MOBILITY DEVICES (AMBULATORY)

Guideline Number: MPG208.04

Approval Date: February 13, 2019

Table of Contents

POLICY SUMMARY ......................................................1
APPLICABLE CODES ...................................................5
PURPOSE ..................................................................6
REFERENCES .............................................................6
GUIDELINE HISTORY/REVISION INFORMATION ............7
TERMS AND CONDITIONS ...........................................8

Related Medicare Advantage Policy Guideline(s)

- KX Modifier
- Mobility Assistive Equipment (NCD 280.3)
- Durable Medical Equipment Reference List (NCD 280.1)
- Mobility Devices (Non-Ambulatory) and Accessories

Related Medicare Advantage Coverage Summary(ies)

- Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid
- Mobility Assistive Equipment (MAE)

POLICY SUMMARY

Overview
For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this local coverage determination, the criteria for "reasonable and necessary", based on Social Security Act §1862(a)(1)(A) provisions, are defined by the following indications and limitations of coverage and/or medical necessity.

Canes, Crutches and Walkers are covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary’s equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific policy guidelines, discussed below, that also must be met.

Guidelines Canes and Crutches
Canes (E0100, E0105) and crutches (E0110 – E0116) are covered if all of the following criteria (1-3) are met:
A standard walker (E0130, E0135, E0141, E0143) and related accessories are covered if all of the following criteria (1-3) are met:
1. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home.
The MRADLs to be considered in this and all other statements in this policy are toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home.
A mobility limitation is one that:
   a. Prevents the beneficiary from accomplishing the MRADL entirely, or,
   b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or,
   c. Prevents the beneficiary from completing the MRADL within a reasonable time frame; and
2. The beneficiary is able to safely use the cane/crutch/walker; and,
3. The functional mobility deficit can be sufficiently resolved by use of a cane or crutch or walker.

If all of the criteria are not met, the cane/crutch/walker will be denied as not reasonable and necessary.

The medical necessity for an underarm, articulating, spring assisted crutch (E0117) has not been established; therefore, if an E0117 is ordered, it will be denied as not reasonable and necessary.
All canes and crutches are billed using the specific codes listed in the Local Coverage Determination regardless of their stated weight capacity. Do not use code E1399 (DME, miscellaneous) to code any type of cane or crutch regardless of special features or weight capacity.

Code E0117 describes an articulating crutch which has two crutch legs connected by a bar between them which helps propel the beneficiary forward.

Code E0118 describes a crutch substitute which can be either a device strapped to the lower leg with a platform or a device with wheels and a platform the beneficiary propels with their sound limb.

Canes or crutches which contain a spring that reduces impact and vibration against the ground should not be billed with E1399. These types of canes or crutches should be coded with the existing codes for canes or crutches.

Code A9270 must be used for a white cane for a blind person.

**Guidelines Walkers**

A standard walker (E0130, E0135, E0141, E0143) and related accessories are covered if all of the following criteria (1-3) are met:

1. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home.
   - A mobility limitation is one that:
     a. Prevents the beneficiary from accomplishing the MRADL entirely, or
     b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, or
     c. Prevents the beneficiary from completing the MRADL within a reasonable time frame;

   and

2. The beneficiary is able to safely use the walker; and

3. The functional mobility deficit can be sufficiently resolved with use of a walker.

If all of the criteria are not met, the walker will be denied as not reasonable and necessary.

Hemi-walkers must be billed using code E0130 or E0135, not E1399.

A walker with trunk support (E0140) is covered for beneficiaries who meet coverage criteria for a standard walker and who have documentation in the medical record justifying the medical necessity for the special features. If an E0140 walker is provided and if the medical record does not document why that item is medically necessary, it will be denied as not reasonable and necessary.

A wheeled walker (E0141, E0143, E0149) is one with either 2, 3, or 4 wheels. It may be fixed height or adjustable height. It may or may not include glide-type brakes (or equivalent). The wheels may be fixed or swivel. A glide-type brake consists of a spring mechanism (or equivalent) which raises the leg post of the walker off the ground when the beneficiary is not pushing down on the frame.

Brakes other than hand operated brakes, provided at the same time as a walker (E0141, E0143, E0149) may not be billed separately upon initial issue. However if billed separately upon initial issue the brakes must be billed using A9900, and the brakes will deny as not separately payable. HCPCS code E0159 (Brake attachment for wheeled walker, replacement each) is applicable for replacement brakes only.

Code E0144 describes a rigid or folding wheeled walker which has a frame that completely surrounds the beneficiary and an attached seat in the back. The medical necessity for a walker with an enclosed frame (E0144) has not been established. Therefore, if an enclosed frame walker is provided, it will be denied as not reasonable and necessary.

