AvMed HEALTH PLANS

Wheelchair Coverage Guidelines

Origination: 03/24/05	**Revised:** 03/21/08	**Annual Review:** 12/15/11

Purpose:

The Medical Technology Assessment Committee will review published scientific literature and information from appropriate government regulatory bodies (when available) related to wheelchairs guidelines in order to determine inclusion in the benefit plan.

Compliance Status:

- Centers for Medicare & Medicaid Services (CMS)

Recommendation:

A recommendation was made by the MTAC following discussion by committee members based on current literature:

Definition

- The term power mobility device (PMD) includes power operated vehicles (POVs) and power wheelchairs (PWCs)

Indications and Limitations of Coverage and/or Medical Necessity

For any item to be covered by AvMed, it must:

- Be a covered benefit
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable statutory and regulatory requirements

Basic Coverage Criteria

All of the basic criteria (A-C) must be met for a PMD (K0800-K0898) or a push rim activated power assist device (E0986) to be covered.

A) The Member has a mobility limitation that significantly impairs his/her ability to participate in one (1) or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing grooming, and bathing in customary locations in the home. A mobility limitation is one (1) that:
   - Prevents the Member from accomplishing an MRADL entirely; **or**
   - Places the Member at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; **or**
   - Prevents the Member from completing an MRADL within a reasonable time frame.

Wheelchair Coverage Guidelines

Recommendation, continued:

Basic Coverage Criteria, continued

B) The Member's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.

C) The Member does not have sufficient upper extremity function to self propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day:
- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one (1) or both upper extremities are relevant to the assessment of upper extremity function;
- An optimally configured manual wheelchair is one (1) with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

POWER OPERATED VEHICLES (K0800-K0808, K0812)

A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria (D-I) are also met.

D) The Member is able to:
- Safely transfer to and from a POV; **and**
- Operate the tiller steering system; **and**
- Maintain postural stability and position while operating the POV in the home.

E) The Member's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient or safe mobility using a POV in the home.

F) The Member's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.

G) The Member's weight is less than or equal to the weight capacity of the POV that is provided.

H) Use of a POV will significantly improve the Member's ability to participate in MRADLs and the Member will use it in the home.

Recommendation, continued:

Basic Coverage Criteria, continued

POWER OPERATED VEHICLES (K0800-K0808, K0812), continued

I) The Member has not expressed an unwillingness to use a POV in the home.

If a POV will be used inside the home and coverage criteria (A-I) are not net, it will be denied as not medically necessary.

Group 2 POVs (K0806-K0808) have added capabilities that are not needed for use in the home. Therefore, payment for a Group 2 POV will be based on the allowance for the least costly medically appropriate alternative. Least costly alternative payment determinations may also be applied to Group 1 POVs that meet coverage criteria.

If coverage criteria (A-I) are met and if a Member's weight can be accommodated by a POV with a lower weight than the POV that is provided, payment will be based on the allowance for the least costly medically appropriate alternative.

POWER WHEELCHAIRS (K0813-K0891, K0898)

A PWC is covered if:

a. All of the basic coverage criteria (A-C) are met; **and**
b. The Member does not meet coverage criterion D, E, or F for a POV; **and**
c. Either criterion J or K is met; **and**
d. Criteria L, M, N, and O are met; **and**
e. Any coverage criteria pertaining to the specific wheelchair type are met.

J) The Member has the mental and physical capabilities to safely operate the PWC that is provided; **or**

K) If the Member is unable to safely operate the PWC, the Member has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the PWC that is provided; **and**

L) The Member's weight is less than or equal to the weight capacity of the PWC that is provided.

M) The Member's home provides adequate access between the rooms, maneuvering space, and surfaces for the operation of the wheelchair that is provided.

Wheelchair Coverage Guidelines

Recommendation, continued:

Basic Coverage Criteria, continued

POWER WHEELCHAIRS (K0813-K0891, K0898), continued

N) Use of a PWC will significantly improve the Member's ability to participate in MRADLs and the Member will use it at home. For Members with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.

O) The Member has not expressed an unwillingness to use a PWC in the home.

If the PWC will be used inside the home and coverage criteria (a)-(e) are not met but the criteria for a POV are met, payment will be based on the allowance for the least costly medically appropriate alternative.

