

# MEDICARE

## LETTER OF MEDICAL NECESSITY CERVICAL TRACTION DEVICE

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Cervical traction unit ordered (mark choice):

\_\_\_\_\_ Saunders Cervical Traction Unit (E0849)  
OR  
\_\_\_\_\_ Pronex Cervical Traction Unit (E0855)

Duration (mark choice): \_\_\_\_\_ Purchase  
OR  
\_\_\_\_\_ Rental for # \_\_\_\_\_ months

Diagnosis: \_\_\_\_\_

The following information is required by Medicare in order to justify the use of a cervical traction unit. Please answer the following questions as they pertain to your patient:

1. Does this patient have a musculoskeletal or neurological impairment requiring traction equipment? Yes No
2. Does this patient require a traction unit capable of generating greater than 20 pounds of traction that is to be used in the home? Yes No
3. Does this patient have a diagnosis of TMJ dysfunction and has this patient received treatment for the TMJ condition? Yes No
4. Does this patient have distortion of the lower jaw or neck anatomy such that a chin halter is not able to be utilized? Yes No
5. Has the appropriate use of the cervical traction unit been demonstrated to this patient and did the patient tolerate the device? Yes No

Physician's Name \_\_\_\_\_

NPI # \_\_\_\_\_ UPIN # \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_



## **Golden State Medical, Inc.**

PAPERWORK NECESSARY PRIOR TO ISSUING A SAUNDERS CERVICAL TRACTION UNIT TO A MEDICARE PATIENT

THE PRESCRIPTION MUST BE WRITTEN ON THE MD'S PRESCRIPTION PAD AND MUST CONTAIN A REQUEST FOR A SAUNDERS CERVICAL TRACTION UNIT, THE DIAGNOSIS AND THE DURATION (RENT OR PURCHASE).

THIS MUST BE ACCOMPANIED BY A LETTER WRITTEN BY THE MD CONTAINING THE FOLLOWING INFORMATION:

“THE PATIENT HAS A MUSCULOSKELETAL OR NEUROLOGIC IMPAIRMENT REQUIRING TRACTION EQUIPMENT.”

THE TREATING PHYSICIAN'S ORDERS REQUEST “A SAUNDERS CERVICAL TRACTION UNIT CAPABLE OF GENERATING GREATER THAN 20 POUNDS OF TRACTION TO BE USED IN THE HOME SETTING” OR “THE PATIENT HAS A DIAGNOSIS OF TMJ DYSFUNCTION AND HAS RECEIVED TREATMENT FOR THE TMJ CONDITION” OR “THE PATIENT HAS DISTORTION OF THE LOWER JAW OR NECK ANATOMY SUCH THAT A CHIN HALTER IS UNABLE TO BE UTILIZED”.

“THE APPROPRIATE USE OF A SAUNDERS HOME CERVICAL TRACTION UNIT HAS BEEN DEMONSTRATED TO THE PATIENT AND THE PATIENT TOLERATED THE SELECTED DEVICE.”

THE TREATING PHYSICIAN MUST JUSTIFY THAT THEIR PATIENT REQUIRES THE SAUNDERS TRACTION AND WILL NOT BENEFIT FROM AN OVER-THE-DOOR TRACTION UNIT.

WE HAVE HAD DIFFICULTY LATELY IN HAVING MEDICARE COVER THE SAUNDERS CERVICAL TRACTION UNITS. WE WILL DO EVERYTHING THAT WE CAN TO HAVE THE CLAIMS PAID. HOWEVER, YOUR MEDICARE PATIENT SHOULD KNOW OF THE POSSIBILITY OF DENIAL. THEREFORE, WE REQUEST THAT ALL MEDICARE PATIENTS SIGN AN ADVANCED BENEFICIARY NOTICE AT THE TIME OF DELIVERY. THIS FORM ADVISES THEM OF THE POSSIBILITY OF CLAIM DENIAL, REVIEWS THE COST OF THE EQUIPMENT (EITHER RENTAL OR PURCHASE) AND INFORMS THEM THAT THEY WILL BE FINANCIALLY RESPONSIBLE SHOULD THE CLAIM DENY DESPITE OUR EFFORTS TO HAVE THE CLAIM PAID.

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