Local Coverage Determination (LCD):
WALKERs (L33791)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

**Contractor Information**

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<th>CONTRACTOR NAME</th>
<th>CONTRACT TYPE</th>
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<th>JURISDICTION</th>
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<td>J-B</td>
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<td>18003 - DME MAC</td>
<td>J-C</td>
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**LCD Information**

**Document Information**

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<th>LCD ID</th>
<th>Original Effective Date</th>
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<td>For services performed on or after 10/01/2015</td>
<td>For services performed on or after 01/01/2017</td>
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**Original ICD-9 LCD ID**

- L27019
- L11450
- L11472
- L11461

**LCD Title**

- <span class="hlight">WALKER</span>

**Proposed LCD in Comment Period**

- N/A

**Source Proposed LCD**

- N/A
CMS National Coverage Policy

CMS Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Section 280.3

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

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.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding “reasonable and necessary” criteria based on Social Security Act § 1862(a)(1)(A) provisions.
In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the “reasonable and necessary” criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

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:
   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 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.

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.
A Detailed Written Order (DWO) (if applicable) 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 a completed DWO, the claim shall be denied as not reasonable and necessary.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

### Coding Information

**Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

**Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

**CPT/HCPCS Codes**

**Group 1 Paragraph:**

The appearance of a code in this section does not necessarily indicate coverage.

**HCPCS MODIFIERS:**
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 or doesn’t meet the definition of any Medicare benefit category

GZ – Item or service expected to be denied as not reasonable and necessary

KX - Requirements specified in the medical policy have been met

**HCPCS CODES:**

**Group 1 Codes:**

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<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
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<tr>
<td>A4636</td>
<td>REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR WALKER, EACH</td>
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<td>A4637</td>
<td>REPLACEMENT, TIP, CANE, CRUTCH, WALKER, EACH.</td>
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<td>A9270</td>
<td>NON-COVERED ITEM OR SERVICE</td>
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<td>A9900</td>
<td>MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE</td>
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<td>E0130</td>
<td>WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT</td>
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<td>WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT</td>
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<td>E0140</td>
<td>WALKER, WITH TRUNK SUPPORT, ADJUSTABLE OR FIXED HEIGHT, ANY TYPE</td>
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<td>E0141</td>
<td>WALKER, RIGID, WHEELED, ADJUSTABLE OR FIXED HEIGHT</td>
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<td>E0143</td>
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<td>E0144</td>
<td>WALKER, ENCLOSED, FOUR SIDED FRAMED, RIGID OR FOLDING, WHEELED WITH POSTERIOR SEAT</td>
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<td>E0147</td>
<td>WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE</td>
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<td>PLATFORM ATTACHMENT, WALKER, EACH</td>
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<td>WHEEL ATTACHMENT, RIGID PICK-UP WALKER, PER PAIR</td>
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<td>E0156</td>
<td>SEAT ATTACHMENT, WALKER</td>
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General Information

Associated Information

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.

GENERAL DOCUMENTATION REQUIREMENTS

In order 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

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Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

Refer to the Supplier Manual for additional information on documentation requirements.

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

**POLICY SPECIFIC DOCUMENTATION REQUIREMENTS**

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

**Miscellaneous**

**Appendices**

**Utilization Guidelines**

Refer to Coverage Indications, Limitations and/or Medical Necessity.

**Sources of Information and Basis for Decision**

N/A

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**Revision History Information**

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<th>REVISION HISTORY NUMBER</th>
<th>REVISION HISTORY EXPLANATION</th>
<th>REASON(S) FOR CHANGE</th>
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| 01/01/2017             | R3                      | Revision Effective Date: 01/01/2017  
COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:  
Removed: Standard Documentation Language  
Added: New reference language and directions to Standard Documentation Requirements  
Added: General Requirements  
DOCUMENTATION REQUIREMENTS:  
Removed: Standard Documentation Language  
Added: General Documentation Requirements  
Added: New reference language and directions to Standard Documentation Requirements  
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: | Provider Education/Guidance |

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<td>07/01/2016</td>
<td>R2</td>
<td>Effective July 1, 2016 oversight for DME MAC LCDs is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the LCDs.</td>
<td>• Change in Assigned States or Affiliated Contract Numbers</td>
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| 10/01/2015            | R1                      | **Revision Effective Date: 10/31/14**  
**COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:**  
Revised: Standard Documentation Language to add covered prior to a beneficiary’s Medicare eligibility  
**DOCUMENTATION REQUIREMENTS:**  
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD  
Added: Instructions for equipment retained from a prior payer  
Revised: Repair to beneficiary-owned DMEPOS | • Provider Education/Guidance |

**Associated Documents**

**Attachments**

N/A

**Related Local Coverage Documents**

Article(s)
A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs
A52503 - Walkers - Policy Article

**Related National Coverage Documents**

N/A

**Public Version(s)**

Updated on 04/20/2017 with effective dates 01/01/2017 - N/A
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.