Subject: Power Wheelchairs

Background: This guideline is for the review of power wheelchairs. A power wheelchair (PWC) is a wheelchair, a wheeled mobility device in which the user sits, that is powered by an automated system, such as a power motor.

Authorization: Prior authorization is required for all power wheelchairs when requested for members enrolled in commercial (HMO, POS, and PPO) products.

Policy and Coverage Criteria:

Basic Power Wheelchair Clinical Coverage

The Plan may authorize coverage of a power wheelchair for members when **all** of the following criteria are met:

- The Member's functional impairments must be documented and managed by a physician with a rehab-related specialty, such as a physical rehabilitation medicine, orthopedics, neurology or rheumatology
- The Member has a mobility limitation that is permanent, and it has been determined that a power wheelchair will be needed for 12 months or longer.
- The Member is not able to safely walk resulting in confinement to a bed or a chair.
- The Member cannot propel a manual wheelchair more than 50 feet.
- The Member is not able to propel a manual wheelchair sufficient distance to manage within the community, including but not limited to attending appointments, working and managing household responsibilities, at least three times per week.
- The Member does not meet the criteria for or is unsafe to use a power operated vehicle.
- The Member has sufficient cognitive and motor ability to operate a power wheelchair safely and without assistance.
- The Member must be able to use the power wheelchair in their home. A home evaluation, including a home accessibility survey and seating evaluation is required. This evaluation may be completed by either a physical therapist or an occupational therapist who has no financial relationship with the supplier **or** a RESNA-certified Assistive Technology Professional (ATP).
- All requested power wheelchair components/accessories must be primarily for use in the home.
- **AND** when **additional** coverage guidelines listed below, specific to Group 2 and Group 3 power wheelchairs and power tilt/recline seating systems, are met

Additional Coverage Guideline's for Specific Power Wheelchairs

- **A Group 2 Single Power Option PWC (K0835-K0840)** is covered when bis covered when basic power wheelchair coverage guidelines (above) are met AND when:

A. Criterion 1 or 2 is met; and
B. Criteria 3 and 4 are met
   1. The Member requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control)
   2. The Member meets coverage criteria for a power tilt and/or a power recline seating system (refer to Coverage Criteria for Power Tilt and/or Recline Seating Systems) and the system is being used on the wheelchair.
   3. The Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the

medical necessity for the wheelchair and its' special features. The PT, OT, or physician may have no financial relationship with the supplier.
4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in person involvement in the wheelchair selection for the Member.

- **A Group 2 Multiple Power Option PWC (K0841-K0843)** is covered when basic power wheelchair coverage guidelines (above) are met AND when:

A. Criterion 1 or 2 is met; and
B. Criteria 3 and 4 are met
   1. The Member meets coverage criteria for a power tilt and recline seating system (refer to Coverage Criteria for Power Tilt and/or Recline Seating Systems) and the system is being used on the wheelchair.
   2. The Member uses a ventilator which is mounted on the wheelchair.
   3. The Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its' special features. The PT, OT, or physician may have no financial relationship with the supplier.
   4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the Member.

- **A Group 3 PWC with no power options (K0848-K0855)** is covered when basic power wheelchair coverage guidelines (above) are met; AND when:

A. The Member's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
B. The Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT, OT, or physician may have no financial relationship with the supplier; and
C. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the Member.

- **A Group 3 PWC with Single Power Option (K0856-K0860**) or with **Multiple Power Options (K0861-K0864)** is covered when:

A. The Group 3 PWC coverage criteria is met; and
B. The Group 2 Single Power Option or Multiple Power Options coverage criteria are met.

<u>Coverage Criteria for Power Tilt and/or Recline Seating Systems (E1002-E1010)</u>

A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered when criteria A, B, and C are met and when criterion D, E, or F is met:

A. Basic power wheelchair coverage guidelines are met **and**
B. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or physician who has specific training and experience in rehabilitation wheelchair evaluations of the Member's seating and positioning needs. The PT, OT, or physician may have no financial relationship with the supplier; **and**
C. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the Member.
D. The Member is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; **or**
E. The Member utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; **or**

