



DETAILED WRITTEN ORDER

Homecare Dimensions

Document #: 09.DWO.HCD.01b
Effective: 09/15/2009

Rev.: B

Title: **Canes and Crutches**

Page #: 1 of 3

Initial Date of Medical Necessity: _____

Patient Name: _____ Medicare #: _____

Address: _____ City: _____ ST: _____ Zip Code _____

Phone #: _____ Cell #: _____ DOB: _____

Email: _____ Length of Need: _____ (99 = Lifetime)

Diagnosis Code: _____

Medical records: The Medical Records must be **supplied with this order** and will need to document that **ALL** of the following criteria are met:

The patient 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; **AND**

The patient is able to safely use the cane or crutch; **AND**

The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

Equipment Ordered: All canes and crutches are billed using the specific codes listed in the Local Coverage Determination regardless of their stated weight capacity

ORDERED	CODE	DETAILED DESCRIPTION OF ORDERED ITEMS
	A4635	Underarm, crutch, replacement, each
	A4636	Replacement, handgrip, cane, crutch, or walker, each
	A4637	Replacement, tip, cane, crutch, walker, each.
	A9270	Non-covered item or service
	E0100	Cane, includes canes of all materials, adjustable or fixed, with tip
	E0105	Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips
	E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips
	E0111	Crutch forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips
	E0112	Crutches underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips
	E0113	Crutch underarm, wood, adjustable or fixed, each, with pad, tip and handgrip
	E0114	Crutches underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips
	E0116	Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each

Treating Physician Signature: _____ Date: _____

Treating Physician Name: _____ NPI: _____

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Mobility Related Activities of Daily Living

Patient: _____

Medicare #: _____ HCD Account #: _____

Mobility related activities of daily living are defined as feeding, toileting, dressing, grooming, and bathing in customary locations of the patient's home.

A mobility limitation is defined as:

- 1) Inability to complete the MRADL entirely
- 2) Patient is at heightened risk of morbidity or mortality when performing the MRADL or
- 3) Is prevented from completing the MRADL in a reasonable amount of time

Please circle yes or no.

- | | | |
|-----|----|--|
| YES | NO | 1. The patient has a mobility limitation that significantly impairs her ability to participate in one or more mobility-related activities of daily living. |
| YES | NO | 2. The patient's mobility limitation cannot be sufficiently resolved with the use of an appropriately fitted cane or walker. |
| YES | NO | 3. The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of manual wheelchair is provided. |
| YES | NO | 4. Use of manual wheelchair will significantly improve the patient's ability to participate in MRADL and the patient will use it on a regular basis in the home. |
| YES | NO | 5. The patient had not expressed an unwillingness to use the manual wheelchair that is provided in the home. |
| YES | NO | 6. Patient cannot self propel in a standard wheelchair in the home. |
| YES | NO | 7. The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair. |

Treating Physician Signature: _____ Date: _____

Treating Physician Name: _____ NPI: _____

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Medicare Mobility Assistive Equipment Policy

Patient: _____

Medicare #: _____ HCD Account #: _____

The MAE uses an algorithmic approach to determine which piece of equipment, if any, is “reasonable and necessary” to assist a Beneficiary in performing the Mobility-Related Activities of Daily Living (MRADL) within the home.

Please answer the following questions in order to determine which piece of equipment is “reasonable and necessary. Circle **Yes** or **NO** for questions:

- 1 thru 5:** If you are ordering a Walker, Cane or Crutches
- 1 thru 7:** If you are ordering a Manual Wheelchair
- 1 thru 8:** If you are ordering a Power Operated Vehicle (POV)
- 1 thru 9:** If you are ordering a Power Wheelchair (PWC)

- | | | |
|------------|-----------|--|
| YES | NO | 1. Does the patient have mobility limitation(s) that significantly impairs their ability to perform one or more MRADLs within their home? |
| YES | NO | 2. Are there other conditions that limit the patient’s ability to participate in MRADLs at home? |
| YES | NO | 3. If limitations exist, can they be compensated sufficiently such that the provisions of MAE will be reasonably expected to significantly improve the patient’s ability to perform or obtain assistance to participate in MRADLs in the home? |
| YES | NO | 4. Does the patient or caregiver demonstrate the capability and willingness to consistently operate the MAE safely? |
| YES | NO | 5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker? |
| YES | NO | 6. Does the patient’s home environment support the use of wheelchairs including scooter/ power-operated vehicles (POV)? |
| YES | NO | 7. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day? |
| YES | NO | 8. Does the beneficiary have sufficient strength and postural stability to operate a POV/ scooter? |
| YES | NO | 9. Are the additional features, provided by a power wheelchair, needed to allow the beneficiary to participate in one or more MRADLs? |

Treating Physician Signature: _____ Date: _____

Treating Physician Name: _____ NPI: _____

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