Corporate Medical Policy

Wheelchairs (Manual and Power Operated)

File Name: wheelchairs_manual_and_power_ operated
Origination: 1/2000
Last Review: 9/2023

Description of Procedure or Service

Mobility assistance may be required for a variety of reasons and for varying durations because the etiology of the disability may be due to a congenital cause, injury, or disease. Some members may need mobility assistance on a short-term basis, while those with chronic conditions or enduring disabilities may require mobility assistance on a permanent basis. This policy discusses 2 types of wheelchairs: manually operated and power operated types. Manual wheelchairs are used for patients who are unable to walk, but have sufficient upper extremity function to propel a wheelchair. Power wheelchairs are used for patients who are unable to walk, or have upper extremity impairment, chronic conditions such as severe end stage pulmonary function, COPD, or severe congestive heart failure.

The power operated vehicle is a three or four wheel non-highway motorized transportation system for patients with impaired ambulation. It is considered Durable Medical Equipment (DME). To qualify as DME, the vehicle must primarily serve a medical purpose and be able to withstand repeated use.

Related Policies:
Durable Medical Equipment (DME)

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

Manually and power operated wheelchairs will be considered eligible for coverage on an individual basis. BCBSNC may provide coverage for wheelchairs when they are determined to be medically necessary because the medical criteria and guidelines shown below are met.

Repair, adjustment or replacement of components, accessories or equipment for covered wheelchairs will be eligible for coverage on an individual basis as well. Reasonable care of the equipment must be documented.

Benefits Application

This medical policy relates only to the services or supplies described herein. Devices and equipment used for environmental accommodation such as, but not limited to, chair lifts, stair lifts, home elevators, standing frames, and ramps are specifically excluded under most health benefit plans.

Durable medical equipment that serves no medical purpose or that is primarily considered a “convenience” and not medically necessary in the sense that they do not serve a specific therapeutic purpose, even though they may contribute to the patient’s independence or ability to assist caretakers in transfers, repositioning, or other aspects of movement during the performance of ADL’s is also excluded under most health benefit plans.

Power Operated Vehicles (Scooters) are considered a convenience item and are therefore excluded from coverage.

Please refer to the Member's Benefit Booklet for availability of benefits for durable medical equipment. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

- See Other Services for **Durable Medical Equipment**. See the BCBSNC Corporate Medical Policy entitled "**Durable Medical Equipment". Wheelchairs are considered Durable Medical Equipment (DME). All criteria stated in the DME medical policy must be satisfied in conjunction with the criteria listed in this policy.**
- **Note:** Power-operated wheelchairs do not require a rental period prior to purchase. All above criteria must be met for approval.

The individual certificate or member benefit should be reviewed to verify eligibility requirements and any prior approval or preauthorization necessary for the rental/purchase of equipment.

- Determination of rental or purchase of DME will be made based on review of diagnosis, severity of illness, and prognosis.
- The DME supplier must meet eligibility and/or credentialing requirements as defined by the BCBSNC Provider Blue Book in order to be eligible for reimbursement.

No accessory items will be covered, including but not limited to car lifts, or other lifts and access ramps.

When Wheelchairs are covered

Wheelchairs

- **Wheelchairs** are considered medically necessary when used by the member for mobility in the performance of activities of daily living in his/her residence and when the criteria outlined below are met. The determination of rental or purchase will be made based on the review of the individual's diagnosis, severity of illness, and prognosis.
- The wheelchair must provide therapeutic benefit to a patient in need because of certain medical conditions and/or illnesses, and;
- The wheelchair is appropriate for the member's weight; and
- The wheelchair must be prescribed by a physician within the scope of his/her license.
- Medical necessity of repair, adjustment or replacement of components, accessories or equipment will be based upon review of documented reasonable care of the equipment.
- **Please also refer to Corporate Medical Policy for Durable Medical Equipment (DME).**

