Based on medical necessity and satisfaction of the criteria below and all other terms of the Mississippi Medicaid program, this item is available for coverage for:

_X_ Beneficiaries under age 21

___ Beneficiaries age 21 and over who are receiving services through the home health program

___ All beneficiaries (no age restriction)

___ Beneficiaries who are pregnant

The provider must refer to the current fee schedule for the acceptable codes and fee schedule allowances available under Medicaid.

The following criteria for coverage apply to cradle, overbed:

This item may be approved for :

___ Rental only

___ Purchase only

___ Rental for X months, then recertification is required

_X_ Rental up to the purchase amount or purchase when indicated

This item must be ordered by a physician, nurse practitioner, or physician assistant. It is expected that physicians, nurse practitioners, or physician assistants order only items within the scope of their specialty. For example, specialized items such as custom wheelchairs or prosthetics and orthotics should be ordered by specialties such as orthopedics and physicians specializing in rehabilitation. Other items are handled through other specialties.

An overbed cradle is a frame for keeping bedclothes from putting pressure on a burn, wound or fracture and/or to minimize the effects of air currents to which a wound may be sensitive.

An overbed cradle may be considered for coverage when one of the following applies:

- The beneficiary has a severe burn or other wound and the bedclothes would cause pressure that might otherwise interfere with healing.
- The beneficiary has an unstable fracture and pressure from bed-clothing could cause pain or otherwise interfere with positioning or healing.

HEALTHSYSTEMS OF MISSISSIPPI
CERTIFICATE OF MEDICAL NECESSITY – OVERBED CRADLE AND RELATED SUPPLIES

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: _____

Medicaid #: _____

Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)

HT: _____ (inches) WT: _____ (lbs)

Date of last visit: _____

Ordering MD/NP/PA Name (First and Last):

_____

Medicaid ID# or MS License #: _____

Telephone #: (____) _____-_____ Ext. _____

SECTION B CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-9-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a severe burn or other wound that might have delayed healing from the pressure of bedclothes?
Y N D	Does the beneficiary have an unstable fracture and could pressure from the bedclothes cause pain or interfere with positioning or healing?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

_____

_____

_____

_____

_____

_____

The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in Section A of this form. I certify that the medical necessity information in Section B is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_____ _____

Signature of Physician / Nurse Practitioner / Physician Assistant Date