Anderson, Duane L (MRN 03805085)

Denied (Not a Covered Benefit)

Referral

Referral # 4116377935

Referral Information

Referral #	Creation Date	Referral Status	Status Update
4116377935	01/16/2025	Denied	01/16/2025: Status History

Status Reason	Referral Type	Referral Reasons	Referral Class
Not a Covered Benefit	DME/P&O	Provide DME/appliance/Brace/supplies only	Outgoing

To Specialty	To Provider	To Location/Place of Service	To Department	To POS Type
Durable Medical Equipment	Lacey, Bellevue Healthcare	BELLEVUE HEALTHCARE-LACEY	none	Home

To Vendor	Referred By	By Location/Place of Service	By Department
none	Hu, Andrew, DPM	OLYMPIA MEDICAL CENTER	OLY PODIATRY

Priority	Start Date	Expiration Date	Referral Entered By
Urgent	01/16/2025	01/16/2025	Hu, Andrew, DPM

Visits Requested	Visits Authorized	Visits Completed	Visits Scheduled
1	0		

Procedure Information

Service Details

Procedure	Modifiers	Revenue Code	Provider	Requested	Approved
~~DME0056 - REF DME CRUTCHES~~	none	~~none~~		0	0
E0118 - CRUTCH SUBSTITUTE, LOWER LEG PLATFORM, WITH OR WITHOUT WHEELS, EACH	RR	none		2 (1/Month x 2)	0

Anderson, Duane L (MRN 03805085)

Diagnosis Information

Diagnosis
M14.671 (ICD-10-CM) - Charcot joint of right foot
E11.42, Z79.4 (ICD-10-CM) - Type 2 diabetes mellitus with diabetic polyneuropathy, with long-term current use of insulin

Referral Notes

Number of Notes: 9

Type	Date	User	Summary	Attachment
External Provider Referral Letter	01/16/2025 9:51 AM	Vandenbosch, Kati Ilene	Auto: 19525-KPWA RFL MESSAGE TEXT	Document on 1/16/2025 9:51 AM by Vandenbosch, Kati Ilene: Referral Notification Document

Note:
Referral Notification

Type	Date	User	Summary	Attachment
External Provider Referral Letter	01/16/2025 9:51 AM	Vandenbosch, Kati Ilene	Auto: 19525-KPWA RFL MESSAGE TEXT	Document on 1/16/2025 9:51 AM by Vandenbosch, Kati Ilene: Referral Notification Document

Note:
Referral Notification

Type	Date	User	Summary	Attachment
External Member Referral Letter	01/16/2025 9:51 AM	Vandenbosch, Kati Ilene	Auto: 19525-KPWA RFL MESSAGE TEXT	Document on 1/16/2025 9:51 AM by Vandenbosch, Kati Ilene: Referral Notification Document

Note:
Referral Notification

Anderson, Duane L (MRN 03805085)

Type	Date	User	Summary	Attachment
Recipient List	01/16/2025 9:51 AM	Vandenbosch, Kati Ilene	Auto: Notification Recipient List	-

Note:

Andrew Hu, DPM
700 Lilly Rd NE
Olympia, WA 98506
THURSTON
UNITED STATES
360-923-7779
In Basket Message queued for PDF generation

800624923-BELLEVUE HEALTHCARE II INC
In Basket Message queued for PDF generation

Type	Date	User	Summary	Attachment
External Provider Referral Letter	01/16/2025 9:51 AM	Vandenbosch, Kati Ilene	Auto: 440046-KPWA RFL MEDICARE NDMC FIRST LEVEL AUTOMATED PRV	-

Note:

RS

KAISER PERMANENTE®
Kaiser Foundation Health Plan of Washington
Review Services
P.O. Box 34589 Seattle WA 98124-1589

Important Kaiser Permanente Medicare health plan information

January 16, 2025

Andrew Hu, DPM
700 Lilly Rd NE
Olympia WA 98506

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

Notice of Denial of Medical Coverage

Date: January 16, 2025 **Member ID Number:** 03805085

Name: Duane L Anderson **Reference Number:** 4116377935

Anderson, Duane L (MRN 03805085)

Date of Birth: 12/19/1957

Your request was denied

We've denied the medical service/item listed below requested by you or your doctor:

Procedure Name	Procedure Code	Requested Quantity	Procedure Type	Modifiers	Revenue Code	Revenue Code Name
CRUTCH SUBSTITUTE, LOWER*	E0118	2 (1/Month x 2)	HCPCS	RR	N/A	N/A

Referred to:

BELLEVUE HEALTHCARE-LACEY
4500 PACIFIC AVE SE
LACEY WA 98503

Provider Specialty: Durable Medical Equipment

Why did we deny your request?

