MEDICAL COVERAGE POLICY	
SERVICE:	**Medicaid Wheelchairs - Powered**
Policy Number:	**271**
Effective Date:	**10/01/2020**
Last Review:	**08/27/2020**
Next Review Date:	**08/27/2021**

Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Medicaid Wheelchairs - Powered

PRIOR AUTHORIZATION: Required.

POLICY: For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

Powered wheelchair may be indicated when **ALL** of the following are present:

1. Ambulation is impaired, and **1 or more** of the following:
   - Mobility-related activities of daily living unable to be completed
   - Mobility-related activities of daily living unable to be completed in reasonable amount of time
   - Mobility-related activities of daily living unable to be completed safely
2. Ambulatory assistive device (e.g., cane, crutches, walker) does not sufficiently resolve mobility deficit.
3. Controls of powered wheelchair can be safely operated.
4. Inability to operate wheelchair manually due to **1 or more** of the following
   - Absence or deformity of upper extremity
   - Cardiopulmonary tolerance decreased
   - Chronic upper extremity pain or dysfunction from injuries or long-term use of manual wheelchair
   - Endurance inadequate
   - Upper extremity strength, range of motion, or coordination inadequate
5. Member able to participate in training
6. Physical layout and surfaces of, and obstacles in, area in which powered wheelchair is to be used permit safe operation of device.
7. Provider or team of experts with appropriate expertise in member's condition has evaluated member, concurs that powered wheelchair is most appropriate means for improving primary or secondary mobility, and has written prescription specifying **1 or more** of the following
   - Powered wheelchair
   - Powered wheelchair accessories, as indicated by **1 or more** of the following:
     - ✓ Control mechanism needed, as indicated by **1 or more** of the following
       - ➢ Attendant control, if member is unable to operate manual or powered wheelchair, and caregiver is unable to operate manual wheelchair but can operate powered wheelchair
       - ➢ Chin control, for member with chin control who is unable to use joystick

- Electronic interface, if member has appropriate speech-generating device that can be operated by powered wheelchair control interface
- Head control, for member with head control who is unable to use joystick
- Joystick, for member with hand control
- Sip and puff control, for member with respiratory control who is unable to use other control mechanisms

✓ Powered elevating leg rest needed due to **1 or more** of the following

- Below knee amputation
- Dependent edema
- Knee extension contracture
- Other clinically important knee joint abnormality

✓ Powered recliner or tilt-in-space backrest needed, as indicated by **1 or more** of the following:

- Adequate weight shifts require reclined or tilted backrest.
- Fully erect seating not possible for member
- High risk for pressure ulcer development or skin breakdown
- Intermittent catheterization needed for bladder management, and member unable to independently transfer from wheelchair to bed
- Poor endurance
- Poor sitting balance
- Respiratory needs require reclined or tilted backrest.

✓ Seat (rigid, elevating) needed for independent transfer to and from wheelchair

8. A Scooter is not appropriate for any of the following:
   - Alternative to joystick, finger-controlled tiller, or thumb-controlled tiller needed
   - Complex supports or seating needed that can only be met via powered wheelchair options
   - Modified frame needed
9. No other uncompensated conditions that limit ability to participate in daily activities or safely operate powered wheelchair (e.g., impaired vision, cognition, or judgment) are present.

Other wheelchair accessories, as indicated by **1 or more** of the following:

1. Anti-tipping devices needed when curb negotiation is not concern, as indicated by **1 or more** of the following:
   - Above knee amputation
   - Instability in wheelchair
   - Spinal cord injury
2. Armrests needed, as indicated by **1 or more** of the following:
   - Desk armrest needed for close access of wheelchair to table
   - Fixed armrest needed for member with infrequent transfers
   - Full-length armrest needed for increased arm support or sit-to-stand positioning
   - Removable armrest needed to facilitate member transfers
   - Standard (not tubular) armrests needed for upper extremity weight shifts, or member weighing greater than 200 pounds (90.7 kg)
   - Swing-away or flip-up armrests needed for active spinal cord injury member, or facilitation of transfers
3. Backrest needed, as indicated by **1 or more** of the following:
   - Linear or planar backrest to ease child's growth

