Letter of Medical Necessity for *Wheelchair*

HCPCS: CODE – K0001 STANDARD WHEELCHAIR

Patient: _____ **Patient Weight** _____

Date of Need_____ **Expected Duration of Need** _____

Diagnosis: _____

_____ **Code** _____

_____ **Code** _____

_____ **Code** _____

A manual wheelchair is covered if:

a. **Criteria A, B, C, D, and E are met; and**
b. **Criterion F or G is met.**

Please check all options that apply:

____ **A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:**

1. **Prevents the beneficiary from accomplishing an MRADL entirely, or**
2. **Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or**
3. **Prevents the beneficiary from completing an MRADL within a reasonable time frame.**

____ **B. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.**

____ **C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.**

____ **D. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.**

____ **E. The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.**

____ **F. The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.**

____ **G. The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.**

___ **Other** _____

I hereby certify that this device is medically necessary.

Physician's Signature **Date**

_____ _____

Printed Name **NPI**

HCPCS: CODE – E1031 TRANSPORT WHEELCHAIR

Patient: _____

Date of Need_____ Expected Duration of Need _____

Diagnosis: _____

_____Code _____

_____Code _____

_____Code _____

A manual wheelchair is covered if:

a. Criteria A, B, C, D, and E are met; and
b. Criterion F or G is met.

Please check all options that apply:

____ A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

1. Prevents the beneficiary from accomplishing an MRADL entirely, or

2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or

3. Prevents the beneficiary from completing an MRADL within a reasonable time frame.

____ B. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

____ C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

____ D. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.

____ E. The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

____ F. The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

____ G. The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

___ Other _____

_____

_____

I hereby certify that this device is medically necessary.

_____ _____

Signature Date

Letter of Medical Necessity for *Patient Lift*

HCPCS: CODE – E0630 PATIENT LIFT

Patient: _____

Date of Birth: _____ **Expected Duration of Need** _____

Patient Weight: _____

Diagnosis: _____

_____ **Code** _____

_____ **Code** _____

_____ **Code** _____

A Patient Lift (E0630, E0635, E0639, E0640) is considered medically necessary DME if the member meets ALL of the following criteria. Please check all Criteria that apply:

__ __ 1. The patient requires transfer from a bed to a chair, wheelchair, or commode.

____ 2. The patient is not able to transfer between a bed and chair, wheelchair, or commode without assistance.

____ 3. The patient would be confined to a bed without assistance in the form of a Patient Lift.

I hereby certify that this device is medically necessary.

_____ _____

Physician's Signature **Date**

_____ _____

Printed Name **NPI**

Letter of Medical Necessity for *Walker with wheels or Rollator*

HCPCS CODE – E0143 WALKER WITH WHEELS OR ROLLATOR

Patient: _____

Patient's Weight: _____ **Date of Need:** _____ **Expected Duration of Need:** _____

Diagnosis Code(s): _____

A Walker with Wheels or Rollator is covered if all of the following criteria are met:

Please check all options that apply:

____ **A. The member has a medical condition impairing ambulation and there is a potential for ambulation;** ***and***

____ **B. There is a need for greater stability and security than provided by a cane or crutches**

___ **Other** _____

I hereby certify that this device is medically necessary.

_____ _____

Physician's Signature **Date**

_____ _____

Physician's Printed Name **NPI**

_____ _____

Physician's Address **Phone Number**

Letter of Medical Necessity for *Patient Lift*

HCPCS: CODE – E0630 PATIENT LIFT

Patient: _____

Date of Birth: _____ **Expected Duration of Need** _____

Patient Weight: _____

Diagnosis: _____

_____ **Code** _____

_____ **Code** _____

_____ **Code** _____

A Patient Lift (E0630, E0635, E0639, E0640) is considered medically necessary DME if the member meets ALL of the following criteria. Please check all Criteria that apply:

____ 1. The patient requires transfer from a bed to a chair, wheelchair, or commode.

____ 2. The patient is not able to transfer between a bed and chair, wheelchair, or commode without assistance.

____ 3. The patient would be confined to a bed without assistance in the form of a Patient Lift.

I hereby certify that this device is medically necessary.