We denied the medical service/item listed above because this service/item is specifically listed as not covered per Medicare either for your specific condition or for any condition.
As a result, we are unable to approve coverage of this request.

This decision is based on Noridian Policies - E0118 - Crutch Substitute. As of May 4, 2017, the Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC) reviewed information about equipment billed with code E0118, and have determined it to remain a noncovered device due to a lack of published clinical literature demonstrating safety and effectiveness.

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask Kaiser Foundation Health Plan of Washington ("Kaiser Permanente") Medicare Advantage (HMO) to review our decision by asking us for an appeal.

Plan Appeal: Ask Kaiser Permanente for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with Kaiser Permanente" for information on how to ask for a plan level appeal.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-866-458-5479 to learn how to name your representative. TTY users call 1-800-833-6388. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

cc: Bellevue Healthcare-lacey
Andrew Hu
BELLEVUE HEALTHCARE LACEY
Duane L Anderson

Important Information About Your Appeal Rights

There are 2 kinds of appeals with Kaiser Permanente

Standard Appeal – We'll give you a written decision on a standard appeal within **30 days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a medical service/item you've already received, we'll give you a written decision within **60 days**.

Fast Appeal– We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to **30 days** for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a medical service/item you've already received.

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within **30 days**.

How to ask for an appeal with Kaiser Permanente

Step 1: You, your representative, or your doctor must ask us for an appeal. Your request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a Standard or Fast Appeal (for Fast Appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal), or other information that explains why you need the medical service/item. Call your doctor if you need this information.

If you're asking for an appeal and missed the deadline, you may ask for an extension and should include your reason for being late.

We recommend keeping a copy of everything you send us for your records. You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal.

For a Standard Appeal:	Mailing Address:	Medicare Member Appeals PO Box 34593 Seattle, WA 98124-1593
	Fax:	206-630-1859
For a Fast Appeal:	Phone:	Toll-free: 1-866-458-5479
	TTY Users Call:	1-800-833-6388
	Fax:	206-630-1859

What happens next?

If you ask for an appeal and we continue to deny your request for a medical service/item, we'll automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

Get help & more information

- Kaiser Permanente Toll Free: 1-888-901-4600 TTY users call: 1-800-833-6388
  Monday–Friday: from 8 a.m. to 8 p.m.
  From October 1 through March 31, hours are from 8 a.m. to 8 p.m., 7 days a week
  or https://wa.kaiserpermanente.org/
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week.
  TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116 or www.eldercare.gov to find help in your community.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0829. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Form CMS 10003-NDMCP OMB Approval 0938-0829 (Expires: 12/31/2024)

Anderson, Duane L (MRN 03805085)

Type	Date	User	Summary	Attachment
Recipient List	01/16/2025 9:51 AM	Vandenbosch, Kati Ilene	Auto: Notification Recipient List	-

Note:
Duane L Anderson
8527 9TH WAY SE
OLYMPIA, WA 98513-2033
THURSTON
UNITED STATES
Sent: Letter
MyChart Message queued for PDF generation

Type	Date	User	Summary	Attachment
External Member Referral Letter	01/16/2025 9:51 AM	Vandenbosch, Kati Ilene	Auto: 20290-KPWA RFL MEDICARE NDMC FIRST LEVEL AUTOMATED MBR	-

Note:

RS

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Kaiser Foundation Health Plan of Washington
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P.O. Box 34589 Seattle WA 98124-1589

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January 16, 2025

Duane L Anderson
8527 9th Way Se
Olympia WA 98513-2033

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Notice of Denial of Medical Coverage

Date: January 16, 2025

Member ID Number: 03805085

Name: Duane L Anderson

Reference Number: 4116377935

Date of Birth: 12/19/1957

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Referred to:

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cc: Bellevue Healthcare-lacey
Andrew Hu
BELLEVUE HEALTHCARE LACEY

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KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (“Kaiser Permanente”) comply with applicable federal civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

Provide free aids and services to people with disabilities to help ensure effective communication, such as:

• Qualified sign language interpreters
• Written information in other formats (large print, audio, and accessible electronic formats)
• Assistive devices (magnifiers, Pocket Talkers, and other aids)

Provide free language services to people whose primary language is not English, such as:
• Qualified interpreters
• Information written in other languages

If you need these services, contact Member Services at 1-888-901-4636 (TTY 711).

