Medical Management & Policy
Fax Number: 412-544-2921

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? **If yes, a written report of an on-site evaluation must be made available.**	Y	N
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?		
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 <u>power tilt or power recline</u> 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.* <u>*AT LEAST ONE*</u> *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.*	Y	N
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 **<u>Physician</u>** 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. _____		

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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