SAMPLE LETTERS OF MEDICAL NECESSITY

A letter of medical necessity (LMN) may be required or helpful for both public and private funding sources to justify certain pieces of DME as both medically necessary and/or medically beneficial to an individual. The sample LMNs that are included at the end of this manual are meant to serve as **EXAMPLES ONLY** to help justify specific prescriptions of specialized DME. Each LMN should be individualized to the person being served. LMNs should include information on alternatives tried, why the alternatives are not appropriate, and specific reasons why the piece of equipment and components are necessary. Justification for the need for each component should be included. **These should not be used as "template" letters.**

Recommended Items for Letter of Medical Necessity for Wheelchairs:

- Client Name and DOB
- Therapist and ATP Names, Titles and Organizations/Companies
- Narrative Statement (See Samples Below)
  - Client diagnoses
  - Client functional/ADL independence level summary, including levels of assistance required
  - If applicable - summary and condition of current wheelchair (Frame/Cushion/Backrest/Headrest, etc)
  - Client wheelchair type recommendation (ex. K0005 manual ultralight rigid frame wheelchair)
  - Ruling out of assistive devices as the sole form of safe, independent mobility
  - ADL performance level with and without wheelchair
  - Wheelchair trials – types of chairs, demonstrate safe ability to use of recommended chair consistently
  - Ruling out of lower level manual/power wheelchairs
  - Reasoning for recommended type of wheelchair (ex. K0001-4 or Group 1 and 2 power wheelchairs)
  - Reasoning for type of seating/positioning
- Client measurements – shoulder width, chest width, L/R shoulder height, hip width, top of head from seat, elbow height, upper leg length, lower leg length, foot length
- Summary of body posture – asymmetries, abnormal alignment/positions, spinal abnormalities, pelvic positioning – anterior/posterior, L/R elevation/depression, L/R rotation, anterior/posterior pelvic tilt
- Home accessibility summary
- Manual muscle tests (MMT) results/ROM/muscle tone
- Wheelchair mobility goals – What will the client be able to do once they get their chair
- Wheelchair components and justification for each component (Can list specific maker for each component)
  - Required Information for Power or Manual Wheelchairs

    Wheelchair Manufacturer and Model

    Seat Dimensions – Width/depth/seat to floor height (STFH)

    Back Rest and Cushion – Size, type and make/model

    Back Canes – type – upright/angle and/or height adjustable

    Arm Rests – types, padding type, adjustability, size, additional upper extremity support

    Head Support – type, size and adjustability

    Leg Rests/Hangers – type, angle to lower extremity support

Foot Plates – angle/depth adjustable, material

Lower Extremity Positioning – strapping, sandals

Additional Body Support – ex. pelvic positioning device (seat belt), chest/trunk straps, trunk laterals, hip guides, hip abductor pommel

- **Power Wheelchairs Only**

  Drive Type – for power wheelchairs – front/mid/rear wheel

  Joystick/Control Interface – can include head array, sip/puff, eye gaze

  Seat Functions – tilt/recline/elevating leg rests/seat elevator/standing

  Expandable Controller/Electronics – for three or more seat functions and/or alternative controls (ex. head array, sip/puff, eye gaze)

  Battery and Charger

  Attendant Control

- **Manual Wheelchairs Only**

  Wheels – rear wheel size/mag or spoke/tire type/push rim type/camber, caster size/forks/type

  Frame Angle – For rigid manual wheelchairs – angle of tubing from seat

  Taper – the narrowing of the tubing from seat to foot plate

  Dump – Difference in seat height from front to back of the chair

Sample of Letter of Medical Necessity Narrative Section: Manual Wheelchair

Chief complaint: Evaluation for mobility equipment

Due to the patient's spinal cord injury, they have {upper/lower extremity} motor sensory, integument, musculoskeletal and neurologic deficits as well as decreased cardiopulmonary endurance. They also have other medical sequelae {INSERT HERE} that impair the ability to complete activities of daily living safely at home.