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with our Civil Rights Coordinator by writing to P.O. Box 35191, Mail Stop: RCR-A3S-03, Seattle, WA 98124-5191 or calling Member Services at the number listed above. You can file a grievance by mail, phone, or online at kp.org/wa/feedback. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with:

• The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

• The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at ttps://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

English

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-888-901-4636** (TTY: **711**).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-901-4636**（TTY：**711**）。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-901-4636** (TTY: **711**).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-901-4636** (TTY: **711**) 번으로 전화해 주십시오.

Russian

ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-901-4636** (TTY: **711**).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-901-4636** (TTY: **711**).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-888-901-4636** (TTY: **711**).

Khmer

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-888-901-4636** (TTY: **711**)។

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-901-4636**（TTY: **711**）まで、お電話にてご連絡ください。

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-901-4636** (TTY: **711**).

Oromo

Anderson, Duane L (MRN 03805085)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-888-901-4636** (TTY: **711**).

Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-888-901-4636** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Arabic

ملحوظة :إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم **1-888-901-4636** (TTY: **711**).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-901-4636** (TTY: **711**).

Lao

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-888-901-4636** (TTY: **711**).

Form CMS 10003-NDMCP OMB Approval 0938-0829 (Expires: 12/31/2024)

Type	Date	User	Summary	Attachment
RS Letter Comments	01/16/2025 9:36 AM	Hu, Andrew, DPM	Auto: 29150-KPWA RFL DME COINSURANCE	-

Note:
DME Patient Coinsurance = 25%, deductible may apply when claim is received.

Type	Date	User	Summary	Attachment
Provider Comments	01/16/2025 9:36 AM	Hu, Andrew, DPM	Provider Comments	-

Note:
Enter other order details here: need knee scooter. Charcot foot. Cant be WB

Wt Readings from Last 1 Encounters:
01/14/25 : (!) 330 lb 6.4 oz (149.9 kg)

Ht Readings from Last 1 Encounters:
06/29/24 : 6' 3.98" (1.93 m)

Referral Order

Anderson, Duane L (MRN 03805085)

Order
REF DME CRUTCHES (Order # 472833208) on 01/16/2025

Questionnaire

Referral Quality Issues	
Other (please describe)	
What type of service is being requested?	None of the Above
Type of Request	
What is being ordered?	
Has the patient been diagnosed with an infection or injury of the perineal area and the sitz bath is part of a planned regimen of home care treatment?	
Is the patient confined to a bed?	
What type of brace is being ordered?	
Select the device being ordered:	
Does the patient have a nonunion of a long bone fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator?	
Does the patient have a failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery?	
Does the patient have congenital pseudarthrosis?	
Has the patient had a failed spinal fusion where a minimum of nine months has elapsed since the last surgery?	
Has the patient had a multilevel spinal fusion surgery?	
Has the patient had a failed spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site?	
Does the patient have a nonunion fracture and a minimum of 2 sets of radiographs prior to treatment with the osteogenesis stimulator?	
Are the radiographs separated by a min of 90 days with each including multiple views of the fracture site, and has a written interpretation stating no clinically significant evidence of	

Anderson, Duane L (MRN 03805085)

fracture healing between the two sets or radiographs?
Is the fracture at a site other than the skull or vertebrae?
Is the fracture not related to a tumor?
Has the patient had a total knee replacement?
Is this device being prescribed for use, nor more than two days from the surgery date and for no longer than 3 weeks post surgery?
Is this being prescribed for treatment of contractures?
Has the patient had a recent injury or surgery that requires both medial and lateral rotation control?
Does the patient have documented knee instability/joint laxity?
What device is being ordered?
Does the patient have weakness or deformity of the foot and ankle?
Does the patient require stabilization for medical reasons?
Does the patient have the potential to benefit functionally?
Does the patient require knee stability?
Does the patient have plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees?
Is there a reasonable expectation of the ability to correct the contracture?
Is the contracture interfering or expected to interfere significantly with the patient's functional abilities?
Is this going to be used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons?
Does the patient have plantar fasciitis?
Does the patient have weakness or deformity of the knee that requires stabilization?
Has the patient had a recent injury to or a surgical procedure on the knee?
Is the patient ambulatory and has knee instability?
Is the examination of the patient's joint laxity documented?
Does the patient have flexion or extension contractures of the knee