A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for beneficiaries who meet coverage criteria for a standard walker and who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand. Obesity, by itself, is not a sufficient reason for an E0147 walker. If an E0147 walker is provided and if the additional coverage criteria are not met, it will be denied as not reasonable and necessary.

Code E0147 describes a 4-wheeled, adjustable height, folding-walker that has all of the following characteristics:
- Capable of supporting beneficiaries who weigh greater than 350 pounds,
- Hand operated brakes that cause the wheels to lock when the hand levers are released,
- The hand brakes can be set so that either or both can lock both wheels,
- The pressure required to operate each hand brake is individually adjustable,
- There is an additional braking mechanism on the front crossbar,
At least two wheels have brakes that can be independently set through tension adjustability to give varying resistance.

A heavy duty walker (E0148, E0149) is covered for beneficiaries who meet coverage criteria for a standard walker and who weigh more than 300 pounds. It may be fixed height or adjustable height. It may be rigid or folding. If an E0148 or E0149 walker is provided and if the beneficiary weighs 300 pounds or less, it will be denied as not reasonable and necessary.

A gait trainer (or sometimes referred to as a rollator) is a term used to describe certain devices that are used to support a beneficiary during ambulation. Gait trainers are billed using one of the codes for walkers. If a gait trainer has a feature described by one of the walker attachment codes (E0154-E0157) that code may be separately billed. Other unique features of gait trainers are not separately payable and may not be billed with code E1399. If a supplier chooses to bill separately for a feature of a gait trainer that is not described by a specific HCPCS code, then code A9900 must be used.

Leg extensions (E0158) are covered only for beneficiaries 6 feet tall or more.

Codes A4636, A4637, and E0159 are only used to bill for replacement items for covered, beneficiary-owned walkers. Codes E0154, E0156, E0157, and E0158 can be used for accessories provided with the initial issue of a walker or for replacement components. Code E0155 can be used for replacements on covered, beneficiary-owned wheeled walkers or when wheels are subsequently added to a covered, beneficiary-owned nonwheeled walker (E0130, E0135). Code E0155 cannot be used for wheels provided at the time of, or within one month of, the initial issue of a non-wheeled walker.

An enhancement accessory is one which does not contribute significantly to the therapeutic function of the walker. It may include, but is not limited to style, color, hand operated brakes (other than those described in code E0147), or basket (or equivalent). Use code A9270 when an enhancement accessory of a walker is billed.

Bundling Rules
A Column II code is included in the allowance for the corresponding Column I code when provided at the same time and must not be billed separately at the time of billing the Column I code.

<table>
<thead>
<tr>
<th>Column I</th>
<th>Column II</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0130</td>
<td>A4636, A4637</td>
</tr>
<tr>
<td>E0135</td>
<td>A4636, A4637</td>
</tr>
<tr>
<td>E0140</td>
<td>A4636, A4637, E0155, E0159</td>
</tr>
<tr>
<td>E0141</td>
<td>A4636, A4637, E0155, E0159</td>
</tr>
<tr>
<td>E0143</td>
<td>A4636, A4637, E0155, E0159</td>
</tr>
<tr>
<td>E0144</td>
<td>A4636, A4637, E0155, E0156, E0159</td>
</tr>
<tr>
<td>E0147</td>
<td>A4636, E0155, E0159</td>
</tr>
<tr>
<td>E0148</td>
<td>A4636, A4637</td>
</tr>
<tr>
<td>E0149</td>
<td>A4636, A4637, E0155, E0159</td>
</tr>
</tbody>
</table>

Documentation Requirements
Section 1833(e) of the Social Security Act precludes payment to any provider of services unless “there has been furnished such information as may be necessary in order to determine the amounts due such provider.” It is expected that the beneficiary’s medical records will reflect the need for the care provided. The beneficiary’s medical records include the physician’s office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

General Documentation Requirements
To justify payment for DMEPOS items, suppliers must meet the following requirements:
• Prescription (orders)
• Medical Record Information (including continued need/use if applicable)
• Correct Coding
• Proof of Delivery

Prescription (Order) Requirements
The supplier for all Durable Medical Equipment, Prosthetic, and Orthotic Supplies (DMEPOS) is required to keep on file a physician prescription (order). A supplier must have an order from the treating physician before dispensing any DMEPOS item to a beneficiary.

