CANE, CRUTCH (L4989) or WALKER (L11450)

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Section I

PATIENT:	**PHYSICIAN:**
Phone:	

Section II

DIAGNOSIS and ORDER

Diagnosis: _____

_____

_____

☐ Cane or crutch
☐ Walker

Length of Need : _____

Section III

(Check **Y** for Yes, or **N** for No)

ADDITIONAL MEDICAL INFORMATION

1. Does the patient require greater stability than can be provided with a cane or crutch? ☐Y ☐N *If "No", patient qualifies only cane or crutch (E0117)*

The walker (E0130, E0135, E0141, E0143) will be denied as not reasonable and necessary, if all of the criteria (2-4) are not met.

2. Does the patient have a mobility limitation that impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home? ☐Y ☐N
   Mobility limitation is one that:
   a. Prevents the patient from accomplishing the MRADL entirely, or
   b. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, or
   c. Prevents the patient from completing the MRADL within a reasonable time frame;

3. Is the patient is able to safely use the walker? ☐Y ☐N
4. Can the functional mobility deficit be resolved with use of a walker? ☐Y ☐N
5. Does the patient's height exceed 6ft? ☐Y ☐N N *If "yes", patient requires leg extensions (E0158)*
6. Does the patient weigh more than 300 pounds? ☐Y ☐N *If "yes", patient requires heavy duty walker (E0148, E0149)*
7. Does the patient have a severe neurologic disorder or other condition causing the restricted use of one hand? ☐Y ☐N *If "yes", patient requires multiple braking system, variable wheel resistance walker (E0147)*

PLEASE ALSO INCLUDE, IF AVAILABLE, H&P, PROGRESS NOTES (MOST RECENT PERTAINING TO DIAGNOSIS), PRESCRIPTION AND/OR ANY OTHER RELEVANT INFORMATION

Physician Signature _____ **Date** _____