

## 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/>	Paralysis <input type="checkbox"/>	Contractures <input type="checkbox"/>
Comments: _____			
Lower Extremity:	Weakness <input type="checkbox"/>	Paralysis <input type="checkbox"/>	Contractures <input type="checkbox"/>
	Amputee <input type="checkbox"/> Level: _____	Left <input type="checkbox"/>	Right <input type="checkbox"/>
Comments: _____		Cast <input type="checkbox"/>	Edema <input type="checkbox"/>
		Ataxia <input type="checkbox"/>	
		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:**

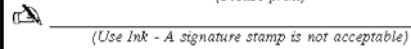
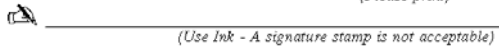
- 1. Does the beneficiary require and use the wheelchair to move around in their place of residence?  Yes  No
- 2. Does the beneficiary have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or need to rest in a recumbent position?  Yes  No
- 3. The 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:**

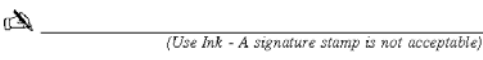
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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)  
 Date: \_\_\_\_\_   
(Use Ink - A signature stamp is not acceptable) (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)