**Detailed Written Orders**
A Detailed Written Order (DWO) (if applicable) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy guideline without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

The detailed written order for non-drug DMEPOS shall include:

- Beneficiary name
- A description of the item to include all items, options or additional features that are separately billed or require an upgraded code. The description can be either a general description (e.g., wheelchair or hospital bed), a brand name/model number, a HCPCS code, or a HCPCS code narrative; For equipment - All options or accessories that will be separately billed or that will require an upgraded code (List each separately); For supplies – All supplies that will be separately billed (List each separately), and for each include: Frequency of use, if applicable quantity to be dispensed
- Date of the order
- Physician/practitioner signature

**Medical Record Documentation**
In the event of a claim review, information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to treating physician/practitioner’s office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for determining that an item is reasonable and necessary. DMEPOS suppliers are reminded that:

- Supplier-produced records, even if signed by the prescribing physician/practitioner, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS CMNs, are subject to corroboration with information in the medical record.
- A prescription is not considered to be part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.

In addition to the general requirements discussed above, certain DMEPOS items may have specific documentation requirements. Details regarding these policy specific requirements are contained in the applicable LCD-related Policy Article.

**Continued Use**
Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the beneficiary’s medical record showing usage of the item, related option/accessories and supplies
- Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements (This is deemed to be sufficient to document continued use for the base item, as well)
- Supplier records documenting beneficiary confirmation of continued use of a rental item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.

**Continued Medical Need**
For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior
to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for
initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time
period. Entries in the beneficiary’s medical record must have been created prior to, or at the time of, the initial DOS to
establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial
provision of the item(s) and/or supplies, there must be information in the beneficiary’s medical record to support that
the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify
continued medical need must be timely for the DOS under review. Any of the following may serve as documentation
justifying continued medical need:
- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or DIF with an appropriate length of need specified
- Timely documentation in the beneficiary’s medical record showing usage of the item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the
policy.

**Proof of Delivery**

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in
their files. Proof of delivery documentation must be made available to UnitedHealth Care Medicare Advantage upon
request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable
and necessary.

**APPLICABLE CODES**

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in
this guideline does not imply that the service described by the code is a covered or non-covered health service.
Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws
that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or
guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4635</td>
<td>Underarm pad, crutch, replacement, each</td>
</tr>
<tr>
<td>A4636</td>
<td>Replacement, handgrip, cane, crutch, or walker, each</td>
</tr>
<tr>
<td>A4637</td>
<td>Replacement, tip, cane, crutch, walker, each</td>
</tr>
<tr>
<td>A9270</td>
<td>Noncovered item or service</td>
</tr>
<tr>
<td>A9900</td>
<td>Miscellaneous DME supply, accessory, and/or service component of another HCPCS code</td>
</tr>
<tr>
<td>E0100</td>
<td>Cane, includes canes of all materials, adjustable or fixed, with tip</td>
</tr>
<tr>
<td>E0105</td>
<td>Cane, quad or 3-prong, includes canes of all materials, adjustable or fixed, with tips</td>
</tr>
<tr>
<td>E0110</td>
<td>Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips</td>
</tr>
<tr>
<td>E0111</td>
<td>Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips</td>
</tr>
<tr>
<td>E0112</td>
<td>Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips, and handgrips</td>
</tr>
<tr>
<td>E0113</td>
<td>Crutch, underarm, wood, adjustable or fixed, each, with pad, tip, and handgrip</td>
</tr>
<tr>
<td>E0114</td>
<td>Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrip</td>
</tr>
<tr>
<td>E0116</td>
<td>Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each</td>
</tr>
<tr>
<td>E0117</td>
<td>Crutch, underarm, articulating, spring assisted, each</td>
</tr>
<tr>
<td>E0118</td>
<td>Crutch substitute, lower leg platform, with or without wheels, each</td>
</tr>
<tr>
<td>E0130</td>
<td>Walker, rigid (pickup), adjustable or fixed height</td>
</tr>
<tr>
<td>E0135</td>
<td>Walker, folding (pickup), adjustable or fixed height</td>
</tr>
<tr>
<td>E0140</td>
<td>Walker, with trunk support, adjustable or fixed height, any type</td>
</tr>
<tr>
<td>E0141</td>
<td>Walker, rigid, wheeled, adjustable or fixed height</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>E0143</td>
<td>Walker, folding, wheeled, adjustable or fixed height</td>
</tr>
<tr>
<td>E0144</td>
<td>Walker, enclosed, 4 sided framed, rigid or folding, wheeled with posterior seat</td>
</tr>
<tr>
<td>E0147</td>
<td>Walker, heavy-duty, multiple braking system, variable wheel resistance</td>
</tr>
<tr>
<td>E0148</td>
<td>Walker, heavy-duty, without wheels, rigid or folding, any type, each</td>
</tr>
<tr>
<td>E0149</td>
<td>Walker, heavy-duty, wheeled, rigid or folding, any type</td>
</tr>
<tr>
<td>E0153</td>
<td>Platform attachment, forearm crutch, each</td>
</tr>
<tr>
<td>E0154</td>
<td>Platform attachment, walker, each</td>
</tr>
<tr>
<td>E0155</td>
<td>Wheel attachment, rigid pick-up walker, per pair</td>
</tr>
<tr>
<td>E0156</td>
<td>Seat attachment, walker</td>
</tr>
<tr>
<td>E0157</td>
<td>Crutch attachment, walker, each</td>
</tr>
<tr>
<td>E0158</td>
<td>Leg extensions for walker, per set of 4</td>
</tr>
<tr>
<td>E0159</td>
<td>Brake attachment for wheeled walker, replacement, each</td>
</tr>
<tr>
<td>E1399</td>
<td>Durable medical equipment, miscellaneous</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>KX</td>
<td>Requirements specified in the medical policy have been met</td>
</tr>
</tbody>
</table>