The ability to perform efficient, safe and structured ambulation with a cane or a walker is not possible as a result of the aforementioned sequelae. The patient's {upper/lower} extremity function is sufficient to self-propel an optimally-configured manual wheelchair in the home setting in order to complete mobility-related activities related to daily living in the home.

An optimally-configured manual wheelchair as a mobility device is medically necessary to improve the patient's ability to safely complete ADLs and other activities in their home setting. The patient's living environment is accessible for the use of a manual wheelchair. The mobility device will enable the patient to complete mobility related activities of daily living (MRADLs), including transfers, household and community mobility (which includes but is not limited to safely attending medical appointments independently or with assistance).

Without the prescribed mobility device, the patient is unable to leave and access other rooms throughout the home including possibly remaining in bed only. If the patient is unable to get out of bed, they are at increased risk to develop joint contractures, atelectasis, pneumonia and/or other respiratory complications, pressure sores, muscle atrophy and/or multiple other medical or psychological problems.

I have completed the decision component of the face to face evaluation.

Physician signature with time/date.

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XXX is a 60-year-old male with history of a C7 complete spinal cord injury secondary to a motor vehicle accident on July 4th, 2020. As a result of the accident, the client presents to the clinic with quadriplegia, hypertonic lower extremities, neurogenic bowel/bladder, and unresolved neuropathic pain

Because of his injury, XXX has limited upper extremity function and no ability to activate muscles in his lower extremities or trunk. He also has limited to no sensation below the level of his injury. The client is independent with attaining sitting and can maintain sitting at the edge of a mat or bed with bilateral upper extremity support. He can also perform safe transfers to/from a manual wheelchair. XXX cannot safely stand or perform assisted ambulation with or without an assistive device. While in the acute inpatient rehabilitation setting, the client has been using a manual wheelchair for all functional mobility beyond his bed – he is safe and consistent with his ability to control a manual wheelchair. At this time, we are recommending a K0005 rigid frame manual wheelchair for mobility in the home, community and at work. XXX works full-time as an accountant for a local business, a job that requires constant independent mobility to get to/from meetings and other work-related activities. Without this device, the client would not be able to get out bed and participate in Mobility Related Activities of Daily Living (MRADLs), including work, family life and personal care. Client's home is accessible for a wheelchair – no stairs to enter, bedroom is on first floor and both bedroom and bathroom doorways are wide enough for wheelchair access.

XXX does not currently own a wheelchair, since he was independent with all mobility until the time of his injury. The client is unable to functionally use a K0001-4 manual wheelchair due to the additional weight of those devices making independent mobility difficult and could result in shoulder dysfunction and pain. K0001-4 manual wheelchairs also do not have a fully adjustable axle, which is only found on a K0005 manual wheelchair. It is vital for this client to have a fully adjustable axle for his manual wheelchair to facilitate optimal wheel positioning for upper extremity access to the push rims and to limit pathological shoulder kinematics that could lead to a shoulder overuse injury that could be painful and require further medical intervention. The K0005 manual wheelchair is also recommended since it is the only weight of chair that the client can independently breakdown/setup and lift in/out of his vehicle. The K0005 manual wheelchair we are recommending will keep the client safe, functional, independent and will limit pain throughout the life of the wheelchair.

We are recommending a rigid back rest to support the client in a safe, pain-free position while being properly aligned for optimal manual wheelchair propulsion, which cannot be attained by a fabric sling back. The seat cushion we are recommending is a pressure-relieving cushion that positions the client safely in his chair, which is needed due to the client's lack of sensation for the skin of the buttocks, length of time in sitting and decreased level of venous return. Without this cushion, the client is at a very high risk for skin breakdown/wounds and potential infections and hospitalization.

Sample of Letter of Medical Necessity Narrative Section: Power Wheelchair

Chief complaint: Evaluation for power mobility

Due to the patient's spinal cord injury, they have upper extremity and lower extremity motor sensory, integument, musculoskeletal and neurologic deficits as well as decreased cardiopulmonary endurance. They also have other medical sequelae {INSERT HERE} that impair the ability to complete activities of daily living safely at home.

