healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Canes and Crutches Billing Guidelines		
Policy Number:	PO-RE-148v1		
Effective Date:	10/01/2025	**Last Approval Date:**	08/18/2025

I. Policy Description

This policy outlines the guidelines for the reimbursement of canes and crutches provided to patients under Healthfirst coverage. It aims to ensure appropriate utilization and prevent unnecessary or duplicate claims for mobility aids.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Medicare PPO
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)
- Essential Plan (EP)
- Managed Long Term Care Plan (MLTCP – Senior Health Partners)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Qualified Health Plan (QHP)

Reimbursement Guide

1. Single Item Reimbursement:
   Healthfirst will only reimburse for one cane or crutch per patient per date of service. Multiple canes or crutches provided on the same date will not be reimbursed unless explicitly justified and approved in advance.

2. Multiple Crutches Restriction:
   The reimbursement policy prohibits the reimbursement of multiple crutches (whether of the same or different types) on the same date of service. This includes any combination of crutch codes billed on a single date.

3. Code Restrictions:
   Crutch codes E0110 through E0116, regardless of the provider, will not be reimbursed when more than one (1) unit is billed on the same date of service. Any billing for more than one (1) unit of these codes on a single date will be considered non-reimbursable.

4. Justification and Prior Authorization:

Any requests for multiple canes or crutches on the same date must be justified with appropriate medical documentation and may require prior authorization.

Adjudication and Appeal Process

1. Reimbursement for canes and crutches will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. Reimbursement is subject to member eligibility, program coverage, and medical necessity at the time the service is provided.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.

II. Applicable Codes

Code	Description	Comment
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	
E0111	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips	
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips, and handgrips	
E0113	Crutch, underarm, wood, adjustable or fixed, each, with pad, tip, and handgrip	
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrips	
E0116	Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each	

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
N/A	

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Expert Specialty Review Panel

VI. Revision History

Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York

State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.