Valley Mission Homecare Pharmacy
12509 E Mission, Ste 103
Spokane Valley, WA 99216
valleymissionrx.com
Phone (509) 928-6400 **Fax (509) 928-6441**

2-WHEEL WALKER / 4-WHEEL WALKER WITH SEAT & WHEEL LOCKS

Eligibility Assessment & Order Guidance Tool

- **This guidance is based on requirements for traditional Medicare Beneficiaries. Although other insurers may have less or more stringent requirements - including potential need for prior authorization - CMS policies serve as the reference standard. For questions, please call Valley Mission Homecare Pharmacy† at (509) 928-6400.**

STEP 1: Verify the patient's medical condition meets Medicare coverage criteria -- ALL BELOW ARE REQUIRED:

- **Patient has a medical condition directly causing ambulation difficulty that significantly impairs or prevents his or her ability to safely or timely participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming and bathing in the home.** *Note: neither "unstable gait" nor "weakness" is a solely sufficient mobility limitation for CMS coverage criteria.*
- **Patient has been evaluated face-to-face for the medical condition identified above within the past 6 months and results of this encounter verify a documented medical need for the walker.**
- **The use of a walker is expected to significantly *improve* the patient's ability to be more successful with *MRADLs* in the *home* and the patient is expected to be a willing participant in the *regular* use of the equipment.** *Importantly, coverage cannot be justified if the intended use is solely for outside the home, nor if the equipment is primarily for the benefit of a caregiver.*
- **Patient has sufficient upper extremity function and other physical and mental capabilities needed to safely operate the walker.**
- **For 4-wheeled walkers with seat & wheel locks: In addition to the above criteria, patient has a medical condition that prevents him or her from walking reasonable distances or standing for extended periods of time without sitting and resting.**
- **For Heavy-Duty or Bariatric walkers: In addition to the above criteria, patient weighs more than 300 lbs**

STEP 2: Complete all sections of the 2-Wheel / 4-Wheel Walker with Seat & Wheel Locks Detailed Written Order (see page 2)

STEP 3: Print and Fax the following documents along with the Detailed Written Order to (509) 928-6441:

1. **The most recent face-to-face visit summary pertaining to ambulation challenges that include discussion of the need for a walker. This must include documentation of required qualifications outlined in STEP 1 above.**
2. **Demographic face-sheet for the patient**

† ***Valley Mission Homecare Pharmacy specializes in the provision of Durable Medical Equipment (DME) and Supplies to Medicare beneficiaries. Information provided here is intended solely to facilitate communication between the Ordering Provider and the DME Supplier to help ensure medical criteria are sufficient for presumptive coverage. This does NOT in any manner replace formal guidance located in the relevant Local Coverage Determination (LCD) specified by the Medicare Administrative Contractor.***

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Detailed Written Order

Patient Information

Last Name	First Name	Middle Name	Date of Birth

Physical Address	City	State	Zip Code

Billing Address (if different)	City	State	Zip Code

Phone	Alternate Phone

Prescriber Information

Last Name	First Name	Credential Type	NPI

Practice Location Address	City	State	Zip Code	Tax ID

Practice Location Phone	Practice Location Fax	Supervising Provider Name and NPI if applicable

Order Detail

Rx (specify type of walker ordered, e.g., "2-wheeled" or "4-wheeled with seat & wheel locks)
Length of Need
Diagnosis (ICD-10) – list codes that directly result in ambulation difficulty. *Neither "unstable gait" nor "weakness" is a solely sufficient mobility limitation for CMS coverage criteria.*
If 4-wheeled walker with seat and wheel locks requested, provide <u>additional</u> diagnosis indicating the need to periodically rest during ambulation
Patient Height & Weight
Additional Detail (e.g., "bariatric" or "heavy-duty", etc, when applicable.

I certify that I am the ordering prescriber specified above and hereby attest that information on this page is true, accurate and complete to the best of my knowledge and that the patient has suitable medical criteria documented in his/her patient record indicating medical necessity for the items listed above. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil or criminal liability. The patient (and his/her caregivers, when applicable) is capable of using this equipment and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Prescriber Signature	Date