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with movement on passive range of motion testing of at least 10 degrees?	
Is the need for a custom fabricated orthosis instead of a prefabricated orthosis documented?	
Is this to reduce pain by restricting mobility of the trunk?	
Is this to facilitate healing following an injury to the spine or related soft tissues?	
Is this to facilitate healing following a surgical procedure on the spine or related soft tissue?	
Is this to support weak spinal muscles and/or deformed spine?	
Has the patient had a mastectomy?	
Has the patient had breast reconstruction?	
Does the patient have a mastectomy form or silicone (or equal) breast prosthesis?	
Does the patient have a mastectomy form?	
Will the external breast prosthesis garment be used in the post-operative period prior to a permanent breast prosthesis or will it be used as an alternative to a mastectomy bra and breast prosthesis?	
Does the member have a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living (MRADL) in the home?	
Will the functional mobility deficit be sufficiently resolved by the use of the cane or crutch, and is the patient able to safely use a cane or crutch?	
Does the patient have a documented episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia?	
Does the patient have familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy?	
Does the patient have either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular	

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ejection fraction less than or equal to 0.35?	
Does the patient need to have a previously implanted defibrillator explanted?	
Does the patient have a diagnosis of Diabetes Mellitus?	
Within the last 6 months, has the patient had an in-person, video, or telephone visit with a physician, NP, or PA to evaluate their diabetes control?	
Has the patient's treating practitioner concluded the patient (or the patient's caregiver) has training using the particular device prescribed as evidenced by providing a prescription for the appropriate supplies and frequency of blood glucose testing?	
Is the patient insulin treated?	
Does the patient have recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan?	
Does the patient have a history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia	
Is the patient physically incapable of utilizing a regular toilet for at least one of the following situations: 1) confined to a single room, 2) confined to one level where there is no toilet, or 3) the home has no toilet facility?	
Bilateral or Lateral?	
Will the compression burn garment be used to treat hypertrophic scarring and joint contractures following a burn injury?	
Is this being requested to treat a wound caused by or treated by a surgical procedure or following a debridement or open venous stasis ulcer?	
For non-surgical wounds, was any type of debridement (surgical, enzymatic, mechanical, biological, autolytic) ever performed on this wound?	

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Select all that apply for the members condition that this item is being requested for:	
Member has venous or lymphatic condition, as indicated by 1 or more of the following:	
CPAP or BIPAP request?	
Does the patient have any of the following? (Hover for info)	
Has the diagnosis been confirmed by polysomnography, either during an inpatient hospital visit or sleep lab, or was OSA suspected at the time of discharge?	
Does the patient use on average 4 hours per night for a minimum of 70% of nights?	
Has there been a re-evaluation by the treating provider within 30-90 days from the initial request with documentation that includes symptoms of OSA are improved; and evidence of adherence to use of the device?	
What is being ordered?	
Is there record of the patient's need for a pump (i.e. gravity feeding is not satisfactory due to reflux or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, glucose fluctuations, gastrostomy/jejunostomy tube used)?	
What is the Administration/Delivery Method?	
Does the patient have full or partial non-function or disease of the structures that normally permit food to reach the small bowel, that will last at least 3 months?	
Does the patient have a disease that impairs digestion and/or absorption of an oral diet, directly or indirectly, by the small bowel, that will last at least 3 months?	
Does the patient's medical record include documentation stating why a standard formula cannot be used?	
What type of Device or Supply is being ordered?	
Does the patient have a covered cochlear implant or a bone-anchored hearing aid (BAHA)?	