I. Manually operated wheelchairs are considered medically necessary for the following conditions:

a. Member has a disease process, injury or disability that would contraindicate weight bearing or ambulation or,

b. Member has a disease process, injury or disability in which there is a decrease in neuromuscular function in the lower extremities, and

c. The member has the ability to self-propel his/her wheelchair.

d. Appropriate diagnoses include, but are not limited to the following:

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i. Multiple Sclerosis

ii. Paraplegia or low level quadriplegia (C6 - T1)

iii. Cerebral Palsy

iv. Cerebral vascular accident

v. Severe congestive heart failure

vi. Fracture femur, hip, pelvic and complex fracture of single /or bilateral lower extremity

vii. Amputee

II. Power operated wheelchairs are considered medically necessary for the following conditions:

a. A manually operated wheelchair is determined to be inadequate to address the member's need for mobility in his/her home, in that the member does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair in the home to perform Mobility-related Activities of Daily Living (MRADLs) during a typical day, **and**

b**.** The member is capable of safely operating the controls of a power operated wheelchair, **and**

c. The member has a condition in which there is a disease process, injury, or disability:

i. which contraindicates weight bearing or ambulation **OR**

ii. which results in decreased neuromuscular function in all four extremities **AND** the member requires support of the trunk; **OR**

iii. other neurological conditions that seriously compromise functional status, such as, but not limited to, CHF Class 3 and 4, COPD, spinal cord injury, stroke with dense hemiplegia, severe Parkinson's disease, and ALS.

d. The request is for Group 1, 2, 3, or 5 power wheelchair, and member meets criteria for specific type of power wheelchair being requested (see below).

III. Criteria for Specific Types of Power Wheelchairs (PWC):

1. Group 1 PWC (K0813-K0816) or a Group 2 PWC (no power option specified – K0820-K0831) is considered medically necessary when all the following conditions are met:

a. Member has a condition in which there is a disease process, injury, or disability which contraindicates weight bearing or ambulation, such as: a cerebral vascular accident; severe congestive heart failure; fracture of femur, hip, pelvic and complex fracture of single/or bilateral lower extremity; is an amputee; **and**

b. 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. Note: The PT, OT, or physician may have no financial relationship with the supplier**.**

2. Group 2 Single Power Option PWC (K0835-K0840) is considered medically necessary if:

a. Member has a condition in which there is a disease process, injury, or disability which contraindicates weight bearing or ambulation, such as a cerebral vascular accident; severe congestive heart failure; fracture of femur, hip, pelvic and complex fracture of single /or bilateral lower extremity; is an amputee; **and**

b. 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,

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switch control); OR the member meets criteria for a power tilt system OR a power recline seating system (single power option) and the system is being used on the wheelchair; **and**

c. 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. Note: The PT, OT, or physician may have no financial relationship with the supplier; **and**

d. 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.

3. Group 2 Multiple Power Option PWC (K0841-K0843) is considered medically necessary if:

a. Member has a condition in which there is a disease process, injury, or disability which contraindicates weight bearing or ambulation, such as: a cerebral vascular accident; severe congestive heart failure; fracture of femur, hip, pelvic and complex fracture of single /or bilateral lower extremity; is an amputee; **and**

b. The member meets criteria for a power tilt AND recline seating system (multi-power system) and the system is being used on the wheelchair; OR the member uses a ventilator which is mounted on the wheelchair; **and**

c. 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. Note: The PT, OT, or physician may have no financial relationship with the supplier; **and**

d. 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.

4. Group 3 PWC (K0848-K0855) with no power options is considered medically necessary if:

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. Note: 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.

5. Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) is considered medically necessary if:

a. The member's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and

b. The respective criteria found under Group 2 Single Power Option PWC (criteria 2.b. to 2.d.) or Group 2 Multiple Power Option PWC (criteria 3.b to 3.d.) are met; and

c. 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. Note: The PT, OT, or physician may have no financial relationship with the supplier; and

d. 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.

6. Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) is considered medically necessary if:

   a. The member is expected to grow in height; and

   b. The respective criteria found under Group 2 Single Power Option PWC (criteria 2.b. through 2.d.) OR Group 2 Multiple Power Option PWC (criteria 3.b. through 3.d) are met, and

   c. 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. Note: The PT, OT, or physician may have no financial relationship with the supplier; and

   d. 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.

IV. Appropriate covered supplies for both the manually and power operated wheelchairs require proper documentation of medical necessity and may include, but are not limited to the following:

i. Custom cushions such as Roho cushions

ii. Pads and supports for the trunk and head

iii. Abduction and adduction pads

iv. Head rests, head extensions, and other straps that may be required to secure the patient

v. Anti-tippers

vi. Shelf or rack for Ventilator

vii. Altered controls, such as hand, mouth/head controls

Refer to Policy Guidelines for details, including Table 1 of special features and their usual indications (note: Table 1 is not an all-inclusive list).

V. Wheelchairs that are specially adapted for children are considered medically necessary when the child is non-ambulatory and either requires more support than a regular wheelchair provides, or is too small for a standard pediatric wheelchair.

VI. Repairs and maintenance: Repair and maintenance of purchased equipment may be a covered if:

- Manufacturer’s warranty has expired; AND
- Maintenance is not more frequent than every six months; AND

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- Repair or maintenance is not the result of misuse or abuse; AND
- Repair cost is less than replacement cost.

Replacement of a wheelchair is considered medically necessary only when the replacement is needed due to a change in the member's physical condition or when the wheelchair is inoperative and cannot be repaired at a cost less than rental or replacement; replacement is generally not required more frequently than every five years, with requests taken into individual consideration (refer to Durable Medical Equipment policy). A replacement mobility assistive device (manual or electric) for appearance, convenience, or comfort is not considered medically necessary.

When Wheelchairs are not covered

Wheelchairs:

1. Wheelchairs that fail to meet the medical criteria in the when covered section are considered not medically necessary.
2. Wheelchairs with stair climbing ability (e.g., iBOT 3000) are considered not medically necessary.
3. Seat elevators for manually and power operated wheelchairs are considered not medically necessary when used solely for the convenience of the individual or the individual's family/caretaker.
4. Items used to support activities of daily living (ADLs) that do not address a mobility limitation such as robotic arms (e.g. KINOVA JACO® assistive arm) are considered not medically necessary. Items used for assistance with ADLs are considered to be self-help or convenience items that are not primarily medical in nature. Custodial or self-help care is not covered.

The following examples of personal convenience items are considered non-covered supplies under most benefit plans for both the manually and power operated wheelchair. This list includes, but is not limited to:

a. Trays (attached to the front of the wheelchair) used solely for appearance, convenience, or comfort purposes;

b. Tie-downs;

c. Personal back packs ;

d. Any option or accessory that is primarily for the purpose of allowing the member to perform leisure, recreation or sports activities;

e. Electrical or mechanical upgrades that do not serve a medical purpose.

f. A replacement mobility assistive device (manual or electric).

Power Wheelchairs (PWC):

1. A Group 2 Single Power Option PWC (K0835-K0840) is considered not medically necessary when it is only provided to accommodate a power seat elevation feature, a power standing feature, or power elevating legrests.

2. Group 4 PWCs (K0868-K0886) are considered not medically necessary because they have added capabilities that are not needed for use in the home.

Policy Guidelines

- **All wheelchairs are subject to medical necessity review.**
- See Billing/Coding and Physician Documentation for documentation requirements.

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- Wheelchairs require a prescription to rent or purchase before they are eligible for coverage.
- Payment of eligible fees will begin on the day the device is delivered, set-up, and ready for use by our member at the location needed.
- **Purchase of both a manual and a power wheelchair within the same 12 month benefit period:** If a member meets the medical necessity criteria and purchases both a manual and a power wheelchair within the same 12 month benefit period, the Plan will allow up to the assigned allowance for a power wheelchair only. The amount previously allowed for the manual chair will be deducted from the allowance for the power wheelchair.

