



Medirect, LLC
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Letter of Medical Necessity for Kneewalker

HCPCS: CODE - E 0118 CRUTCH SUBSTITUTE, LOWER LEG PLATFORM,
WITH OR WITHOUT WHEELS

Patient: _____

Date of Need _____ Expected Duration of Need _____

Diagnosis: _____

_____ Code _____

_____ Code _____

_____ Code _____

____ Patient has ***Fracture Dislocation Tendon Rupture Surgery*** which requires **ABSOLUTE NON WEIGHT BEARING** to maximize chance for optimal healing and recovery. This patient is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches, but can do so with the kneewalker.

____ Patient has an ***Ulcer Infection*** which requires **ABSOLUTE NON WEIGHT BEARING** to maximize chance for optimal healing and recovery. This patient is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches, but can do so with the kneewalker.

____ Patient has a ***Neurologic Musculoskeletal*** condition which makes him/her unable to effectively or safely bear weight on one foot. The kneewalker will greatly increase this person's ability to function independently.

____ Other _____

I hereby certify that this device is medically necessary.

Signature

Date