Mobility Devices (Ambulatory)

Guideline Number: MPG208.07
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Terms and Conditions

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Policy Summary

See Purpose

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 member'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, E0111, E0112, E0113, E0114, E0116) are covered if all of the following criteria (1-3) are met:

1. The member 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:
   - Prevents the member from accomplishing the MRADL entirely, or,
   - Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or,
   - Prevents the beneficiary from completing the MRADL within a reasonable time frame;

And

2. The beneficiary is able to safely use the cane or crutch; and,
3. The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

If all of the criteria are not met, the cane or crutch 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. There is insufficient published clinical literature demonstrating safety and effectiveness in the Medicare population to establish the medical necessity for these products. Refer to the CGS News & Publication-E0118 – Crutch Substitute.

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. A white cane for a blind person is noncovered since it is more of an identifying and self-help device than an item which makes a meaningful contribution in the treatment of an illness or injury (see CMS National Coverage Determinations Manual (CMS Pub. 100-03), Chapter 1, Part 4, Section 280.2).

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:
   - Prevents the beneficiary from accomplishing the MRADL entirely, or
   - Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, or
   - 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 member 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 members 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 member 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 member 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, E0156, 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 members 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, member-owned wheeled walkers or when wheels are subsequently added to a covered, beneficiary-owned non-wheeled 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.

Column I	Column II
E0130	A4636, A4637
E0135	A4636, A4637
E0140	A4636, A4637, E0155, E0159
E0141	A4636, A4637, E0155, E0159
E0143	A4636, A4637, E0155, E0159

Column I	Column II
E0144	A4636, A4637, E0155, E0156, E0159
E0147	A4636, E0155, E0159
E0148	A4636, A4637
E0149	A4636, A4637, E0155, E0159

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.

Documentation Requirements-General

There are numerous CMS manual requirements, reasonable and necessary requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justified. In the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying payment. Refer to the LCD, NCD or other CMS Manuals for more information on what documents may be required.

See Article A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs.

Applicable Codes

The following list(s) of procedure and/or diagnosis 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.

HCPCS Code	Description
A4635	Underarm pad, crutch, replacement, each
A4636	Replacement, handgrip, cane, crutch, or walker, each
A4637	Replacement, tip, cane, crutch, walker, each
A9270	Noncovered item or service
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
E0100	Cane, includes canes of all materials, adjustable or fixed, with tip
E0105	Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tips
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips
E0111	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips, and handgrips
E0113	Crutch, underarm, wood, adjustable or fixed, each, with pad, tip, and handgrip
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrip
E0116	Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each
E0117	Crutch, underarm, articulating, spring assisted, each
E0118	Crutch substitute, lower leg platform, with or without wheels, each
E0130	Walker, rigid (pickup), adjustable or fixed height

HCPCS Code	Description
E0135	Walker, folding (pickup), adjustable or fixed height
E0140	Walker, with trunk support, adjustable or fixed height, any type
E0141	Walker, rigid, wheeled, adjustable or fixed height
E0143	Walker, folding, wheeled, adjustable or fixed height
E0144	Walker, enclosed, four-sided framed, rigid or folding, wheeled with posterior seat
E0147	Walker, heavy-duty, multiple braking system, variable wheel resistance
E0148	Walker, heavy-duty, without wheels, rigid or folding, any type, each
E0149	Walker, heavy-duty, wheeled, rigid or folding, any type
E0153	Platform attachment, forearm crutch, each
E0154	Platform attachment, walker, each
E0155	Wheel attachment, rigid pick-up walker, per pair
E0156	Seat attachment, walker
E0157	Crutch attachment, walker, each
E0158	Leg extensions for walker, per set of four
E0159	Brake attachment for wheeled walker, replacement, each
E1399	Durable medical equipment, miscellaneous

Modifier	Description
KX	Requirements specified in the medical policy have been met

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) and Articles

LCD	Article	Contractor	DME MAC
L33733 Canes and Crutches	A52459 Canes and Crutches-Policy Article	CGS	AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VA, VI, WV ID, IL, KY, MI, MN, OH, WI
		Noridian	CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WY
L33791 Walkers	A52503 Walkers-Policy Article	CGS	AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VA, VI, WV ID, IL, KY, MI, MN, OH, WI
		Noridian	CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WY

LCD	Article	Contractor	DME MAC
N/A	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 ID, IL, KY, MI, MN, OH, WI
		Noridian	CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WY

CMS Claims Processing Manual

Chapter 20; § 100.3 Limitations on DMERC Collection of Information

CMS Benefit Policy Manual

Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services

CMS Medicare Program Integrity Manual

Chapter 5 Items and Services Having Special DME Review Considerations

CMS Transmittal(s)

Transmittal 468
Transmittal 574

UnitedHealthcare Commercial Policy

Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements

Other(s)

CGS News & Publication-E0118-Crutch Substitute
Clinical Coverage for MAE Coverage, CMS Website
Decision Memo for Mobility Assistive Equipment CAG-00274N, CMS Website
The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, Repairs and Replacements, Article ICN905283, CMS website
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))

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.

Date	Summary of Changes
02/09/2022	Policy Summary *Guidelines: Canes and Crutches* • Removed language pertaining to walkers (refer to the section titled *Guidelines: Walkers)* • Added language to indicate: ○ There is insufficient published clinical literature demonstrating safety and effectiveness in the Medicare population to establish the medical necessity for crutch substitute; refer to the DME MAC CGS News & Publication article titled *E0118 – Crutch Substitute* ○ A white cane for a blind person is non-covered since it is more of an identifying and self-help device than an item which makes a meaningful contribution in the treatment of an illness or

Date	Summary of Changes
	injury; see the Centers for Medicare & Medicaid (CMS) *National Coverage Determinations (NCDs) Manual (CMS Pub. 100-03), Chapter 1, Part 4, Section 280.2)* Supporting Information • Updated *References* section to reflect the most current information • Archived previous policy version MPG208.06

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 NCDs, LCDs, LCAs, 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.

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.

*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.