Mobility Devices (Ambulatory)

Policy Number	MDA08242013RP	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	02/12/2014

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies 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.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated.

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.

For an item to be covered by Medicare, a detailed written order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed DWO, the item will be denied as not reasonable and necessary.

Reimbursement Guidelines

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.

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. 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 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.

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 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.

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

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.

Prescription (Order) Requirements

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

Dispensing Orders

Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary’s name
- Prescribing Physician’s name
- Date of the order and the start date, if the start date is different from the date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

For the “Date of the order” described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).
Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements.
The dispensing order must be available upon request.

Detailed Written Orders

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.
A detailed written order (DWO) is required before billing. Someone other than the ordering physician may

produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

For items provided on a periodic basis, including drugs, the written order must include:

Item(s) to be dispensed

- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable.

The detailed description in the written order may be either a narrative description or a brand name/model number.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements. The DWO must be available upon request.

A prescription is not considered as 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.

Medical Record Information

The Indications and Limitations of Coverage and/or Medical Necessity section of this LCD contains numerous reasonable and necessary (R&N) requirements. The Nonmedical Necessity Coverage and Payment Rules section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

Supplier-produced records, even if signed by the ordering physician, 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 Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

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 physician'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 the purpose of determining that an item is reasonable and necessary.

Continued Use

ontinued 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 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as any person who can sign and accept the delivery of DMEPOS on behalf of the beneficiary.

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. For walkers, there are two methods of delivery:

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service

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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
E0144	A4636, A4637, E0155, E0156, E0159
E0147	A4636, E0155, E0159
E0148	A4636, A4637
E0149	A4636, A4637, E0155, E0159

Note: HCPCS code E0159 (Brake attachment for wheeled walker, replacement each) is applicable for replacement brakes ONLY.

CPT / HCPCS Codes

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 3-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
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, 4 sided framed, rigid or folding, wheeled with posterior seat
E0147	Walker, heavy-duty, multiple braking system, variable wheel resistance

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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 4
E0159	Brake attachment for wheeled walker, replacement, each
E1399	Durable medical equipment, miscellaneous

Modifiers

Code	Description
EY	No physician or other licensed health care provider order for this item or service
GA	Waiver of liability statement issued as required by payer policy, individual case
GY	Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit
GZ	Item or service expected to be denied as not reasonable and necessary
KX	Requirements specified in the medical policy have been met
TW	Back up equipment

References Included (but not limited to):

CMS NCD(s)

NCD 280.1 Durable Medical Equipment Reference List

NCD 280.3 Mobility Assistive Equipment (MAE)

CMS LCD(s)

Numerous LCDs

CMS Article(s)

Numerous Articles

CMS Claims Processing Manual

Chapter 20; § 100.3 Limitations on DMERC Collection of Information

UnitedHealthcare Medicare Advantage Coverage Summaries

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

Mobility Assistive Equipment (MAE)

UnitedHealthcare Reimbursement Policies

KX Modifier

Mobility Assistive Equipment (NCD 280.3)

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

Others

Decision Memo for Mobility Assistive Equipment, CMS Website

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DME MAC Bulletins:

- Noridian Healthcare Solutions Bulletin – Platform Crutch Clarification, Noridian Website
- National Government Services Bulletin Article for E0118 – Crutch Substitute, National Government Services Website
- NHIC Bulletin Article for E0118 - Crutch Substitute, NHIC Website
- CGS Administrators Bulletin Article for E0118 - Crutch Substitute, CGS Website

The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, CMS Website

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

Noridian Walker Unbundling Billing for Brakes, Noridian Website

History

Date	Revisions
07/29/2014	Administrative udpates
02/12/2014	Annual review, no changes made
11/20/2013	Administrative udpates
09/11/2013	Policy created taken to committee for approval