PROVIDER POLICIES & PROCEDURES

CRUTCH SUBSTITUTE

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for a crutch substitute. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

A crutch substitute, also known as a knee walker or a roll-a-bout, is a device to assist an individual with walking while they are healing from a certain medical condition, illness, or injury to a lower extremity. This device can either be strapped to the lower leg with a platform or it can be a device with wheels and a platform, allowing the individual to propel with their unaffected leg.

CLINICAL GUIDELINE

Coverage guidelines for a crutch substitute are made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

A crutch substitute may be considered medically necessary when the following criteria are met:

A. The individual is not able to use crutches secondary to a lack of strength or is at an increased risk for falls; or
B. A crutch substitute will enable the individual to comply with a practitioner's order for non-weight bearing status while maintaining activities of daily living within the home and/or in the community.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization of a crutch substitute is required. Requests for coverage are reviewed in accordance with procedures in place for reviewing requests for durable medical equipment. Coverage determinations are based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for a crutch substitute:

1. Fully completed authorization request via on-line web portal; and
2. Signed prescription by a physician, advanced practice registered nurse (APRN), or physician assistant (PA) within the past six (6) months; and
3. Clinical documentation supporting medical necessity as outlined in the *Clinical Guideline* section of this policy; and
4. Medical evaluation by the individual's primary practitioner documenting the level of functionality of the lower extremity within the last 6 (six) months of the request; and
5. Pricing information as outlined in the *DSS Pricing Policy for MEDS Items.*

EFFECTIVE DATE

This policy for the prior authorization for a crutch substitute for individuals covered under the HUSKY Health Program is effective May 01, 2024.

LIMITATIONS

Not Applicable

CODES:

Code	Description
E0118	Crutch substitute, lower leg platform, with or without wheels

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP:** Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain

the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

REFERENCES

- Centers for Medicare & Medicaid Services (CMS). Policy Article: Canes and Crutches (A52459). Revision effective date 01/01/2020. Available at: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52459. Accessed on January 22, 2024.
- Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD)-Canes And Crutches. Revision effective date 01/01/2020. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33733&ver=19&=

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	March 2024	Approved at the CHNCT Medical Reviewer meeting on March 13, 2024. Approved at the March 18, 2024 CHNCT Clinical Quality Subcommittee meeting. Approved by DSS on March 28, 2024.
Updated	March 2025	Updated documentation and prescription requirements from twelve (12) months to six (6) months in the Procedures section. HUSKY Plus removed. Changes approved at the March 12, 2025, CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on March 17, 2025. Approved by DSS on April 3, 2025.