If the PWC will be used inside the home and coverage criteria (a)-(c) are not met and the criteria for a POV are not met, it will be denied as not medically necessary.

Specific Types of Power Wheelchairs

I. **Group 1 PWC (K0813-K0816) or a Group 2 PWC (K0820-K0829**) is covered if all of the coverage criteria (a)-(e) for a PWC are met and the wheelchair is appropriate for the Member's weight.

II. **Group 2 Single Power Option PWC (K0835-K0840)** is covered if all of the coverage criteria (a)-(e) for a PWC are met and if:
   A. Criterion 1 or 2 is met; **and**
   B. Criterion 3 is 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 control).

   2. The Member meets coverage criteria for a power tilt or recline seating system with one (1) or two (2) actuators and the system is being used on the wheelchair.

   3. The Member has a specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or independent practicing practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the

wheelchair and its features. The PT, OT, or independent practicing practitioner may have no financial relationship with the supplier.

Recommendation, continued:

Basic Coverage Criteria, continued

Specific Types of Power Wheelchairs, continued

II. **Group 2 Single Power Option PWC (K0835-K0840)** is covered if all of the coverage criteria (a)-(e) for a PWC are met and if, continued:

If a Group 2 Single Power Option PWC is provided and if II (A) or II (B) is not met (including, but not limited to situations in which it is only provided to accommodate a power seat elevation feature, a power standing feature, or only power elevating leg rests) but the coverage criteria for a PWC are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 PWC.

III. **Group 2 Multiple Power Option PWC (K0841-K0843)** is covered if all of the coverage criteria (a)-(e) for a PWC are met and if:

A. Criterion 1 or 2 is met; **and**
B. Criterion 3 is met:

1. The Member meets coverage criteria for a tilt and/or recline seating system with three (3) or more actuators 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 PT or OT, or a independent practicing practitioner 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 the independent practicing practitioner may have no financial relationship with the supplier.

If a Group 2 Multiple Power Option PWC is provided and if III (A) or III (B) is not met but the criteria for another PWC are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 PWC.

Wheelchair Coverage Guidelines

Recommendation, continued:

Basic Coverage Criteria, continued

Specific Types of Power Wheelchairs, continued

IV. **Group 3 PWC with no power options (K0848-K0855)** is covered if:

A. All the coverage criteria (a)-(e) for a PWC are met; **and**
B. The Member is unable to independently stand and pivot to transfer due to a neurological condition or myopathy; **and**
C. The Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, independent practicing practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents medical necessity for the wheelchair and it special features. The PT, OT, or independent practicing practitioner may have no financial relationship with the supplier.

If a Group 3 PWC is provided and criterion (A) is met but either criterion (B) or (C) is not met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2PWC.

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

A. The Group 3 criteria IV (A) and IV (B) are met; **and**
B. The Group 2 Single Power Option (criteria II [A] and II [B] or Multiple Power Options (criteria III [A] and III [B] respectively are met.

If a Group 3 Single Power Option or Multiple Power Options wheelchair is provided and criterion IV (A) is met but all of the other coverage criteria are not met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 or Group 3 PWC.

VI. **Group 4 PWCs (K0868-K0886)**

These have added capabilities that are not needed for use in the home. Therefore, if these wheelchairs are provided and coverage criteria for a Group 2 or Group 3 PWC are met, payment will be based on the allowance for the least costly medically appropriate alternative.

If a Group 4 PWC is billed with a KX modifier, payment at the time of the initial automated processing will be based on the allowance for the comparable Group 3 PWC.

Recommendation, continued:

Specific Types of Power Wheelchairs, continued

VII. **Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891**) is covered if:

A. All the coverage criteria (a)-(e) for a PWC are met; **and**
B. The Member is expected to grow in height; **and**
C. The Group 2 Single Power Option (criteria II [A] and II [B] or Multiple Power options (criteria III [A] and III [B]) respectively are met.

If a Group 5 PWC is provided but all the coverage criteria are not met, payment will be based on the allowance for the least costly medically appropriate alternative.

VIII. **A Push Rim Activated Power Assist Device (E0986) for a manual wheelchair** is covered if all of the following criteria are met:

A. All of the criteria for a power mobility device listed in the Basic Coverage Criteria section are met; **and**
B. The Member has been self-propelling in a manual wheelchair for at least one year; **and**
C. The Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as PT or OT, or independent practicing practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the need for the device in the Member's home. The PT, OT, or independent practicing practitioner may have no financial relationship with the supplier.