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Is this request for convenience or to upgrade to a newer technology?	
Is the current component obsolete or no longer supported?	
Is the current component no longer meeting the patient's needs?	
Has the patient had a formal evaluation of their cognitive and communication abilities by a speech-language pathologist (SLP)?	
Does the patient's medical condition result in a severe expressive speech impairment?	
Can the patient's speaking needs be met using natural communication methods?	
Have other forms of treatment been considered and ruled out?	
Will the patient's speech impairment benefit from the speech generating device?	
Does the treating practitioner have a copy of the SLP's written evaluation and recommendation?	
Does the patient have an absence or shrinkage of an eye due to a birth defect, trauma, or surgical removal?	
Has the patient had more than 2 eye polishing services within this year?	
What is being ordered?	
Is the patient using a covered insulin pump?	
Does the patient vhave Diabetes Mellitus?	
Does the patient have C-Peptide level <110% (or has renal insufficiency w/C-peptide level <200%) & fasting sugar drawn at the same time <225 mg/dl?	
Does the patient have a positive Beta cell autoantibody test?	
Has the patient completed comprehensive diabetes education program, multiple daily insulin injections (3/day), frequent self-adjustments of insulin dose for at least 6 months, has documented glucose self-testing at least 4x/day during the 2 months prior?	
Does the patient have HbA1c>7%, or history of recurring hypoglycemia, or wide fluctuations in blood glucose before mealtime, or "Dawn	

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phenomenon" w/fasting blood sugars frequently >200mg/dL, or history of sever glycemic excursions?	
Has the patient been on an insulin pump prior to enrollment with plan and has documented frequency of glucose self-testing at least 4x/day (on average) during the month prior to enrollment?	
Does the patient have a medical condition that requires positioning of the body in ways not feasible with an ordinary bed due to pain, CHF, or chronic pulmonary disease?	
Does the patient have aspiration problems requiring head of bed elevation >30 degrees and have a need for frequent changes in body positions, and/or an immediate need for a change in body position?	
Does the patient require traction equipment requiring attachment to a hospital bed?	
Are Hospital Bed accessories or a replacement mattress needed?	
Type of Accessories:	
Is this being provided for a patient-owned Hospital Bed?	
Does the patient require a trapeze to sit up because of a respiratory condition, to change body positions for other medical reasons, or to get in and out of bed?	
Does the patient have a condition that requires a safety enclosure that would be an integral part of a hospital bed?	
Is a bed cradle needed to prevent the patient from having contact with the bed coverings?	
Does the patient have a condition that requires bed rails?	
Is the patient confined to a bed?	
Does the patient's condition require a replacement mattress?	
Is this request for a Negative Pressure Wound Therapy pump or supplies?	
Does the patient have a chronic stage 3 or 4 pressure ulcer, a neuropathic ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology?	
Has the patient been appropriately turned and positioned, and has used a	

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group 2 or 3 support surface, and has had their moisture and incontinence appropriately managed?	
Has the patient been on a comprehensive diabetic management program and has reduction in pressure on a foot ulcer been accomplished?	
Has the patient had compression badages and/or garments cosistnetly applied and have leg elevation and ambulation been encouraged?	
Has wound therapy, with documented eval, care, & wound measurement by a medical professional, dressings to maintain a moist wound area, debridement of necrotic tissue, & provisions for adequate nutritional status been tried or considered & ruled out?	
Does the patient have an ulcer or wound found in an inpatient setting, and after wound treatments have been tried or considered & ruled out, Negative Pressure Wound Therapy is used because the treating practitioner determines it is the best treatment?	
Does the patient have complications of a surgically created wound or a traumatic wound where there is documentation of medical necessity for an accelerated formation of granular tissue which cannot be achieved by other available topical wound treatments?	
Is the patient currently using a Negative Pressure Would Therapy pump?	
Does the patient have angina pectoris in the absence of hypoxemia, dyspnea without cor pulmonale or the evidence of hypoxemia, severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but the in absence of systemic hypoxemia, or a terminal illness that does not affect the ability to breathe?	