The ability to perform efficient, safe and structured ambulation with a cane or a walker is not possible as a result of the aforementioned sequelae. The patient's upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home setting in order to complete mobility-related activities related to daily living in the home.

A scooter cannot provide independent functional mobility in the home setting because it cannot provide safe seating options to address the current and progressive medical needs of this patient including skin breakdown, neuromuscular scoliosis as well as pelvic obliquity and tilt. Also, due to impaired motor strength and dexterity in the { INSERT JOINTS etc, hands, forearm, shoulder} the patient is unable to reach and manipulate the tiller. They are unable to functionally operate a scooter due to concerns with pressure relief and decreased truncal control and function.

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A power mobility device is medically necessary to improve the patient's ability to safely complete ADLs and other activities in their home setting. The patient's living environment is accessible for the use of a wheelchair. The requested power mobility device will enable the patient to complete mobility related activities of daily living (MRADLs), including transfers, household and community mobility (which includes but is not limited to safely attending medical appointments independently or with assistance). Without the prescribed mobility device, the patient is unable to leave and access other rooms throughout the home including possibly remaining in bed only. If the patient is unable to get out of bed, they are at increased risk to develop joint contractures, atelectasis, pneumonia and/or other respiratory complications, pressure sores, muscle atrophy and/or multiple other medical or psychological problems.

I have completed the decision component of the face to face evaluation.

Physician signature with time/date.

Background Information/Medical History and Client/Parental Concerns:

XXX is a 20-year-old individual who sustained a C2 complete spinal cord injury, with concomitant brain injury, with multiple facial fractures and a fracture in bilateral forearms, due to an unprovoked assault on her university campus, where she was pushed down a flight of stairs in a parking garage in October of 2020. As a result of the spinal cord injury, she has no motor function or sensation below the level of her injury. The client presents with quadriplegia, and has no ability to move her arms or legs. XXX is unable to stand, ambulate or sit – she is dependent on others for all functional mobility without a power wheelchair. XXX has a tracheostomy and is ventilator-dependent for respiratory function. The client has been an inpatient at our inpatient rehabilitation facility for the past 8 weeks, and has a supportive family that is safe and comfortable with ventilator use, suctioning and tracheostomy care. XXX has demonstrated the ability to maintain upright while using a power wheelchair for over eight hours a day, while performing safe power-tilt facilitated pressure reliefs every 20-30mins. She has worked extensively with her therapy team to practice power wheelchair mobility with a sip/puff device, and she has demonstrated independent, safe and consistent control of the chair during daily sessions of 1-3 hours a day and is independent on the inpatient unit at all other times while the client is awake and active. The client has made multiple out-trips with her therapists, and has demonstrated safe use over uneven surfaces, ramps, cross walks and entering/exiting accessible vehicles. XXX's family has purchased an accessible rear-entry vehicle. They have made modifications to their family home, including their bathrooms, doorways and her personal bedroom. The house has no stairs to enter.

We recommend a group 3 power wheelchair for XXX with sip/puff control, power tilt, recline, and elevating leg rests. XXX has no upper or lower extremity function and would not be able to propel a manual wheelchair. The group 3 power wheelchair would allow her to be independent in the home, at university (she plans on returning to school, this upcoming fall) and in the community. The client would be unsafe in a group 1 or group 2 power wheelchair due to lack of the ability to maintain sitting balance in either device, the lack of necessary seating functions or appropriate wheelchair suspension. The client would not be able to control either group 1 or 2 due to lack of lack of ability to integrate a sip/puff system into those types of devices. The client requires multiple seat functions (tilt/recline/elevating leg rests) for safe pressure relieving, independent repositioning, dependent ADL performance/clothing changes, edema management and rest breaks.

