PROVIDER COMPLIANCE TIPS FOR CANES AND CRUTCHES

PROVIDER TYPES AFFECTED

Physicians, Durable Medical Equipment (DME) Suppliers, and other Practitioners who write prescriptions for canes and crutches

BACKGROUND

The Medicare Fee-For-Service improper payment rate for canes and crutches for the 2018 reporting period was 56.3 percent, representing a projected improper payment amount of $2,251,957.[1]

Canes and crutches are covered under the Durable Medical Equipment benefit [Social Security Act §1861(s)(6)]. For a beneficiary's DME to be eligible for reimbursement, health care professionals must meet the reasonable and necessary requirements set out in the related Local Coverage Determination entitled Local Coverage Determination (LCD): Canes and Crutches (L33733).[2]

REASONS FOR DENIAL

For the 2018 reporting period, insufficient documentation accounted for 77.9 percent of improper payments for canes and crutches. Additional error types for canes and crutches in the 2018 reporting period included other (20.9 percent).[1]

TO PREVENT DENIALS[2]

Canes (E0100, E0105) and crutches (E0110 - E0116) 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.

   MRADLs include toileting, feeding, dressing, grooming, and bathing.

   A mobility limitation is one that:
   a. Prevents the beneficiary from accomplishing the MRADL entirely
   b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL
   c. Prevents the beneficiary from completing the MRADL within a reasonable time frame

2. The beneficiary can safely use the cane or crutch
3. Use of a cane or crutch sufficiently resolves the functional mobility deficit

1 2018 Medicare Fee-for-Service Supplemental Improper Payment Data
2 Local Coverage Determination (LCD): Canes and Crutches (L33733)

If all the criteria are not met, Medicare will deny the claim for the cane or crutch 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.

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 treating practitioner's office records, hospital records, nursing home records, home health agency records, records from other health care 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

RESOURCES

FOR MORE INFORMATION ABOUT...	RESOURCE
2018 Medicare Fee-for-Service Supplemental Improper Payment Data	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.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=gAAAACAAAAAA&