

Medical Necessity Guidelines: Power Wheelchairs

Effective: May 1, 2023

Prior Authorization Required If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
<p>Applies to: COMMERCIAL Products <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409 • CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</p> <p>TUFTS HEALTH PUBLIC PLANS Products <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055 <input type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055 <input type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404 <input type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304 *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p>SENIOR Products • Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List • Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</p>	

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

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.

BASIC POWER WHEELCHAIR CLINICAL COVERAGE CRITERIA

Tufts Health 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 distances 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 GUIDELINES FOR SPECIFIC POWER WHEELCHAIRS

- **A Group 2 Single Power Option PWC (K0835 – K0840)** 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 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.

COVERAGE CRITERIA FOR POWER TILT AND/OR RECLINE SEATING SYSTEMS (E1002-E1010)

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.

Tufts Health 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. Tufts Health 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

LIMITATIONS

- Tufts Health 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.
- Tufts Health Plan will not cover access ramps, home or vehicle wheelchair lifts or home adaptations.
- Tufts Health 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
- Tufts Health 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

CODES

The following HCPCS codes require prior authorization:

Code	Description
K0010-K0014	Motorized/power wheelchair, Motorized/power wheelchair base
K0813-K0864	Power wheelchair group 1,2 and 3

Code	Description
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

REFERENCES

- Centers for Medicare & Medicaid. NCD for Mobility Assistive Equipment (MAE) Retrieved on February 1, 2014 from cms.hhs.gov/mcd
- Centers for Medicare & Medicaid. LCD for Wheelchair Options/Accessories retrieved on December 10, 2014 from cms.gov/medicare-coverage-database/details/lcd-details
- Centers of Medicare & Medicaid Benefit Policy Manual Chapter 15 retrieved on December 10, 2014. cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- 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&bc=gAAAAACAAAAAAA%3d%3d&
- Center for Medicare and Medicaid National Coverage Determination (NCD) for Mobility Assistive Equipment 280.3 accessed on October 3, 2016 from cms.gov/medicare-coverage-database/details/ncd-details
- 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
- Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment, 130 CMR 409.420

APPROVAL HISTORY

October 2, 2006: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:

- January 19, 2007: Additional limitations to non-medically necessary accessories added
- February 28, 2007: Additional requirement for replacement wheelchair added: Member must meet the criteria for coverage of an electric/ power wheelchair.
- May 16, 2008: Criteria updated and simplified without substantive changes.
- April 6, 2009: Reviewed and renewed without changes.
- March 2010: Reviewed at Medical Specialty Policy Advisory Committee (MSPAC), no changes.
- April 2011: Reviewed at MSPAC, no changes.
- April 11, 2012: Reviewed and renewed at Integrated Medical Policy Advisory Committee (IMPAC), no changes.
- September 11, 2013: Reviewed by IMPAC, renewed without changes.
- February 1, 2014: Wording updated.
- April 9, 2014: Reviewed at IMPAC, approved for an effective date of July 1, 2014, with coding added to the listed limitations, E2300, E2301, and E2600.
- December 3, 2014: Adopted by Tufts Health Plan – Network Health Commercial Plans and Tufts Health Plan – Network Health Medicaid Plans.
- December 10, 2014: Reviewed by IMPAC, approved for an effective date of April 1, 2015. Added language to clarify safe ambulation. Criteria for group 2 and 3 power wheelchairs and power tilt and/or recline seating systems added. Adaptations to current PWC added to replacement PWC coverage guidelines and use for at least 5 years coverage guideline removed. Clarification of reasonable useful lifetime of a power wheelchair added.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- December 9, 2015: Reviewed by IMPAC, renewed without changes
- December 31, 2015: Coding updated. Per AMA CPT®, effective January 1, 2016 the following code(s) added: E1012.
- October 24, 2016: Reviewed by IMPAC. For effective date April 1, 2017, criteria changes to allow seating and home evaluations to be performed by OT, PT and/or ATP providers. K0899 will require prior authorization. Removal of criteria requirement "must have the ability to transport device". Added to limitations group 4 power wheelchairs and coverage of a power wheelchair in

addition to Member's primary mobility device. Removal of Tufts Health Together to reflect new MNG for this plan, effective April 1, 2017.

- December 14, 2016: Reviewed by IMPAC, renewed without changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- November 8, 2017: Reviewed by IMPAC, renewed without changes
- May 9, 2018: Reviewed by IMPAC. For effective date October 1, 2018, criteria requiring power wheelchair components/accessories be primarily for use in the home added to basic power wheelchair coverage guidelines.
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 10, 2020: Fax number for Unify updated
- July 21, 2021: Reviewed at IMPAC. For effective date October 1, 2021: Backup camera added to limitations section
- October 20, 2021: Reviewed by IMPAC. Effective October 20, 2021, JACO assistive robotic arm for use by patients with neuromuscular disease added to limitations section
- November 16, 2022: Reviewed by MPAC, renewed without changes
- December 21, 2023: Reviewed by MPAC with no changes for integration with Harvard Pilgrim Health Care effective May 1, 2023

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and 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 our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

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