



PROVIDER COMPLIANCE TIPS FOR CANES & CRUTCHES



UPDATES

- Replaced the earlier year's data with 2019
- Updated the Background section

INTRODUCTION

This publication is meant to educate providers on coverage and proper billing for canes and crutches.

PROVIDER TYPES AFFECTED

Physicians and other practitioners who write prescriptions for canes and crutches and Durable Medical Equipment (DME) suppliers.

BACKGROUND

The Medicare Fee-for-Service (FFS) improper payment rate for canes and crutches for the 2019 reporting period was 31.8 percent, which is a projected improper payment amount of \$1,727,018.

The DME benefit [Social Security Act §1861(s) (6)] covers canes and crutches. For a beneficiary's DME to be eligible for reimbursement, the reasonable and necessary requirements set out in the related Local Coverage Determination (LCD) entitled "[Local Coverage Determination \(LCD\): Canes and Crutches \(L33733\)](#)" must be met.

TO PREVENT DENIALS

The DME benefit [Social Security Act 1861(s) (6)] covers canes (E0100, E0105) and crutches (E0110 - E0116) if all of the following criteria (1-3) are met:

1. The beneficiary has a mobility limitation that significantly impairs their ability to take part 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 in doing the MRADL entirely, or,
 - b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to trying to perform an MRADL; or,
 - c. Prevents the beneficiary from completing the MRADL within a reasonable time;
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 aren't met, Medicare (or whoever) will deny the cane or crutch as not reasonable and necessary.

The medical necessity for an underarm, articulating, spring assisted crutch (E0117) hasn't been established; so, if you order E0117, Medicare (or whoever) will deny as not reasonable and necessary.

DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act prevents payment to any provider of services unless "there has been furnished such information as may be necessary to determine the amounts due such provider." It's expected that the beneficiary's medical records will show the need for the care given. The beneficiary's medical records include the treating practitioner'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 or use if applicable)
- Correct Coding
- Proof of Delivery

RESOURCES

Table 1. Canes and Crutches Resources

Resources	Website
2019 Medicare Fee-for-Service (FFS) Supplemental Improper Payment Data	https://www.cms.gov/files/document/2019-medicare-fee-service-supplemental-improper-payment-data.pdf
Local Coverage Determination (LCD): Canes and Crutches (L33733)	https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33733&ver=10&-CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=canes&KeywordLookUp=Title&KeywordSearchType=And&bc=gAAAA-CAAAAA&
Social Security Act 1861(s) (6)	https://www.ssa.gov/OP_Home/ssact/title18/1861.htm

Please [Contact your MAC](#) for any updates or changes to the Policy Article (PA) and the LCD regarding policy and general documentation requirements.

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