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The patient had a qualifying blood gas, performed by a treating practitioner or qualified provider during the patient's illness or within 2 days of discharge from a hospital (documented) & the provision of oxygen, in the home setting, will improve the condition?	
Does the patient have an arterial PO2 at or below 55 mm Hg or an arterial oxygen sat at or below 88% taken at rest (awake) while breathing room air?	
Does the patient have an arterial PO2 at or below 55 mm Hg, or an arterial oxygen sat at or below 88 %, taken during sleep for a patient who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen sat at or above 89% while awake.	
Does the patient have a decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen sat more than 5% from baseline sat, taken during sleep and associated with symptoms of hypoxemia?	
Does the patient have an arterial PO2 at or below 55 mm Hg or an arterial oxygen sat at or below 88%, taken during exercise for a patient who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen sat at or above 89% while at rest?	
Does the patient have an arterial PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent?	
Does the patient have dependent edema suggesting CHF, pulmonary hypertension or cor pulmonale, determined by measure of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG, or Erythrocythemia with a hematocrit > 56%?	
Does the patient have the absence of hypoxemia and a medical condition with distinct physiologic, cognitive, and/or functional symptoms documented in high-quality, peer-reviewed literature to be improved by oxygen therapy?	
Oxygen Saturation or PaO2 level:	
Measurement:	
Date of oxygen saturation or PaO2 level measurement:	

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Testing Conditions:	
Describe needed change:	
Type of Pad or Mattress?	
Is the patient completely immobile (i.e., the member can't make changes in the body position without assistance?	
Does the patient have limited mobility (i.e., the member can't make changes in body position significant enough to alleviate pressure)?	
Does the patient have one of these conditions; impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status?	
Does the patient have any stage pressure ulcer on the trunk or pelvis?	
Does the paitient have multiple stage 2 pressure ulcers located on the trunk or pelvis which have failed to improve over the past month?	
Has the patient been on an ulcer treatment program including, a Group 1 support surface, assessment by a licensend healthcare professional, turning and positioning, wound care, moisture/incontinence control, nutritional assessment and invtervention?	
Does the patient have large or multiple stage 3 or 4 pressure ulcer(s) on the trunk or pelvis?	
Has the patient had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis in the past 60 days and has been on a Group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility in the past 30 days?	
What type of Patient Lift or Transfer Device is being ordered?	
Does the patient need to be transferred between a bed and a chair, wheelchair or commode?	
Without the use of a lift, would the patient be conifined to a bed?	
Is this sling or seat being ordered as a replacement for a covered lift?	
Does the patient have severe arthritis of the hip or knee or have a severe neuromuscular disease?	

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Is the seat lift mechanism being prescribed to effect improvement, or arrest or retard deterioration in the patient's condition?	
Is the patient completely incapable of standing up from a regular armchair or any chair in their home?	
Once standing, does the patient have the ability to ambulate?	
Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position been tried already?	
What type of Pneumatic Compression is being ordered?	
Does the patient have lymphedema?	
Does the patient meet one or more of the following criteria (Check all that apply)	
Is the patient's lymphedema documented to be unresponsive to other clinical treatment over the course of a required four-week trial?	
Does the patient have chronic venous insufficiency with venous stasis ulcers of the lower extremity?	
Does the patient have all of the following: edema in the affected lower extremity; one or more venous stasis ulcer(s); the ulcer(s) have failed to heal after a six-month trial of conservative therapy directed by the treating practitioner?	
Does the member have lymphedema extending onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve?	
Has the chest, trunk and/or abdominal lymphedema has failed to improve with a four-week trial?	
What is being ordered?	
Is this being ordered as a replacement piece to a covered wheelchair?	
Does the patient have a mobility limitation that limits their ability to participate in one or more MRADLs within the home and that limitation cannot be resolved with a cane or walker?	
Does the patient have sufficient upper extremity function to self propel a manual wheelchair in the home to perform MRADLs?	

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Has the patient had a face to face visit in the last 6 months?
Is this being ordered for use with a covered brace?
Does the patient have chronic obstructive lung disease, chronic bronchitis, or emphysema?
Does the patient have a neuromuscular disease?
Is the patient's condition causing a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions?
Has the patient or caregiver received appropriate training by a physician or therapist?
Request Type:
Does the patient have Diabetes Mellitus?
Does the patient have 1 or more of these conditions; amputation of other foot or partial of either foot, previous foot ulceration, pre-ulcerative callus, peripheral neuropathy with callus formation, foot deformity, or poor circulation, either foot?
Has the patient had a face to face visit with the provider managing their diabetes care (and the members conditions are documented in their medical record), within 6 months of this order?
Does the patient have a foot deformity that cannot be accommodated by a depth shoe?
Is this to be used as part of a covered leg brace and is medically necessary for the propoer functioning of the brace?
Is this prosthesis being used by the patient for treatment or rehab during an inpatient stay?
Is this prosthesis reasonable and necessary for use by the patient in their home setting?
Is this prosthesis being delivered to the patient no more than 2 days prior to a discharge from an inpatient stay, or to a patient who is not currently inpatient?
Does the patient use of a respiratory suction pump to clear secretions?