F. The power seating system is needed to manage increased tone or spasticity.

The Plan has determined the reasonable useful lifetime of a power wheelchair to be 5 years. Computation of the useful lifetime is based on when the equipment is delivered to the Member, not the age of the equipment. Replacement due to wear is not covered during the reasonable useful lifetime of the equipment. The Plan will review requests for power wheelchair replacements on case-by-case basis and may cover a replacement power wheelchair when the following criteria are met:

- The Member meets the above criteria for a power wheelchair and one of the following:
    - A decline in the Member's functional status has been documented and current wheelchair does not support the Member's functional status. Adaptations to current power wheelchair will not meet Member's functional needs and/or are not cost effective.
    - Current power wheelchair no longer functions, and repair and/or replacement parts are no longer available or cost-effective

Exclusions:

- The Plan will not authorize the coverage of a power wheelchair and/or accessories and components in the following circumstances:
    - When used for convenience
    - When used primarily for recreation or leisure
    - When used for community mobility only
    - In addition to Member's primary mobility device (e.g., manual wheelchair, power operated vehicle)
    - When deemed not medically necessary
    - **Group 4 PWCs (K0868-K0886)** have added capabilities that are not needed for use in the home. Therefore, if these wheelchairs are provided, they will be denied as not reasonable and necessary.
- The Plan will not cover access ramps, home or vehicle wheelchair lifts or home adaptations.
- The Plan will not cover the following wheelchair modifications or accessories, including but not limited to:
    - Snow tires
    - Stair climbing wheelchair; e.g., iBOT® Mobility System (iBALANCE® Technology)
    - Power seat elevation system, any type (E2300)
    - Power standing system, any type (E2301)
    - Wheelchair seat cushion, powered (E2610)
    - Environmental control unit
    - Wheelchair backup camera
- The Plan will not cover the following wheelchair accessory as it is considered investigational. Refer to Medical Necessity Guidelines: Noncovered Investigational Services: -JACO assistive robotic arm for use by patients with neuromuscular disease

Coding:

Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.

HCPCS Code	Description
K0010-K0014	Motorized/power wheelchair, Motorized/power wheelchair base
K0813-K0864	Power wheelchair group 1,2 and 3
K0890-K0891	Power wheelchair group 5
K0898	Power wheelchair, not otherwise classified
K0899	Power mobility device, not coded by DME PDAC or does not meet criteria
E1002-E1012	Wheelchair accessory, power seating system

Billing Guidelines:

Member's medical records must document that services are medically necessary for the care provided. Harvard Pilgrim Health Care maintains the right to audit the services provided to our members, regardless of the participation status of the provider. All documentation must be available to HPHC upon request. Failure to produce the requested information may result in denial or retraction of payment.

References:

1. Centers for Medicare & Medicaid. NCD for Mobility Assistive Equipment (MAE) Retrieved on February 1, 2014 from cms.hhs.gov/mcd
2. Centers of Medicare & Medicaid. LCD for Wheelchair Options/Accessories retrieved on December 10, 2014 from cms.gov/medicare-coverage-database/details/lcd-details
3. Centers of Medicare & Medicaid Benefit Policy Manual Chapter 15 retrieved on December 10, 2014. cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
4. Centers for Medicare and Medicaid. Local Coverage Determination (LCD) L33789 Power Mobility Devices accessed on October 3, 2016 from cms.gov/medicare-coverage-database/details/lcd details.aspx?LCDId=33789&ver=11&CoverageSelection=Both&ArticleType=All&PolicyType=Final& s=Massachusetts&KeyWord=mobility+device&KeyWordLookUp=Title&KeyWordSearchType=And&b c=gAAAACAAAAAAAA%3d%3d&
5. Center for Medicare and Medicaid National Coverage Determination (NCD) for Mobility Assistive Equipment 280.3 accessed on October 3, 2016 from cms.gov/medicare-coveragedatabase/details/ncd-details
6. Centers for Medicare and Medicaid LCD for Manual Wheelchair Bases (L33788) accessed on October 3, 2016 from cms.gov/medicare-coverage-database/details/lcd-details
7. Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment, 130 CMR 409.420

Summary of Changes:

Date	Change
12/22	New MNG adopted for integration with Tufts Health Plan

Approved by Medical Policy Committee: 12/21/22
Approved by Clinical Policy Operational Committee: 2/23
Policy Effective Date: May 1, 2023
Initiated: 12/22