If all of the coverage criteria are not met, it will be denied as not medically necessary.

Coverage criteria for power mobility devices are based on a stepwise progression of medical necessity. If coverage criteria for the device that is provided are not met and if there is another device that meets the Member's medical needs (as defined by the policy), payment will be based on the allowance for the least costly medically appropriate alternative.

Determinations of least costly alternative will take into account the Member's weight, seating and needs, and needs for the other special features (i.e., power seating systems, alternative drive controls, ventilators).

Based on the criteria defined in this procedure, some types of PMDs will never be paid in full but will always be either paid at the least costly alternative (if coverage criteria are met) or denied (if coverage criteria for PMD are not met).

Wheelchair Coverage Guidelines

Recommendation, continued:

Miscellaneous

- A POV or PWC with Captain's Chair is not appropriate for a Member who needs a separate wheelchair seat and/or back cushion. If a skin protection and/or positioning seat or back cushion that meets coverage criteria are provided with a POV or a PWC with Captain's Chair, the POV or PWC will be denied as not medically necessary.

- If a Member needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it is appropriate to provide a Captain's Chair seat (if the code exists) rather than a sling/solid seat/back and a separate general use seat and/or back cushion. If a general use seat and/or back cushion is provided with a PWC with a sling/solid back, total payment for those items will be based on the allowance for the least costly medically appropriate alternative (e.g., the code for the comparable PWC with the Captain's Chair, if that code exits).

- If a Member's weight can be accommodated by a PWC with a lower weight capacity than the wheelchair that is provided, payment will be based on the allowance for the least costly medically appropriate alternative.

- A seat elevator is a non-covered option on a PWC.

- An add-on to convert a manual wheelchair to a joystick-controlled PMD (E0983) or to a tiller-controlled PMD (E0984) will be denied as not medically necessary.

- Payment is made for only one (1) wheelchair at a time. Backup chairs are denied as not medically necessary.

- One (1) month's rental of a PWC or POV (K0462) is covered if a Member-owned wheelchair is being repaired. Payment is based on the type of replacement device that is provided but will not exceed the rental allowance for the PMD that is being repaired.

- A PMD will be denied as not medically necessary if the underlying condition is reversible and the length of need is less than three (3) months (e.g., following lower extremity surgery, which limits ambulation).

Wheelchair Coverage Guidelines

Recommendation, continued:

Non-Medical Necessity Coverage And Payment Rules

Orders:

- For a POV or PWC to be covered, AvMed must receive from the treating independent practicing practitioner a written order containing all the elements specified in the documentation.

- A PMD may not be ordered by a podiatrist; if it is, it will be denied as non-covered.

Face-To-Face Examination:

- For a POV or PWC to be covered, the treating independent practicing practitioner must conduct a face-to-face examination of the Member before writing the order. If this requirement is not met, the claim will be denied as non-covered. (Exceptions: If this examination is performed during a hospital or nursing home stay.)

- If the POV or PWC is a replacement during the 5-year useful lifetime of an item in the same performance Group that was previously covered by Medicare, face-to-face examination is not required. Note: Replacement during an item's useful lifetime is limited to situations involving loss or irreparable damage from a specific accident or natural disaster (e.g., fire, flood).

- The independent practicing practitioner may refer the Member to a licensed/certified medical professional, such as a PT or OT, who has experience and training in the mobility evaluations to perform part of the face-to-face examination.

Miscellaneous:

- If a POV or PWC is only for use outside the home, it will be denied as non-covered.

- Reimbursement for the wheelchair codes includes all labor charges involved in the assembly of the wheelchair; reimbursement also includes support services, such as delivery, set-up, and education about the use of the PMD.

- Upgrades that are beneficial primarily in allowing the Member to perform leisure or recreational activities are non-covered.

AvMed HEALTH PLANS

Wheelchair Coverage Guidelines

References:

1. Medicare Coverage Guidelines: NCA for Mobility Assistive Equipment (CIAG-0o274N); July 2007.

2. Medicare Coverage Guidelines: NCD for Mobility Assistive Equipment (MAE) (280.3); August 2007.

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed Health Plans' benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed Health Plana makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed Health Plana service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.