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Does the patient have a tracheostomy?
Is the patient on a ventilator?
Does the patient have an orthopedic impairment requiring traction equipment which prevents ambulation during the period of use?
Does the patient have a muskuloskeletal or neurological impairment requiring cervical traction equipment?
Has the patient had demonstration of appropriate use of home cervical traction device and tolerated use?
Does the patient meet one or more of the following criteria (Check all that apply)
Does the patient have neuromuscular disease and chronic respiratory failure consequent to chronic obstructive pulmonary disease?
Does the patient have thoracic restrictive diseases and chronic respiratory failure consequent to chronic obstructive pulmonary disease?
Request Type?
Does the patient have a full thickness wound, wound with light to moderate exudate, or a wound that has stalled or has not progressed toward a healing goal?
Does the patient have a wound with heavy exudate, a third dgree burn, or active vasculitis?
Does the patient have a moderate to highly exudative full thickness wound or wound cavity?
Is the patient's wound covered with eschar?
Is the gauze being used for dressing changes no more than 3 times per day for a dressing without a border and once per day for a dressing with a border?
Does the patient have a full thickness wound with minimal or no exudate?
Does the patient have a stage 2 ulcer?
Does the patient have a wound with light to moderate exudate?
Does the patient have an open, partial thickness wound with minimal exudate or a closed wound?

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Is this being used to hold wound cover dressings in place?
Is this patient currently receiving Home Health Care?
Type of Walker or Gait Trainer?
Does the patient have a mobility limitation that significantly impairs the ability to participate in one or more mobility-related activities of daily living (MRADL), and will the deficit be resolved by the use of the device, and can the patient safely use the device?
Is the patient unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand?
Are Walker Accessories needed?
Type of Accessories:
Is this being provided for a patient - owned walker?
Type of Request:
Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker?
Does the patient's home provide adequate access between rooms, manuevering space, and surfaces for use of a manual wheelchair?
Does the patient have a mobility limitation that impairs their ability to participate in mobility-related activities of daily living (MRADLs) entirely?
Does the patient have a mobility limitation that impairs their ability to complete MRADLs in a reasonable time frame?
Does the patient have a mobility limitation that impairs their ability to participate in MRADLs and would put them at heightened risk of morbidity or mortality secondary to the attempts to perform the MRADLs?
Will use of a manual wheelchair significantly improve the patient's ability to participate in MRADLs and will they have expressed that they will use it on a regular basis in the home?
Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel in a manual wheelchair?

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Does the patient have a caregiver who is available, willing, and able to provide assistance with the wheelchair?	
Does the patient require a lower seat height (17-18") because of short stature or to enable them to place their feet on the ground for propulsion?	
Is the patient able to self-propel in a lightweight wheelchair, but cannot in a standard wheelchair?	
Is the patient able to self-propel the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair?	
Does the patient spend at least 2 hours per day in the wheelchair and require a seat width, depth, or height that cannot be accommodated in a standard or lightweight chair?	
Does the patient have severe spasticity?	
Does the patient have sufficient strength and postural stability to utilize a Rollabout chair?	
Has the patient had an evaluation performed by a licensed/certified medical professional (LCMP), who has specific training and experience in rehab wheelchair evaluations and that documents the medical necessity and it's special features?	
Is the wheelchair being provided by a Rehabilitative Technology Supplier that employs a RESNA-certified Assistive Technology Professional who specializes in wheelchairs and who has direct, in-person involvement in the chair selection for the patient?	
Place Of Delivery:	
Alternative Business Name:	
Alternative Address Line 1:	
Alternative Address Line 2:	
Alternative City:	
Alternative State:	
Alternative ZIP Code:	
Alternative Phone:	
Patient Height (in):	
Patient Weight (lbs):	
Ok to substitute an in network provider if the chosen referred to	

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provider is not in the member's network?

Is this a retrospective request?

Name of Requestor:

Requestors Contact #:

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