- Molded backrest to accommodate clinically important orthopedic asymmetries

4. Casters needed, as indicated by **1 or more** of the following:
   - Casters of 5 inch (12.7 cm) diameter for sports or children's chairs
   - Casters of 8 inch (20.3 cm) diameter (pneumatic or semi-pneumatic) for rough surfaces or outdoors
   - Casters of 8 inch (20.3 cm) diameter (standard) for smooth surfaces and indoors
5. Cushion needed, as indicated by **1 or more** of the following:
   - Air-filled cushion, for seating stability
   - Air-filled villous cushion, for heat dissipation and pressure relief
   - Contoured foam cushion (coated or with gel insert), for durability and seating stability
   - Foam cushion (standard)
   - Gel-filled cushion, for heat dissipation
6. Footrest needed, as indicated by **1 or more** of the following:
   - Fixed footrest, when transfers and portability are not concerns
   - Swing-away footrest, for easier transfers and improved portability
7. Headrest needed, as indicated by **1 or more** of the following:
   - Poor head control
   - Reclining wheelchair
8. Parking locks or parking brakes needed, as indicated by **1 or more** of the following:
   - Brake extension, if member cannot reach from ipsilateral side (eg, hemiplegic member)
   - High-mounted, if needed by member and do not interfere with transfers
   - Toggle or lever parking locks or brakes (standard)
9. Seat needed, as indicated by **1 or more** of the following:
   - Molded seat, when required to accommodate clinically important orthopedic asymmetries
   - Rigid seat to ease child's growth, or when postural control is preferred and relative heaviness is acceptable
   - Vinyl sling (standard for adults), when postural control or accommodation is not concern
10. Seatbelt, safety belt, or pelvic strap needed for safety, or to maintain pelvis in good position in member with weak upper body muscles, upper body instability, or muscle spasticity(10)
11. Support needed, as indicated by **1 or more** of the following:
    - Anterior support needed for poor trunk control (eg, shoulder straps, shoulder retractors, chest straps, vests)
    - Lateral support needed for poor trunk control or scoliosis (eg, lateral pelvic supports or hip guides, lateral chest pads)
    - Posterior support needed for poor head or neck control (eg, headrests or head supports)
12. Tires needed, as indicated by **1 or more** of the following:
    - All-terrain tires, for frequent soft or sandy terrain
    - Pneumatic tires, for carpeting or frequent outdoor use
    - Solid rubber tires (standard), for low rolling resistance on flat or smooth surfaces

All components of the wheelchair assessment and fitting have been completed by the QRP (attach QRP attestation form)

Documentation Required for Review: Diagnosis, Medical history, QRP form

OVERVIEW:

Powered wheelchairs, in addition to their use as primary aids to help restore mobility-related activities of daily living, can be secondary mobility options used outside the home to prevent falls, increase safety, preserve energy and strength, and improve socialization and quality of life in appropriate patients. As compared with manual wheelchairs and scooters, powered wheelchairs require little physical effort to use, making long-distance travel easier. They also offer greater independent control over positioning and postural support; however, they require higher cognitive ability and are difficult to transport.

CODES:

Important note:
CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	
HCPCS Codes	E1002, E1003, E1004 K0012, K0013, K0014, K0015, K0017, K0018, K0019, K0020, K0037, K0038, K0039, K0040, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052, K0053, K0056, K0065, K0069, K0070, K0071, K0072, K0073, K0077, K0098, K0108, K0669, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898 Note: not all required prior authorization.
ICD10 codes:	

CMS:

POLICY HISTORY:

Status	Date	Action
New	08/27/2020	New policy

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. The health plan will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to the health plan so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. TMHP- 2.2.16.10 Seating Assessment for Manual and Power Custom Wheelchairs
2. The Alberto N Agreement (Section 8.1) states that all DME policies, guidelines, or provider manuals will prominently display the following statement when describing the scope of DME available to beneficiaries:

Medicaid beneficiaries under the age of 21 years are entitled to all medically necessary DME. DME is medical necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or condition. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid beneficiaries under the age of 21 years if medically necessary. Likewise time period for replacement of DME will not apply to Medicaid beneficiaries under the age of 21 years if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item or quantity is medical necessary.

3. NCD- 280.3 Mobility Assistive Equipment (MAE)