Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: PRESSURE-REDUCING SUPPORT SURFACES

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
Height (in.) Weight (lbs.)	Telephone number	
Address*	*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.	

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

Mark all items that apply.

Diagnosis code(s)	Date of placement	Estimated length of need
Recommended product (brand, model name or number, etc.)		

Group 1 surface [Prior authorization is not required, but at least one of the following criteria must be documented.]

- ☐ The individual cannot make changes in body position without assistance.
- ☐ The individual cannot independently make changes in body position sufficient to alleviate pressure.
- ☐ The individual has a pressure sore (of any stage) on the trunk or pelvis.
- ☐ The individual's circulation is compromised.

Group 2 surface [Prior authorization is not required if the individual underwent wound surgery within the preceding 30 days.]

- ☐ The individual underwent a surgical procedure involving the closure of a wound with a skin graft or skin flap.
  Date of surgery: ___/___/_____

[Prior authorization is required in all other circumstances.]

- ☐ The individual has a stage III or stage IV pressure sore on the trunk.
- ☐ The individual has multiple stage II wounds.
- ☐ The individual has third-degree burns (irrespective of whether grafting has been performed).
- ☐ Within the preceding 60 days, the individual underwent a surgical procedure involving the closure of a wound with a skin graft or skin flap. Date of surgery: ___/___/_____

A description of the treatment protocol is included. ☐ Page 2 ☐ Attachment

Group 3 surface [Prior authorization is required.]

The individual is being treated for a stage III or stage IV wound. The following information is included as indicated:

- Description of the wound ☐ Page 2 ☐ Attachment
- Record of the individual's body weight ☐ Page 2 ☐ Attachment
- Results of blood tests ☐ Page 2 ☐ Attachment
- Comprehensive nutritional assessment performed by a registered dietitian ☐ Page 2 ☐ Attachment

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

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

False certification constitutes Medicaid fraud.

Name of individual _____ Medicaid ID number _____

Supporting Information

Group 2 surface

Description of wound treatment protocol

Group 3 surface

Description of the wound

Date	Location	Length	Width	Depth	Appearance	Stage

Group 3 surface

Record of the individual's body weight

Weight	Date	Weight	Date	Weight	Date	Weight	Date	Weight	Date

Group 3 surface

Results of blood tests

	Albumin Prealbumin	Date	Protein	Date	Hbg	Date	HCT	Date
1								
2								
3								
4								
5								

Group 3 surface

Comprehensive nutritional assessment performed by a registered dietitian

Name of dietitian	Signature of dietitian	License number	Date of signature

False certification constitutes Medicaid fraud.