XXX requires a deep contoured back rest with a horizontal chest strap to keep her in upright and limit her falling out of the wheelchair. A multiple-chamber air-filled seat cushion is recommended for the client, since she is in the chair for 8+ hours a day, she has insensate buttocks, and cannot sense potential skin breakdown. While XXX is meticulous with her pressure breaks, she is still at a very high risk for skin breakdown, and this type of cushion would help mitigate the potential of open areas/wounds, which may lead to infections and potential additional medical care. XXX also requires bilateral arm troughs with raised hand supports to limit discomfort/pain from potential progression of subluxation with bilateral upper extremities.

Sample of Letter of Medical Necessity: Power Wheelchair

To Whom It May Concern:

Ms. XXX is a 47 year old female with spinal cord dysfunction related to a cervicothoracic astrocytoma. She has paraplegia, scoliosis and spasticity as a result of her spinal cord involvement. In addition, she has polyradicular weakness on the right arm and a median and ulnar neuropathy on the left.

She requires the use of a custom power wheelchair due to weakness in the upper and lower extremities resulting in the ability to safely ambulate. She is unable to accomplish basic in-home activities of daily living such as safely getting from the bedroom to kitchen for meals or bathroom for toileting/hygiene. She is unable to use a cane/walker or self-propel any type of manual wheelchair due to her upper and lower extremity weakness, poor balance and poor endurance. She is unable to operate a scooter safely due to her weakness, scoliosis and spasticity. She requires significant assistance to transfer in/out of her wheelchair.

She requires a custom seat for positioning, pressure relief and spasticity management. She also requires a custom seat back and headrest. She is able to operate a joystick for control with the left hand. Tilt in space and adjustable seat lift are needed for pressure relief and activities of daily living. She requires a backup camera for safety.

I can be reached for any questions or concerns. Please extend every courtesy of coverage.

Sincerely,

Sample of Letter of Appeal: Power Wheelchair

To Whom It May Concern:

I am writing this letter of appeal on behalf of Mr. XXX. He was notified that the following procedure codes were not covered for his motorized wheelchair, E2377, E2313, E2300, E2311.

The power adjustable seat height (E2300 and E2311) allows for vertical adjustment of the seat height, increasing reach and providing independence for ADLS. It promotes safety with and improved lateral transfers by allowing a level transfer or transfer from a higher to lower surface, which is gravity assisted. It also facilitates forward transfer by allowing legs and hips to be more extended.

Mr. XXX has limited assistance at home, primarily from his wife who works. Elevation of his wheelchair would allow him to transfer at a modified independent level to and from his wheelchair and bed as well as to his shower chair and commode. In addition, it would allow him to reach for items safely in his medicine cabinet in the bathroom for grooming and hygiene. Elevation would allow him to reach light switches throughout his home given their height from the floor. It would allow him to perform meal prep independently and safely. The elevation feature would allow him to reach items in cabinets and microwave or freezer safely. Finally, the power seat elevation would allow Mr. XXX to have eye contact with others and will reduce cervical strain and thoracic pain he experiences from poor positioning. It also provides him psychological benefits of speaking eye to eye with family members and colleagues.

The expandable controller (E2377) is the power module located in the base of the chair that allows the input device to communicate with the drive motors and gearbox. The harness (e2313) is required with the expandable controller and provides the necessary connections for operations. These are necessary given Mr. XXX's wheelchair requirement of a multi-switch hand control interface to achieve the functions of drive, tilt in space, recline, power leg elevation and seat elevation. He requires the tilt in space feature for swelling and to prevent skin breakdown. He has already been hospitalized for pressure related skin injuries over the past year. He requires the tilt feature for orthostasis related to his spinal cord injury. He requires leg elevation for swelling and seat elevation for the reasons above. In addition, although he has hand function, his upper extremity function is limited by pain and his trunk control; therefore, when in recline or tilt he would have trouble navigating a multi-switch hand control.

