Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY
WHEELCHAIRS

Only applicable sections of this form need to be completed and submitted.

	Section					
	A	B	C	D	E	Repair
Purchase/rental authorization of a manual wheelchair	X	X				
Purchase/rental authorization of a power mobility device	X		X			
Purchase authorization of additional parts or accessories not included in the basic equipment package	X			X		
Purchase authorization of custom seating	X				X	
Need verification of a repair						X
EXAMPLE:						
Purchase of a power wheelchair with an expandable controller, a head array, and custom seating	*X*		*X*	*X*	*X*	

The prescriber or qualified evaluator must furnish all clinical information (e.g., diagnosis, functional assessment, recommendation). The provider may furnish non-clinical details (e.g., customer's personal identifying information, HCPCS code, serial number, warranty period).

Section A – Identifying Information

Customer	**Evaluator**	**Provider**
Name	Name	Name Care Medical
Medicaid ID number	Medicaid provider number	Medicaid provider number 0526818
Date of birth	NPI, if applicable, or license number	NPI 1588732812
Height (in.) Weight (lbs.)	Telephone number	
Address*	*Note: Provision of or payment for a non-custom wheelchair used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	

Clinical Indicators

Diagnosis code(s)	Prognosis
Number of hours per day of wheelchair use, current or estimated	Estimated length of need
Most important clinical or functional factors to consider 1. 2. 3.	

False certification constitutes Medicaid fraud.

Name of individual _____ Medicaid ID number _____

Section B – Recommendation for a Manual Wheelchair

☐ **Purchase** ☐ **Rental for ___ Months** ☐ **Modification**

Requested dates of rental From ___/___/_____ to ___/___/_____	Prior dates of rental From ___/___/_____ to ___/___/_____
Description of capacity limitations (e.g., of cardiopulmonary function, neuromuscular function, muscle tone, range of motion, strength, stamina, balance, coordination) necessitating a manual wheelchair ☐ This information is attached in another format.	
Current wheelchair — Manufacturer, make, model, age	
Explanation of features needed to address specific functional needs (e.g., low seat, heavy duty frame, lightweight frame, capacity to "grow" with a child) ☐ This information is attached in another format.	
Specific item recommended [Parts and accessories not included in the basic equipment package should be listed in Section D.] Suggested format: *Quantity; HCPCS code; manufacturer; model; description; condition (new, used)*	
Warranty period ☐ This information is attached in another format.	
I certify that a manual wheelchair will provide a level of functionality for this individual that cannot be achieved with an assistive device such as a cane, a crutch or crutches, or a walker.	

Signature of evaluator/prescriber	Date of evaluation	Date of signature (if different)

Statement of Medical Necessity

I certify that the following statements are true for this individual: *Ambulation is not possible, takes inordinate physical effort, or causes considerable physical discomfort.* *The recommended wheelchair, part, or accessory is suited to the purposes and daily routines of the individual.*		
Signature of prescriber	NPI	Date of signature

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Name of individual _____ Medicaid ID number _____

Section C – Recommendation for a Power Mobility Device

☐ **Purchase** ☐ **Rental for ___ Months** ☐ **Modification**

Requested dates of rental	Prior dates of rental
From ___/___/_____ to ___/___/_____	From ___/___/_____ to ___/___/_____

"Power mobility device (PMD)" is a collective term for a power wheelchair or a power-operated vehicle (POV, commonly referred to as a "scooter").

Description of capacity limitations (e.g., of cardiopulmonary function, neuromuscular function, muscle tone, range of motion, strength, stamina, balance, coordination) necessitating a PMD

☐ This information is attached in another format.

Current mobility device — Manufacturer, make, model, age

Functional description of the individual

Mark all statements about the individual that apply.

☐ Has demonstrated the ability to transfer safely to and from a POV.

☐ Has demonstrated the ability to operate a POV tiller steering system safely.

☐ Has demonstrated the ability to maintain postural stability and position on a POV.

☐ Will use the PMD intermittently only in level, smooth, unobstructed environments.

☐ Travels not only on smooth, level surfaces (tile, low-pile carpet, pavement) but also over thick carpet, gravel, grass, uneven terrain, high thresholds or surface transitions, steep ramps, hills, curbs, or other obstacles.

☐ Travels over longer distances (e.g., across school campus, to and from bus stops) or over extended periods of time without recharging the battery.

☐ Engages in activities (e.g., running errands, crossing intersections) that may call for increased speed for safe and efficient travel.

☐ Currently weighs less than 125 pounds and is expected to grow.

☐ May need adjustment or minimal configuration of a standard seat (e.g., size, back angle).

☐ Needs a standard seat that will accommodate the following type of cushion: _____.

☐ Needs a powered tilting or reclining seat for the following therapeutic or functional reasons: _____

_____.

☐ Needs the following drive control interface (other than a standard joystick): _____.

☐ Will use two or more power accessories (e.g., power elevating legrests, power seat elevation, peripheral devices, ventilator).

☐ Will have additional needs in the near future that can be accommodated by the recommended PMD.

☐ This information is attached in another format.

Continued on the next page

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Name of individual _____ Medicaid ID number _____

Section C – Recommendation for a Power Mobility Device, continued

Specific item recommended
[Parts and accessories not included in the basic equipment package should be listed in Section D.]
Suggested format: *Quantity; HCPCS code; manufacturer; model; description; condition (new, used)*

Warranty period

☐ This information is attached in another format.

