

Certificate of Medical Necessity (CMN) for Motorized Wheelchair

Date: ____/____/____ **Requesting Provider:** _____

Pt. Name: _____ **I.D. Number:** _____

1. Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home? Y N

2. Does the patient's home provide adequate access between rooms, adequate maneuvering space, and appropriate floor surfaces for use of a motorized wheelchair? Y N

If yes, a written report of an on-site evaluation must be made available.

3. Does the patient have sever weakness of the upper extremities due to a neurologic, muscular or cardiopulmonary disease/condition; and is the patient unable to operate any type of manual wheelchair? Y N

4. Does the patient require a wheelchair for mobility in their residence? Y N

5. Does the patient have mental capabilities (e.g. cognition, judgment) and physical capabilities (e.g. vision) sufficient for safe mobility using a motorized wheelchair? Y N

6. Does the patient meet the coverage criteria for a power tilt or power recline system (MA policy E-56): *A specialty evaluation was performed by a licensed/certified medical professional, such as a (PT) or (OT) or physician, who has specific training and experience in rehabilitation wheelchair evaluations of the patient's seating and positioning needs. The PT, OT, or physician may have no financial relationship with the supplier.* Y N

AT LEAST ONE of the following criteria must also be met:

- Patient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift;
- Patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from wheelchair to bed;
- The power seating system is needed to manage increased tone or spasticity.

7. Do these requested powered seating accessories serve to promote insensate skin integrity, and are not for patient/caregiver comfort or convenience? Y N

8. Does the patient require a drive control interface other than a hand or chin operated standard proportional control (examples but not limited to head control, sip and puff, switch control) ? Y N

9. Is the patient unable to independently stand and pivot transfer due to a neurological/orthopedic condition or myopathy. Y N

10. Has a rehabilitation therapist evaluation been performed by a licensed/certified Physical or Occupational therapist with specific training in rehabilitation wheelchair evaluations? Y N

11. The date of the face to face **Physician** examination _____ Y N

12. How many hours per day does the patient usually spend in the wheelchair?
Round up to the next hour using 1 – 24. _____

**Certificate of Medical Necessity (CMN) for Motorized Wheelchair
Continued**

Contact Name: _____

Phone : _____

Physician Signature (Stamps are not acceptable)

Date

Key - **(Y)**es, **(N)**o, **(D)**oes not apply

Requested Information:

1. Typed physician face to face examination
2. Wheelchair evaluation if available
3. Home Evaluation if available