GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATION OF MEDICAL NECESSITY FOR POWER WHEELCHAIR

PT/OT EVALUATION REQUIRED

Certification Type/Date: INITIAL _____/_____/_____ REVISED _____/_____/_____	
Members Name:	**Members Medicaid Number (Do Not List Mother's ID):**
Patient DOB_____/_____/_____ Sex_____ HT._____(in) WT._____(lbs.)	
Suppliers Name: **Suppliers NPI Number:**	Suppliers Address and Telephone Number:
Physicians Name: **Physicians NPI Number:**	Physicians Address and Telephone Number:
HCPCS Code(s)	
Place of Service	

Primary Diagnosis _____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity:_____

ICD 10 Diagnosis Code(s)_____ Length of Need_____

PHYSICAL EXAMINATION:

Provide detailed results of the physical examination as it relates to the member's mobility needs, and any related needs for special accommodations, options or accessories.

Ambulatory Status	Is the member ambulatory? ☐ YES ☐ NO If yes, describe in detail:
Ability to Self-Propel	Does the member have the ability to self-propel? ☐ YES ☐ NO If no, does the member have a caregiver willing and able to assist in propelling? ☐ YES ☐ NO Explain:
Cognitive Ability	Describe the member's cognitive ability:
Endurance	Describe the member's level of endurance:
Neck and Head Control	Describe the member's ability to control their head and neck:

Trunk	Provide review of exam of the member's trunk:
Pelvis/Hips	Hips Provide review of exam of the member's pelvis/hips:
Upper Extremities:	Provide review of exam of the member's upper extremities:
Lower Extremities:	Provide review of exam of the member's lower extremities:
Skin Integrity	Provide review of exam of member's skin integrity:

Provide a detailed rationale as to why a manual wheelchair with the same options/accessories will not meet the specific needs of the member, and why the power wheelchair is required:

_____

_____

Provide justification for the medical necessity of power tilt or recline if applicable:

_____

_____

Was an environmental assessment performed on the member's home with documented dimensions of rooms, doorways, floor coverings, etc.? ☐ YES ☐ NO

Does the home accommodate the PMD, providing sufficient room to maneuver the device, turn around, and have a flat, level surface that allows the device to be used as safely and effectively? ☐ YES ☐ NO

Describe the activities of daily living and associated environments in which the wheelchair is required for use:

☐ Home (required for in-home ambulation) Percentage of time required _____

☐ School (member's enrolled in school either in-home or in the community): Enrolled at_____

Hours per day_____ ☐ Community Use (school, physician visits, etc.) Other Explain_____

Does the member have a custom manual or power wheelchair issued during the following time frame?

a) The last 5 years for members over 21? ☐ YES ☐ NO
b) The last 3-5 years for members under 21? ☐ YES ☐ NO

EQUIPMENT ORDERED

Please provide the HCPCS code and the description of the item determined to be the most appropriate for the member in the tables below. Provide a detailed rationale of why this equipment was selected and why any available least costly alternative was not deemed appropriate, where one exists.

Patient Name:_____**DOB:**_____

HCPCS	BASE

Describe the specific wheelchair **base** that is most appropriate for this member and provide a detailed rational:

_____

_____

_____

HCPCS	MODIFICATIONS, OPTIONS, ACCESSORIES

Describe the specific **modifications, options, and accessories** that are most appropriate for this member and provide a detailed rational:

_____

_____

_____

Ordering Physician

I certify that the power wheelchair listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

Physical or Occupational Therapist (PT/OT)

The Physical or Occupational Therapist who performed the evaluation for this device must complete the following:

PT/OT Signature _____ Date_____/_____/_____

PT/OT Printed Name _____

PT/OT GA License Number _____Expiration Date _____/_____/_____

Licensed DME Supplier

The NRRTS Member who completed the assessed this member and made equipment recommendations in collaboration with the ordering physician and PT/OT must complete the following:

NRRTS Member Signature _____Date_____/_____/_____

Printed Name of NRRTS Member _____

License/Certification # _____ Expiration Date _____/_____/_____

Attach a copy of license or certification with prior authorization request.

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.