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

# Certificate of Medical Necessity for a Motorized Wheelchair, Custom or Standard

***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 motorized wheelchair. 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— Motorized Wheelchair Requested:**

a) Standard HCPCS Code(s) _____ b) Custom HCPCS 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) Have they tried the chair? ☐ Yes ☐ No

**SECTION 4—Diagnoses Information:**

Diagnoses: _____

Date of onset: _____

**SECTION 5—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 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: _____ 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— 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 9—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 10—Motorized 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. Does the beneficiary have a need for arm height different than those available using non-adjustable arms? ☐ Yes ☐ No
6. Does the beneficiary have severe weakness of the upper extremities due to a neurological, muscular, or cardiopulmonary disease/condition that precludes the use of a manual wheelchair? ☐ Yes ☐ No
7. Is this beneficiary able to safely operate the requested equipment? ☐ Yes ☐ No
8. Is this beneficiary able to safely transfer themselves independently from one surface to another? ☐ Yes ☐ No

**SECTION 11—Narrative description of the wheelchair and cost and justification for higher cost frames, second wheelchair, tilt recline:**

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

**SECTION 12—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: _____<br>Title: _____<br>(OT, PT, RESNA, etc.)<br>Signature: _____<br>Date: _____ | DME Provider Name: _____<br>Signature: _____ |

**SECTION 13—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: _____