall(s) ☐ Dizziness/Vertigo ☐ Incoordination ☐ Ataxia ☐ Severe shortness of breath
b) Transfer: ☐ Self ☐ Self, but with great difficulty ☐ Self with a transfer device ☐ Stand by assistant ☐ With assistance ☐ Mechanical or person lift
c) Pertinent physical findings: Edema (location): _____
Pressure sore(s), stage and location: _____
☐ Amputee ☐ Cast ☐ Ataxia
Paralysis/weakness (location): _____
Sitting Posture/Deformity: _____
Cognitive status: _____
Vision: ☐ Impaired ☐ Normal

Contractures: _____

SECTION 7—Living Environment:

☐ House/condominium ☐ Apartment ☐ Stairs ☐ Elevator ☐ Ramp
☐ Hills ☐ SNF ☐ ICF/DD ☐ B&C ☐ 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: _____

SECTION 8—Hospital Bed:

Document that this beneficiary requires positioning not feasible in an ordinary bed:

Is frequent repositioning required throughout the day? ☐ Yes ☐ No
Explain: _____
Is frequent repositioning required throughout the night? ☐ Yes ☐ No
Can the beneficiary or caretaker use a ‘‘manual’’ bed? ☐ Yes ☐ No
If no, explain why:

For any anti-decubitus bed, please attach to the TAR, photos and explanation of previous therapies attempted, the nutritional status, and the latest hemoglobin and hematocrit of the beneficiary.

SECTION 9—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 10—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: _____