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Dear Physician,

Walkers are eligible for Medicare coverage under the durable medical equipment (DME) benefit as mobility assistive equipment. Medicare's national coverage determination (NCD) for mobility assistive equipment describes a hierarchical approach to prescribing mobility assistive equipment. The hierarchical approach is captured in the Walkers Local Coverage Determination (LCD), as well. Under the hierarchical approach, standard walkers (E0130, E0135, E0141, E0143) and related accessories are covered if all 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 can safely use the walker; and,

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

If the above 1-3 criteria are met and the beneficiary weighs more than 300 pounds, then Medicare will cover a heavy-duty walker (E0148, E0149). If the above 1-3 criteria are met and the beneficiary is unable to use a standard walker due to a severe neurologic condition or other condition that restricts the use of one hand, then a heavy duty, multiple braking system, variable wheel resistance walker (E0147) is eligible for coverage. A walker with trunk support (E0140) is eligible for coverage when the above 1-3 criteria are met and the medical record documentation justifies that the special features of the walker are medically necessary.

Medical Necessity Documentation

All items billed to Medicare require an order. For DME prescribing, Medicare uses a standard written order that must include the following elements:

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order Date
- Description of the item - The description can be a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
- Quantity to be dispensed, if applicable
- Treating Practitioner Name or NPI
- Treating practitioner's signature

CMS requires that the walker be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Information to support the medical necessity of a walker will come from your, and other qualified healthcare practitioners', documentation. The medical record documentation for the walker should paint a picture of your patient's functional abilities and limitations in their home on a typical day. It should contain as much objective data as possible. The examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability. Vague terms such as

“difficulty walking” are insufficient since they do not objectively address the mobility limitation or provide a clear picture of the patient's mobility deficits when participating in MRADLs. 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 to the supplier upon request.

If the walker will be used inside the home and the above coverage criteria are not met, the walker will be denied as not reasonable and necessary. If the walker is only for use outside the home, it will be denied as non-covered/no benefit, as the DME benefit requires use within the home for coverage eligibility. If the walker is not covered, then all related accessories will be denied as not reasonable and necessary.

Finally, your patient’s DME supplier may ask you to provide the documentation from your medical records on a routine basis to assure that Medicare will pay for these items and that your patient will not be held financially liable. Providing this documentation is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. No specific authorization is required from your patient. Also note that you may not charge the supplier or the beneficiary to provide this information.

This summary is not intended to take the place of the written law, regulations, NCDs, or LCDs. Coverage, coding and documentation requirements may be found in the Walkers LCD (https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDid=33791) and LCD-related Policy Article (https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52503), located in the Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database/search.aspx. Your participation and cooperation with the supplier in this process will allow your patient to receive the most appropriate type of mobility equipment. We appreciate all your efforts in providing quality services to your Medicare patients.

Sincerely,

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