

Letter of Medical Necessity – Sample

Date: _____

Medical Director: _____

Address: _____

Regarding: Request of WalkPort for **PATIENT NAME**

Patient Name: _____

Diagnosis: _____

Date of Birth: _____

Insurance ID Number: _____

CPT Code(s): _____

Place of Service: Home _____

Est. Length of Need: _____

To Whom It May Concern:

Purpose. The purpose of this letter is to request the WalkPort supported walk station for my patient, **PATIENT NAME**. The WalkPort will provide **PATIENT NAME** with multiple physical and medical benefits, helping to reduce burden of care and medical expenses.

Establish your credentials, and relationship with the patient:

I am a physical therapist in private practice serving patients in both home-care and long-term care setting. I have an MS in physical therapy, have practiced for 20 years, am licensed in State, and am current in continuing education units. I have been **PATIENT NAME** home-care physical therapist for the past _____.

Explain the Patient's Diagnosis/ History

PATIENT NAME is a ___ year old male/female with *LIST DIAGNOSIS, ONSET DATE AND HOW INJURY OCCURRED*. Prior to this injury, **PATIENT NAME** was a healthy, active individual. *LIST CURRENT DEFICITS, INCLUDING STRENGTH, ROM, AND FUNCTIONAL CHANGES*.

Secondly, to their diagnosis, **PATIENT NAME** presents with lower extremity muscular weakness, impaired motor control and poor balance. This restricts their endurance and puts them at a high risk for falls.

As a result, **PATIENT NAME** spends about 15 hours a day in his wheelchair and is progressively losing what little functional abilities remain. Prolonged sitting also puts them at an increased risk for pressure ulcers, contractures, decreased lower extremity bone density and compromised circulation. These changes can lead to further complications such as recurrent urinary tract infections, increase in risk of fractures, diabetes, and early cardiovascular disease. Without the appropriate support and equipment, all these factors can lead to frequent and lengthy hospitalizations, expensive medical costs, and need for greater care.

Describe why the device is medically necessary:

Because of **PATIENT NAME** diagnosis, their mobility is limited. The WalkPort is medically necessary for **PATIENT NAME** because it will give them the much-needed support and safety to perform the therapy on their own.

1.) **Ease of set up and use.** The WalkPort is designed for easy, independent transfer and setup. From **PATIENT NAME** wheelchair, they can transfer onto the device and set up the machine on their own during trials. Other devices require 2-3 additional people to help the user get setup, which is costly and time-consuming, and not practical for home use.

2.) **Supported Standing & Walking.** The WalkPort will fully support **PATIENT NAME** while standing to maintain optimal posture alignment and ensure patient's safety. This change of position allows alteration in pressure distribution for skin integrity. The upright position also improves respiration, digestion, circulation, and bowel/bladder function. The safety features allow them to use the device frequently, as the literature supports 3 times per week is the minimum frequency that is necessary for optimal recovery and function.

3.) **Guided Walk Therapy.** High repetition locomotor(walking) training has been shown to improve ambulatory function of people with neurological injury. The benefits of walking are well-documented for individuals with SCI, and these health improvements can include improved cardiovascular and pulmonary function, improved bone density, reduction in spasticity, reduced risk of skin breakdown, improved range of motion and strength, improved bowel and bladder function, and enhanced glucose tolerance.

During the trial with the WalkPort today, **PATIENT NAME** was able to perform therapy without supervision and the level of safety was such that **PATIENT NAME** would be confident that they can perform this activity independently at home. Their physician and the members of the assessment team agree that **PATIENT NAME** has the potential to improve his motor functions with appropriate durable medical equipment, making the WalkPort a medical necessity.

Current Program of Intervention and Equipment Trial

PATIENT NAME has been actively involved in physical therapy at our facility, including trial of the WalkPort walk therapy station. They have shown improvements in *LIST GAINS MADE DURING THERAPY- HIGHLIGHT STRENGTH GAINS, ROM IMPROVEMENTS, BOWEL/BLADDER, ANY CARDIOVASCULAR CHANGES (BLOOD PRESSURE, HEART RATE, ETC), GAIT ABILITY, BALANCE, FUNCTIONAL CHANGES (EASE OF TRANSFERS, REDUCTION IN CAREGIVER ASSISTANCE, ETC).*

Recommendations

The WalkPort was chosen for **PATIENT NAME** over other devices for a variety of reasons:

1.) **It is multi-functional.** It was chosen over a standing frame as it provides not only stationary standing, but **PATIENT NAME** can also perform supported walking in the device by using the upper body to propel the legs to walk.

2.) **It has a small footprint.** The WalkPort was chosen over other body weight supported walking systems due to its small footprint. It fits through standard doorways and is similar in size to a standard piece of mainstream cardiovascular equipment. Other devices are large, and impractical for home storage and use.

3.) **It is cost-effective.** The WalkPort is also the least costly stationary, supported walking device on the market for home use.

Certification

It is my opinion, according to the evaluation and trialing of durable medical equipment for **PATIENT NAME**, that the most effective and least costly option for safe supported standing and walking would be the WalkPort. This device will ensure **PATIENT NAME** independence and ability to remain at home.

Additionally, it

will provide them with rehabilitation potential by enabling frequent opportunities for standing gait training and recovery of gait function. The above prescribed durable medical equipment is medically necessary for this **PATIENT NAME**.

Thank you for your assistance in maximizing **PATIENT NAME** function.

Sincerely,

Affirmed,

Signature of Therapist / Date

Signature of Physician / Date

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Email: _____

Email: _____