Explanation, if appropriate, of why a PMD with a different group classification (e.g., group 2 power wheelchair instead of group 3 power wheelchair) would not be sufficient to meet the individual's needs

Other comments

I certify that the following statements are true:
A PMD will provide a level of functionality for this individual that cannot be achieved with a manual wheelchair.
The individual (or an assistant) has sufficient capabilities to take proper care of and to operate the recommended PMD safely in typical environments.
The individual's place of residence is (or will be) accessible; the individual will be able to use the PMD without assistance to enter and leave the residence, the main living area, the kitchen and dining area, the individual's bedroom (or the room with the individual's bed), and a bathroom. The place of residence has adequate electrical service. The PMD can be transported when necessary and stored so that it is protected from the elements.

Signature of evaluator/prescriber	Date of evaluation	Date of signature (if different)

Statement of Medical Necessity

I certify that the following statements are true for this individual:
Ambulation is not possible, takes inordinate physical effort, or causes considerable physical discomfort.
The recommended wheelchair, part, or accessory is suited to the purposes and daily routines of the individual.

Signature of prescriber	NPI	Date of signature

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Name of individual _____ Medicaid ID number _____

Section D – Parts and Accessories Not Included in the Basic Equipment Package

Specific item recommended Suggested format: *Quantity; HCPCS code; manufacturer; model; description; condition (new, used); interrelationship (if any) with other parts and accessories; explanation of why the item is necessary for this particular individual or why the frequency limit is exceeded*
Warranty period ☐ This information is attached in another format.
Usual and customary charge for each "miscellaneous" or "not otherwise specified" item
Other comments

Signature of evaluator/prescriber	Date of signature

Statement of Medical Necessity

I certify that the following statements are true for this individual: *Ambulation is not possible, takes inordinate physical effort, or causes considerable physical discomfort.* *The recommended wheelchair, part, or accessory is suited to the purposes and daily routines of the individual.*		
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Name of individual _____ Medicaid ID number _____

Section E – Custom Seating

Problems necessitating a custom seating system

Mark all areas that apply.

- ☐ 1. Sitting posture/balance
- ☐ 2. Head position
- ☐ 3. Shoulder/scapula position
- ☐ 4. Spinal curvature
  - ☐ Scoliosis: ☐ < 20° ☐ 20°–70° ☐ > 70° ☐ Fixed ☐ Flexible
  - ☐ Lordosis: ☐ < 20° ☐ 20°–70° ☐ > 70° ☐ Fixed ☐ Flexible
  - ☐ Kyphosis ☐ < 20° ☐ 20°–70° ☐ > 70° ☐ Fixed ☐ Flexible
- ☐ 5. Pelvic displacement
  - Sagittal tilt: Direction _____ Degree _____
  - Lateral tilt: Direction _____ Degree _____
  - Rotation: Direction _____ Degree _____
- ☐ 6. Leg/hip/knee/foot position (e.g., dislocation, contracture)
- ☐ 7. Other skeletal structure _____
- ☐ 8. Muscle tone
  - Score (e.g., on the Modified Ashworth Scale): ___
- ☐ 9. Range of motion
- ☐ 10. Upper extremity function
- ☐ 11. Lower extremity function
- ☐ 12. Skin condition/integrity (e.g., susceptibility to decubitus ulcers)
- ☐ 13. Sensation
- ☐ 14. Ability to shift body weight
- ☐ 15. Bowel or bladder function
- ☐ 16. Other consideration _____

Explanation of the problem, how a custom seating system will address it, and why the individual's needs (e.g., for prolonged sitting, postural support, or pressure reduction) cannot be met adequately with a standard seat, prefabricated seat cushion, removable positioning accessory or combination of accessories, spinal orthosis, or other device

☐ This information is attached in another format.

If the individual currently has a spinal orthosis, explanation of why both a spinal orthosis and a seating system are required

Full description of the recommended custom seating system, including fabrication or construction method

☐ This information is attached in another format.

Signature of evaluator/prescriber	Date of evaluation	Date of signature (if different)

Technical specification of the recommended custom seating system, including relevant HCPCS codes and estimated cost

☐ This information is attached in another format.

Name of provider representative	Signature	Date of signature

Statement of Medical Necessity

I certify that the following statements are true for this individual:

Ambulation is not possible, takes inordinate physical effort, or causes considerable physical discomfort.

The recommended wheelchair, part, or accessory is suited to the purposes and daily routines of the individual.

Signature of prescriber	NPI	Date of signature

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This page is to be completed by the provider.

Repair

Customer name	Medicaid ID number	
Provider name	Medicaid provider number	
Wheelchair — manufacturer, model, serial number		
Date on which the equipment/part/accessory to be repaired was originally delivered or installed		
Reason for repair, including a description of the wear, damage, or malfunction		
Description, including dates, of previous repairs made to this same equipment/part/accessory		
Parts needed to complete repair Suggested format: *Quantity; HCPCS code; manufacturer; model; part number; serial number; condition (new, used); warranty period*		
Estimated labor time needed		
Other comments		
Name of provider representative	Signature	Date of signature

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