State of California - Health and Human Services Agency

Department of Health Care Services

# CERTIFICATE OF MEDICAL NECESSITY FOR ALL DURABLE MEDICAL EQUIPMENT (DME)

***(EXCEPT WHEELCHAIRS AND SCOOTERS)***

***The 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 Durable Medical Equipment. 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—Equipment Requested:

a) _____

b) STANDARD: _____ BARIATRIC: _____

c) Replacing existing equiment? Yes ❒ No ❒ If yes, explain why: _____

d) Attach repair estimate if replacement with similar equipment is requested.

e) Other DME the beneficiary has: _____

f) How many hours per day of usage? _____

g) Accessories requested and why: _____

h) Custom features requested and why: _____

i) Other equipment currently in the home: Cane ❒ Walker ❒ Crutches ❒ Prosthesis ❒ Manual Wheelchair ❒ Power Wheelchair ❒ Hospital Bed ❒ Oxygen ❒ POV (scooter) ❒ Other: _____

j) Patient currently using the following equipment: _____

k) When/How often: _____

l) State specific reason for accessories requested: _____

**SECTION 4—Diagnosis Information**

Diagnoses: _____ Date of onset: _____

Prognosis: _____

**SECTION 5—Pertinent History:**

_____

_____

**SECTION 6—Functional Status:**

Beneficiary's height: _____ Beneficiary's weight: _____

a) Ambulation: Independent ❒ Walker/Cane ❒ Assisted ❒ Unassisted ❒ Unable ❒ Bed confined ❒
Recent fall(s) ❒ Dizziness/Vertigo ❒ Incoordination ❒ Ataxia ❒ Severe shortness of breath ❒

b) Transfer: Self ❒ Self, but with great dificulty ❒ Self with a transfer device ❒
Stand by assistant ❒ With assistance ❒ Mechanical or person lift ❒

c) Pertinent physical findings: Edema (location):
Pressure sore(s), state and location: Amputee ❒ Cast ❒ Ataxia ❒

Paralysis/weakness (location): _____ Sitting Posture/Deformity: _____

Cognitive status: _____ Vision: Impaired ❒ Normal ❒

Contractures:

**SECTION 7—Living Environment:**

House/condominium ❒ Apartment ❒ Stairs ❒ Elevator ❒ Ramp ❒ Hills ❒ SNF ❒ ICF/DD ❒ B&C ❒

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:

**SECTION 8—Hospital Bed:**

Document that this beneficiary requires positioning not feasible in an ordinary bed: _____

_____

Is frequent repositioning required throughout the day? Yes ❒ No ❒ Explain: _____

Is frequent repositioning required throughout the night? Yes ❒ No ❒

Can the beneficiary or caretaker use a "manual" bed? Yes ❒ No ❒

If no, explain why: _____

_____

For any anti-decubitus bed, please attach to the TAR, photos and explanation of previous therapies attempted, the nutritional status, and the latest hemoglobin and hematocrit of the beneficiary.

**SECTION 9—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 10—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)*