State of California - Health and Human Services Agency

CERTIFICATE OF MEDICAL NECESSITY

California Department of Health Services

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 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—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 HCPCS Code(s):
c) Replacing existing equipment? ❒ Yes ❒ No Model/Serial #:	Explain "Yes" Answer: Date of purchase:
d) Attach repair estimate if replacement with similar equipment is requested.	
e) Other DME the beneficiary currently 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: _____ 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—Transportation:

To/from medical appointments? ❒ Yes ❒ No 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 effectively propel any 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
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 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:

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