Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: PNEUMATIC COMPRESSION DEVICES AND ACCESSORIES

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Address*	Telephone number	

*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.

A HCPCS code corresponding to each pneumatic compression device or accessory specified by the prescriber

Certification [This section may be transcribed by the provider.]
Additional sheets may be attached.

a. The individual has lymphedema in at least one extremity and has undergone four weeks of therapy involving the use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb. There was no significant improvement, or significant symptoms persisted. ○ Yes ○ No ○ N/A	The individual has chronic venous insufficiency (CVI) and has undergone six months of therapy involving the use of an appropriate compression bandage system or compression garment, appropriate wound dressings, exercise, and elevation of the limb. There was no significant improvement, or significant symptoms persisted. ○ Yes ○ No ○ N/A

b. Date of evaluation	c. Diagnosis code(s)	d. Estimated length of need ○ _____ months ○ Lifetime

e. Symptoms observed, measurements taken, and other relevant information	f. Specific pneumatic compression device and accessories
g. The individual's clinical response to treatment during evaluation	h. Treatment plan (including pressure, frequency and duration, and monitoring schedule)
i. The individual's capacity for tolerating the prescribed treatment	j. Ability of the individual (or someone assisting the individual) to use the device correctly and consistently

Suitability Assessment [This section may be transcribed by the provider.]

The prescribed device has been used for at least one month, and it satisfactorily meets the individual's needs. ○ Yes ○ No	Date of evaluation

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification and suitability information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.