

Name of provider: _____

Provider NPI # _____

Medicaid Legacy # _____

**Ohio Department of Job and Family Services
Certificate of Medical Necessity/Prescription
Continuous Passive Motion (CPM) Devices**

Instructions: The Certificate of Medical Necessity (CMN) must be used for all Continuous Passive Motion Devices under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Note: The use of a CPM device does not require a prior authorization when utilized for a single knee surgery.

Name of recipient:	Billing Number:
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<input type="checkbox"/> Yes <input type="checkbox"/> No Consumer lives in a personal residence	<input type="checkbox"/> Total Knee replacement surgery <input type="checkbox"/> Right knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both	Date of Surgery ____/____/____	Date of Birth ____/____/____
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the CPM being used as a substitute to conventional provider delivered physical therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Can consumer independently turn the CPM device on and off?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is consumer willing to participate in a course of rehabilitation in relation to the medical event prompting the request for CPM therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the consumer been properly instructed on how to use the device in support of his/her ordered therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the consumer aware of and understands any emergency procedures regarding the use of the CPM device?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the consumer be supplied with a 24 hr, 7 day a week telephone number to be utilized in case of an emergency situation during the entire rental period of the CPM device?

Actual # of days the CPM device is to be utilized: (Max allowable is 21 days) → _____ days	Dates CPM to be used: From ____/____/____ to ____/____/____
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The maximum days allowable for the utilization of a CPM device is 21 days per medical event, per knee.

Section B—Physician Attestation and Signature/Date (Signed no more than 30 days prior to date of service)

Physician's name (PRINTED) _____

I certify that I am the physician identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Physician signature: (No stamps)	Date: ____/____/____	Ohio Medicaid Provider # : _____
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