

## Medical Policy



### Gait Trainers for Ambulation

#### ▼Description

Gait trainers are used to provide balance, postural control and additional support during ambulation due to a medical condition for members who have demonstrated the capability of walking with the device and are unable to use a less intensive alternative assistive device.

#### ▼Policy

Gait trainers are referred to the Northwood Rehab Specialist/Case Review department for individual coverage determination.

Gait trainers may be considered reasonable and necessary for children and adults when the below criteria are met:

1. Member is able to stand upright in the device and demonstrates adequate head control, lower-extremity and trunk strength (3/5, fair) to be supported in the gait trainer for functional ambulation.
2. The member requires moderate to maximum support for walking and are capable of walking with this device. Medical conditions may include but are not limited to:
  - Ataxia
  - Brain and spinal cord injuries
  - Cerebral Palsy
  - Multiple Sclerosis
  - Muscular Dystrophy
  - Musculoskeletal conditions affecting mobility
  - Neurological conditions affecting mobility
3. The member
  - a. Does not have lower-extremity contractures that would preclude purposeful functional ambulation, and
  - b. Has adequate trunk and lower extremity range of motion to support functional mobility
4. The alignment of the member's lower extremity is such that the foot and ankle can tolerate a standing or upright position as well as independent reciprocal movement.
5. The member does not have complete paralysis of the hips and legs.

6. The member has shown clinically meaningful improvement in purposeful mobility, ambulation, function, or physiologic symptoms, or maintained status with the use of the selected gait trainer during a trial period (e.g. used in an inpatient, school or outpatient setting) as measured by a tool that assesses functional ambulation capacity and the member is able to follow a home therapy program incorporating the use of the gait trainer.
7. There is a written home therapy plan developed with emphasis on skill carryover, and goals that target the member's functional use of the requested gait trainer in the home, and there is a caretaker who can appropriately supervise use of the gait trainer.
8. The member is able to perform functional mobility and participate in Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL) using the requested gait trainer.
9. If the request is for replacement of an existing gait trainer, there is sufficient clinical documentation to support that the member has maintained functional ambulation with the use of the gait trainer and alternatives have been trialed and ruled out.

#### ▼ Coverage Limitations

Gait trainers are considered not medically necessary under, but not limited to, the following instances:

1. There is no expected improvement in mobility or maintenance of function.
2. The anticipated functional benefits of the gait trainer can be achieved through less-costly alternatives.
3. The member currently has equipment to accomplish the same purpose.

#### ▼ Documentation Requirements

Documentation must include all of the following information:

- Medical diagnosis
- Member age
- Current level of functioning
- Less intensive alternatives have been tried and unsuccessful; (i.e.; walker, cane, etc.).
- Trial gait trainer and outcome
- Medical necessity for accessories (leg/arm straps, etc).
- Location where the gait trainer will be used
- Name and model of gait trainer being requested

### ▼ HCPCS Level II Codes and Description

E8000	Gait trainer, pediatric size, posterior support, includes all accessories and components
E8001	Gait trainer, pediatric size, upright support, includes all accessories and components
E8002	Gait trainer, pediatric size, anterior support, includes all accessories and components

### ▼ Important Note:

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation and Northwood will use the applicable state requirements to determine required quantity limit guidelines.

Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

## ▼References

1. Dias D et al. Can we improve gait skills in chronic hemiplegics? A randomized control trial with gait trainer. Eura Medicophys. 2007 Dec;43(4):499-504.
2. MassHealth. Guidelines for Medical Necessity Determination for Gait Trainers. Effective date 03/05/2018.

## Applicable URAC Standard

Core 8	Staff operational tools and support
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## Change/Authorization History

Revision Number	Date	Description of Change	Prepared / Reviewed by	Approved by	Review Date:
A	02-15-11	Initial Release	Susan Glomb	Ken Fasse	n/a
01	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri	05
02	11-08-11	Annual Review. Added References to Policy	Susan Glomb	Dr. B. Almasri	Nov. 11
03	11-29-12	Annual review – no changes.	Susan Glomb	Dr. B. Almasri	Nov. 2012
04	12-18-13	Annual review. No changes	Susan Glomb	Dr. B. Almasri	
05	11-25-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri	
06	11-16-15	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	November 2015
07	11-17-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	November 2016
08	11-14-17	Annual review. No changes.	Carol Dimech	Dr. C. Lerchin	November 2017
09	11-14-18	Annual Review. Updated policy to reflect MH coverage criteria and limitations to coverage.	Lisa Wojno	Dr. C. Lerchin	November 2018