MEDX
medical equipment

What's needed for a new referral:

- Demographics
- Detailed Written Order Signed/Dated by physician
- Most recent Face-To-Face note discussing the item the patient is needing as well as the diagnosis

CANES & CRUTCHES

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Canes (E0100, E0105) and crutches (E0110, E0111, E0112, E0113, E0114, E0116) are covered if all of the following criteria (1-3) are met:

1. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home.

   The MRADLs to be considered in this and all other statements in this policy are toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home.

   A mobility limitation is one that:

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

   And,

2. The beneficiary is able to safely use the cane or crutch; and,
3. The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

If all of the criteria are not met, the cane or crutch will be denied as not reasonable and necessary.

The medical necessity for an underarm, articulating, spring assisted crutch (E0117) has not been established; therefore, if an E0117 is ordered, it will be denied as not reasonable and necessary.

GENERAL

Standard Written Order (SWO) must be communicated to the supplier before a claim is submitted. If the supplier lls for an item addressed in this policy without first receiving a completed SWO, the claim shall be denied as not reasonable and necessary.

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DETAILED PHYSICIANS ORDER
DURABLE MEDICAL EQUIPMENT

Patient: _____ Date of Order: _____ HT: ____ WT: _____

Address: _____ DOB: _____ Length of Need: 99

_____ Diagnosis Codes: _____

Equipment Needed:

____ E1038 Transport chair (weight <= 300 lbs.)
____ K0001 Standard Manual Wheelchair
____ K0003 Lightweight Manual Wheelchair
____ K0004 High Strength Lightweight Manual Wheelchair
____ K0006 HD Manual Wheelchair (weight > 250 lbs.)
____ K0007 Extra HD Manual Wheelchair (weight > 300 lbs.)

Additional Accessories for K0001 – K0007 wheelchairs
Non Standard Seat Width
____ E2201 (>=20"-<24") ____ E2202 (24"-27")
____ Seat Cushion – Please specify:
E2601, E2602, E2603*, E2604*, E2622*, E2623*
____ Back Cushion – Please specify:
E2611, E2612
____ Heel Loops/ Standard leg rests (E0951) ___Right ____ Left
____ Elevating Leg rests (K0195) ___Right ___ Left
____ Articulating Leg rests (K0053)
____ Anti-Tippers (E0971) ___ Right ___ Left
____ Brake extensions (E0961) ___ Right ___ Left
____ Height adjustable arms (E0973) ___ Right ___ Left
____ Arm Trough (E2209)* ___ Right ___ Left
____ Amputee support (E1020)* ___ Right ___ Left
____ Swing away Hardware (E1028) ___ Right ___ Left
____ 1 arm drive attachment (E0958) ___ Right ___ Left
____ Lap tray (E0950)
____ Oxygen tank holder (E2208)
Verify covered diagnosis

____ E0260 Semi-electric hospital bed w/ mattress
____ E0261 Semi-electric hospital bed w/o mattress
____ E0265 Full electric hospital bed (ABN required)
____ E0303 HD hospital bed extra wide (350-600 lbs)
____ E0143 Standard Walker (No wheels)
____ E0143 Wheeled walker
____ E0143 Wheeled walker with seat (Rollator)
____ E0156 Walker Seat for Rollator
____ E0100 Cane-Standard Aluminum
____ E0105 Quad Cane (sm or lg)

____ **If other please specify:**

_____
_____
_____
_____
_____
_____

Physicians
Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Physicians
Signature: _____
(Original no stamps please)

Date: _____

NPI: _____

Showroom location for new patients and walk-ins:
1005 N Kingshighway Ste 12 Cape Girardeau ph. 573-803-2390 fax. 573-803-1247