

Ohio Department of Medicaid  
**CERTIFICATE OF MEDICAL NECESSITY  
WHEELCHAIRS**

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

	Section					Repair
	A	B	C	D	E	
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:*

<i>Purchase of a power wheelchair with an expandable controller, a head array, and custom seating</i>	X		X	X	X	
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***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
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI, if applicable, or license number	NPI
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 ___/___/___
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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)
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### 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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## Section C – Recommendation for a Power Mobility Device

Purchase     Rental for \_\_\_ Months     Modification

Requested dates of rental From ___/___/___ to ___/___/___	Prior dates of rental From ___/___/___ to ___/___/___
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"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.

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Has demonstrated the ability to transfer safely to and from a POV.</li> <li><input type="checkbox"/> Has demonstrated the ability to operate a POV tiller steering system safely.</li> <li><input type="checkbox"/> Has demonstrated the ability to maintain postural stability and position on a POV.</li> <li><input type="checkbox"/> Will use the PMD intermittently only in level, smooth, unobstructed environments.</li> <li><input type="checkbox"/> 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.</li> <li><input type="checkbox"/> Travels over longer distances (e.g., across school campus, to and from bus stops) or over extended periods of time without recharging the battery.</li> <li><input type="checkbox"/> Engages in activities (e.g., running errands, crossing intersections) that may call for increased speed for safe and efficient travel.</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Currently weighs less than 125 pounds and is expected to grow.</li> <li><input type="checkbox"/> May need adjustment or minimal configuration of a standard seat (e.g., size, back angle).</li> <li><input type="checkbox"/> Needs a standard seat that will accommodate the following type of cushion: _____.</li> <li><input type="checkbox"/> Needs a powered tilting or reclining seat for the following therapeutic or functional reasons: _____.</li> <li><input type="checkbox"/> Needs the following drive control interface (other than a standard joystick): _____.</li> <li><input type="checkbox"/> Will use two or more power accessories (e.g., power elevating legrests, power seat elevation, peripheral devices, ventilator).</li> <li><input type="checkbox"/> Will have additional needs in the near future that can be accommodated by the recommended PMD.</li> </ul> |
|--|--|

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)
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**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.*

Signature of prescriber

NPI

Date of signature

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## Section E – Custom Seating

Problems necessitating a custom seating system

Mark all areas that apply.

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

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)
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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
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### 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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Ohio Department of Medicaid  
**CERTIFICATE OF MEDICAL NECESSITY: WHEELCHAIRS**

***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: <i>Quantity; HCPCS code; manufacturer; model; part number; serial number; condition (new, used); warranty period</i>		
Estimated labor time needed		
Other comments		
Name of provider representative	Signature	Date of signature

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