_____ _____

Physician's Signature **Date**

_____ _____

Printed Name **NPI**

Necessity for a Bedside Commode

HCPCS: CODE - E0163 - COMMODE CHAIR, MOBILE OR STATIONARY, WITH FIXED ARMS
E0165 - COMMODE CHAIR, MOBILE OR STATIONARY, WITH DETACHABLE ARMS
E0168 - COMMODE CHAIR, EXTRA WIDE AND/OR HEAVY DUTY, STATIONARY OR MOBILE, WITH OR WITHOUT ARMS, ANY TYPE, EACH

Please complete this order form in its entirety in order for the patient to receive the necessary equipment.

Patient Information

Patient Name:	**Date of Birth:**
Address:	**Height:**
	Weight:
Phone Number:	**Length of Need:**
Primary Insurance ID #:	**Secondary Insurance ID #:**
Diagnosis code(s):	

Additional Information:	

E0163 - COMMODE CHAIR, MOBILE OR STATIONARY, WITH FIXED ARMS **is covered if criteria A, B, OR C is met**
E0165 - COMMODE CHAIR, MOBILE OR STATIONARY, WITH DETACHABLE ARMS **OR**
E0168 - COMMODE CHAIR, EXTRA WIDE AND/OR HEAVY DUTY, STATIONARY OR MOBILE, WITH OR WITHOUT ARMS, ANY TYPE, EACH **is covered if criteria A, B, or C AND D, E, or F is met.**

Please check all options that apply:

___ A. The beneficiary is confined to a single room (_____), or
(which room)

___ B. The beneficiary is confined to one level of the home environment and there is no toilet on that level (_____), or
(which room)

___ C. The beneficiary is confined to the home and there are no toilet facilities in the home.

___ D. The beneficiary weighs 300 lbs or more, or

___ E. Detachable arms are necessary to facilitate transferring the beneficiary, or

___ F. The beneficiary has a body configuration that requires extra width, or

Physician's Signature: _____ **Date:** _____

Printed Name: _____ **NPI:** _____

Address: _____

_____

Necessity for a Semi Electric Hospital Bed

Please complete this order form in its entirety in order for the patient to receive the necessary equipment.

Patient Information

Patient Name:	**Date of Birth:**
Address:	**Height:**
	Weight:
Phone Number:	**Length of Need:**
Primary Insurance ID #:	**Secondary Insurance ID #:**
ICD 9 / Diagnosis Code(s):	

Additional Information:	

For Coverage of a hospital bed, one of the following criteria must be met; please check all that are applicable:

___ The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed.
___ The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.
___ The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows of wedges must have been considered and ruled out.
___ The patient requires traction equipment which can only be attached to a hospital bed.

A variable height, semi-automatic hospital bed is covered when either of the following criteria are Met; please check which is applicable:

___ The patient requires a bed height different that a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.
___ The patient requires frequent changes in body position.
___ The patient has an immediate need for a change in body position.

Does the patient meet either of these conditions? Yes____ No____ (Please check which is applicable)

Physician's Signature: _____ **Date:** _____

Printed Name: _____ **NPI:** _____

Address: _____

_____

Necessity for a Kneewalker

HCPCS: CODE - E 0118 CRUTCH SUBSTITUTE, LOWER LEG PLATFORM, WITH WHEELS

Please complete this order form in its entirety in order for the patient to receive the necessary equipment.

Patient Information

Patient Name:	**Date of Birth:**
Address:	**Height:**
	Weight:
Phone Number:	**Length of Need:**
Primary Insurance ID #:	**Secondary Insurance ID #:**
Diagnosis code(s):	

Additional Information:	

For Coverage of a kneewalker, one of the following criteria must be met; please check all that are applicable:

___ Patient has *Fracture Dislocation Tendon Rupture Surgery* which requires ABSOLUTE NON WEIGHT BEARING to maximize chance for optimal healing and recovery. This patient is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches, but can do so with the *Roll-A-Bout.*

___ Patient has an *Ulcer Infection* which requires ABSOLUTE NON WEIGHT BEARING to maximize chance for optimal healing and recovery. This patient is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches, but can do so with the *Roll-A-Bout.*

___ Patient has a *Neurologic Musculoskelatal* condition which makes him/her unable to effectively or safely bear weight on one foot. The *Roll-A-Bout* will greatly increase this person's ability to function independently.

___ Other _____

_____

_____

Physician's Signature: _____ **Date:** _____

Printed Name: _____ **NPI:** _____

Address: _____

_____