I can be reached for any questions or concerns. I have included all prior documentation regarding Mr. XXX's wheelchair for reference. I ask you extend every courtesy of coverage for him.

Example LMN for a Standing Frame:

XXX is a 21 year old female with a diagnosis of a traumatic brain injury due to being hit by a car on XXXXX, who has been under our care here at (facility name.) Prior to her injury, Patient x was independent in ambulation and all activities of daily living. She was diagnosed with a left intracranial hemorrhage and underwent a left hemicraniectomy by the neurosurgeon, Dr. x at X Hospital. In addition, she also suffered a right femur fracture which was surgically fixed on (date.) The remainder of her acute care course is significant for placement of a tracheostomy and PEG tube. Initial rehabilitation course was significant for the treatment of spasticity and heterotopic ossification in the right hip. After that initial rehabilitation course, she was discharged home from (facility name) on (date). After several episodes of increased storming and increased spasticity, she was referred to (facility name) and was admitted on (date) for spasticity management. While at (facility name,) she was started on several different medications for spasticity management and to promote neurorecovery. The patient was transferred to X Hospital and had an intrathecal baclofen pump placed by Dr. X on (date.) During her rehabilitation stay, she has trialed and utilized the EasyStand standing frame and her mother has received hands on education in assisting with transfers as well as set up and take down of (patient name) in the standing frame. Patient x caregiver is proactive in her care and is independent with assisting Patient x in all areas of activities of daily living. Functionally, Patient x is dependent and requires assistance for all functional mobility due to the effects of her traumatic brain injury.

The EasyStand will allow Patient x to transfer from a sitting to a fully upright standing position while keeping her fully supported. During physical therapy sessions, she tolerates up to 25 consecutive minutes in a full standing position and is able tolerate full standing without any signs or symptoms of distress or hypotension.

The medical benefits of a standing program include:

- Improvement of range of motion through prolonged lower extremity stretching for prevention of contractures in hips, knees, and ankles, which are commonly associated with prolonged sitting
- Prevention of pressure injuries by allowing for an alternate pressure relief position
- Improvement of cardiovascular/respiratory systems
- Improvement of kidney, bladder, and bowel regularity and function
- Improvement in trunk control and posture to assist with balance
- Decreased spasticity and pain

For these reasons, it is highly recommended that Patient x utilize the EasyStand standing frame safely at home to optimize her positioning and upright tolerance.

Sincerely,
(Physician and therapist names and titles with signature lines)

Sample LMN for a Mobile Arm Support

To Whom it May Concern,

XXX has received outpatient occupational therapy services under my care from [DATE] to present. He sustained a [level] spinal cord injury due to XXX. He is now dependent for all of his care, except for self-operated power wheelchair due to the result of his injuries.

This letter serves as documentation of medical necessity for bilateral mobile arm supports (specifically, JAECO/Rancho MuliLink Mobile Arm Supports). XXXhas poor trunk, deltoid, bicep control due to the high level of his spinal cord injury. Although he is developing some tenodesis and active hand grasp and release, this is essentially ineffective for function without a mobile arm support, as he cannot bring his hands together and can only momentarily lift a hand from his lap.

With the right mobile arm support, XXX has demonstrated the ability to eat with a built-up spoon with minimal assistance, allowing him dignity and higher level of independence, lessened burden of care, and further strengthening and neuromuscular healing of his entire UE. He has recently developed active flexion as well as improved tenodesis in his left hand. Trials with the left mobile arm support have allowed the patient more successful active positioning of the left UE in the workspace for right hand self-assist.

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XXX is a XXX. Regular use of bilateral mobile arm supports along with additional training in therapy sessions will allow this patient to better participate in his training, including management of tablet and electronic tools for delivery of educational content.

Please contact me if further documentation is needed for this patient.