**PURPOSE**

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

**REFERENCES**

**CMS National Coverage Determinations (NCDs)**

NCD 280.3 Mobility Assistive Equipment (MAE)
Reference NCD: [NCD 280.1 Durable Medical Equipment Reference List](#)

**CMS Local Coverage Determinations (LCDs)**

<table>
<thead>
<tr>
<th>LCD</th>
<th>DME</th>
</tr>
</thead>
</table>
| L33733 (Canes and Crutches) | **CGS**: AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VA, VI, WV  
**CGS**: ID, IL, KY, MI, MN, OH, WI  
**Noridian**: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT  
**Noridian**: AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WY |
| L33791 (Walkers) | **CGS**: AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VA, VI, WV  
**CGS**: ID, IL, KY, MI, MN, OH, WI  
**Noridian**: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT  
**Noridian**: AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WY |
CMS Articles

<table>
<thead>
<tr>
<th>Article</th>
<th>DME MAC</th>
</tr>
</thead>
</table>
| A52459 (Canes and Crutches - Policy Article - Effective October 2015) | CGS: AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VA, VI, WV  
|          | CGS: ID, IL, KY, MI, MN, OH, WI  
|          | Noridian: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT  
|          | Noridian: AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WV |
| A52503 (Walkers - Policy Article - Effective October 2015) | CGS: AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VA, VI, WV  
|          | CGS: ID, IL, KY, MI, MN, OH, WI  
|          | Noridian: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT  
|          | Noridian: AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WV |
| A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs | CGS: AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VA, VI, WV  
|          | CGS: ID, IL, KY, MI, MN, OH, WI  
|          | Noridian: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT  
|          | Noridian: AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WV |

CMS Claims Processing Manual
Chapter 20; § 100.3 Limitations on DMERC Collection of Information

CMS Medicare Program Integrity Manual
Chapter 5 Items and Services Having Special DME Review Considerations

MLN Matters
Article MM3791, An Algorithmic Approach to Determine if Mobility Assistive Equipment Is Reasonable and Necessary for Medicare Beneficiaries with a Personal Mobility Deficit (CR3791 - Mobility Assistive Equipment (MAE))
Article MM8158, New Healthcare Common Procedure Coding System (HCPCS) Codes for Customized Durable Medical Equipment
Article MM7248, Calendar Year (CY) 2011 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
Article MM8304, Detailed Written Orders and Face-to-Face Encounters
Article SE19003, Proof of Delivery Documentation Requirements
Proof of Delivery Documentation Requirements MLN Matters Article — New

UnitedHealthcare Commercial Policies
Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements

Others
Decision Memo for Mobility Assistive Equipment CAG-00274N, CMS Website
Medicare Learning Network ICN 905283, The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, CMS Website
Noridian Healthcare Solutions, Walker Unbundling Billing for Brakes
Decision Memo for Mobility Assistive Equipment (CAG-00274N), CMS Website
CGS News & Publication – E0118 – Crutch Substitute
Provider Inquiry Assistance-Related to MLN Matters Article MM3791, An Algorithmic Approach to Determine if Mobility Assistive Equipment (MAE) is Reasonable and Necessary for Medicare Beneficiaries with a Personal Mobility Deficit (CR 3791 – Mobility Assistive Equipment (MAE))
Clinical Coverage for MAE Coverage, CMS Website
The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, Repairs and Replacements, Article ICN905283, CMS website
Canes and Crutches: Provider Compliance Tips Fact Sheet — New

GUIDELINE HISTORY/REVISION INFORMATION

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2019</td>
<td>Reorganized policy template; relocated Terms and Conditions and Purpose</td>
</tr>
</tbody>
</table>
TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.