Sincerely,

Sample LMN for a Shower Commode Chair

Statement of Medical Necessity:
(Spinal Cord Injury)

Mr./Ms. [Patient's name] currently presents with a neurogenic bowel, which is a direct result of **[His/her] [Diagnosis]**. Neurogenic bowel is a condition that must be managed using a specialized bowel program designed to assist with the elimination of solid wastes. In order to successfully complete [His/her] bowel program, **Mr./Ms. [Patient's name]** must rely upon specialized mechanical stimulation techniques, pharmacological interventions, dietary changes, and specialized durable medical equipment. The absence of any of these critical bowel care components could lead to excess stool in the rectum. Excess stool in the rectum can cause bowel impaction leading to costly and unnecessary re-hospitalization or autonomic dysreflexia, a potentially life-threatening emergency medical condition. In addition, without these critical bowel care components, **Mr./Ms. [Patient's name]** will be at risk for skin breakdown and pressure ulceration secondary to an increase in the duration of the bowel care routine and/or more frequent bowel accidents.

The recommended **[Name of commode chair as written on prescription]** commode chair was trialed and selected specifically in order to allow **Mr./Ms. [Patient's name]** to safely and appropriately manage **[His/her]** neurogenic bowel. The duration of **Mr./Ms. [Patient's name]** bowel program can be as long as 45 minutes. During that time period it is critical for **Mr./Ms. [Patient's name]** to remain in an upright and supported position. An upright position is important, in order to take advantage of gravity assisted emptying of the lower bowel. **Mr./Ms. [Patient's name]** is currently **[Patient's level of assistance]** for all toileting and bathing tasks. In addition, **[He/she]** is unable to utilize standard commodes due to absent or limited trunk control. A custom commode chair equipped with an adjustable seat to back angel, external postural supports, and tilt in space feature is necessary in order to provide the necessary postural stability that is required for increased safety and fall prevention while completing bathing and toileting tasks. In addition, padded seat and back surfaces are required in conjunction with the chairs tilt in space function in order to assist with pressure relief and to prevent further skin breakdown. A u-shaped commode opening oriented to the **[Direction of opening]** is necessary in order to allow a trained health care provider or care giver to appropriately complete all of **Mr./Ms. [Patient's name]** bowel management needs. Adjustable angle footrests are necessary for appropriate lower extremity positioning and accommodation of limitations in ankle range of motion. ***[If applicable]*** An Otto Bock headrest is necessary for appropriate head positioning during tilt in space for pressure relief. ***[If applicable]:* (one or two)** Otto Bock padded arm(s) are necessary for stability and fall prevention during toileting and transfer completion. [If applicable]: Lateral supports are necessary for postural alignment and stability as well as fall prevention during toileting [and/or] bathing. ***[If applicable]:* Seat and/or Chest belt(s) is/are** necessary for enhanced safety and fall prevention with toileting.

Mr./Ms. [Patient's name and family member/caregiver (if appropriate)] has trialed and has been successfully trained in the safe and effective use of the prescribed **[Name of commode chair as written on prescription]** commode chair. The recommended commode chair is an integral part of the long-term treatment of **Mr./Ms. [Patient's name]** 's medical condition and is considered medically necessary.

OT: _____

License #: _____

Date: _____

Sample LMN for a Hospital Bed

Rx:
Semi-electric hospital bed-quantity 1
Gel overlay-quantity 1
ICD 10/Diag
HT/WT
LON-99 months

For the hospital bed the patient must meet the below criteria and the MD note must contain language similar to the following. The MD note must specifically say the pt need a semi-electric hospital bed because:

A hospital bed is covered if one or more of the following criteria (1-4) are met:

1. The patient has a medical condition (specify condition) which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, ***or***
2. The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, ***or***
3. 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 or wedges must have been considered and ruled out, ***or***
4. The patient requires traction equipment which can only be attached to a hospital bed.

Additional Phrases:

The patient has a medical condition **[Diagnosis]** which requires positioning of the body in ways not feasible with an ordinary bed, and requires frequent changes in body position. ***or***

The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain due to **[Diagnosis]**, and requires frequent changes in body position. ***or***

The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to **[Diagnosis]**. Pillows or wedges have been considered and ruled out, and requires frequent changes in body position. ***or***

The patient requires traction equipment, which can only be attached to a hospital bed and requires frequent changes in body position.

Sample LMNs for Pressure Reducing Surfaces:

Group 1 support surfaces: Foam, air, water or gel mattresses or mattress overlays and pressure pads.

Group 2 support surfaces: Powered air flotation beds, powered pressure reducing air mattresses, and non-powered advanced pressure reducing mattresses.

Group 3 support surfaces: air-fluidized beds.

Below you will see criteria which currently need to be met for each group. This should be documented in your LMN and supported by the medical record. Please see CMS.gov for updated criteria and further details on devices in each category as they can change.

Group 1 Support Devices:

Medical Necessity: Must meet the following criteria

A. Criterion 1, or

B. Criterion 2 or 3 and at least one of criteria 4-7
   1. Complete immobility: The individual cannot make changes in body position without assistance
   2. Limited mobility: The individual cannot independently make changes in body position significant enough to alleviate pressure
   3. Any stage pressure ulcer on the trunk or pelvis
   4. Impaired nutritional status
   5. Fecal and/or urinary incontinence
   6. Altered sensory perception
   7. Compromised circulatory status

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Group 2 Support Devices:

Medical Necessity: Must meet the following criteria

A. Criteria 1 and 2 and 3, or

B. Criterion 4, or

C. Criteria 5 and 6

   1. Multiple stage II pressure ulcers located on the trunk or pelvis
   2. Individual has been on a comprehensive ulcer treatment program for at least the past 30 days
   3. The ulcers have worsened or remained the same over the past month
   4. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis
   5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days - note: usually considered medically necessary only up until 60 days past surgery)
   6. The individual has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days)

Group 3 Support Devices:

Medical Necessity: Must meet ALL of the following criteria

1. The individual has a stage III or IV pressure injury or is status post muscle/skin flap repair of a stage III or IV pressure injury.
2. The individual has limited mobility and is unable to ambulate
3. In the absence of an air-fluidized bed, the individual would require institutionalization
4. A written order from the treating physician based upon a comprehensive assessment and evaluation of the individual after completion of a course of conservative treatment designed to optimize conditions that promote wound healing
5. The length of conservative treatment needs to be at least one month in duration without progression toward wound healing.
6. A trained adult caregiver is available to assist the individual with all activities of daily living and comprehensive wound care management as well as training in the management and proper use of the air-fluidized bed.
7. A physician directs the home treatment regimen and re-evaluates and re-certifies the need for the air-fluidized bed every three months
8. All other alternative equipment has been considered and ruled out.

Use of a group 3 support surface (air-fluidized bed) is considered not medically necessary under any of the following circumstances:

A. The individual has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions)

B. The individual requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material

C. The caregiver is unwilling or unable to provide the type of care required by the individual on an air-fluidized bed

D. Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1600 pounds or more)

E. Electrical system is insufficient for the anticipated increase in energy consumption

F. Other known contraindications exist

Rx
Type of Mattress, quantity 1
Diagnosis
Ht/Wt
Length of need: 99 months

Sample LMN for Exercise Equipment

A letter of medical necessity may be necessary for SCI individuals to get exercise equipment covered by insurance. We include it here for reference only and should be individualized to the needs of the person and type of equipment prescribed. It has several components:

1. Identifying information
   a. Name of insured
   b. Date of Birth
   c. Policy Number
   d. Group Number
   e. Medicaid number (if applicable)
   f. Physician's name
   g. Date
2. Date of last physical/ medical evaluation
3. Diagnosis of medical condition (be specific)
4. Pertinent medical history
   a. Describe if the disability is temporary or permanent and its evolution over time
   b. Describe the rationale for the equipment
   c. Describe how the equipment will improve functional abilities or improve the individual's disability
5. Document why the equipment is medically necessary
6. Physician's signature, professional qualifications, and contact information