  The following table contains a list of special features or customizations, including the usual indications considered when determining the wheelchair needs of a member. Non-standard features of a wheelchair are considered medically necessary only when the member's condition meets the criteria for the item. This is not an all-inclusive list.

Table 1 :

Feature	Usual Indications
Lightweight	Member cannot propel self in a standard wheelchair but can and does propel self in a lightweight wheelchair.
Ultra lightweight	Member cannot propel self in a standard or lightweight wheelchair but can and does propel self in an ultra lightweight wheelchair.
Hemi wheelchair	Member has paralysis in one arm and/or leg and propels self in the wheelchair; OR is of short stature and requires lower seat height (17"-18") that enables member to place his/her feet on the ground for propulsion.
Full Reclining, Semi-Reclining, or Tilt in Space Wheelchair	Member is a quadriplegic; OR Has trunk or lower extremity casts/braces that require special positioning; OR Has a fixed hip angle; OR Has excess extensor tone of the trunk muscles. A full or semi-reclining back option for prophylaxis of sacral decubiti without a prior history of skin breakdown is considered not medically necessary.
Heavy Duty	Member weighs more than 250 pounds; or has severe spasticity.
Extra Heavy Duty	Member weighs more than 300 pounds.
Wide Heavy Duty	Member's hip width is greater than 18 inches.
Arm trough	Member has quadriplegia, hemiplegia, or uncontrolled arm movement.
Back Support	Member requires trunk and upper body support. Considerations when determining appropriate back support include: neurological impairments, flexible asymmetrical/symmetrical deformities or fixed asymmetrical/symmetrical deformities.
Adjustable arm height option	Member requires an arm height that is different than that available using non-

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	adjustable arms AND the member spends at least 2 hours per day in a wheelchair.
KINOVA JACO assistive robotic arm	A wheelchair-mounted assistive device purported to improve levels of independence for individuals with loss of upper body motor function. The device features 6 interlinking segments corresponding to shoulder, elbow, and wrist. Using a joystick or other control interface (e.g., sip and puff, head control, head array), the arm and hand can be moved in 3-dimensional space and the two or three fingers can be opened and closed for gripping. The robotic arm is intended to mimic a fully functioning arm. Although this device is purported to improve levels of independence for those with loss of upper body motor function, there is insufficient clinical literature to support safety and improved health outcomes.
Crutch and can holder	Not medically necessary.
Detachable arms	Member transfers from wheelchair to bed/chair by “sliding over” and cannot walk or stand and pivot to transfer.
Detachable, swing-away foot rests	Not eligible for separate reimbursement. Should be billed separately only when they are replacement parts.
Hook-on headrest extension	Member has weak neck muscles and needs headrest for support; OR meets the criteria for and has a reclining back on the wheelchair.
Reinforced back or seat upholstery	When used with a power operated wheelchair AND the member weighs more than 200 pounds. When used in conjunction with heavy duty or extra heavy duty wheelchair bases, is not eligible for separate reimbursement. Reinforced back and seat upholstery are not medically necessary if used in conjunction with other manually operated wheelchairs.
Elevating Leg Rests	Member has musculoskeletal condition, case or brace that prevents 90 degrees of knee flexion; OR Below the knee amputation in the early rehabilitation phase; OR Meets the criteria for and has a reclining wheelchair; OR Has significant lower extremity edema that requires having an elevating leg rest.
Safety belt/pelvic strap	Member has weak upper body muscles, upper body instability or muscle spasticity requiring belt/strap to maintain proper positioning.
Seat Cushions	A solid seat insert is covered when the member spends at least 2 hours per day in a wheelchair that meets coverage criteria. An adjustable or non-adjustable skin protection seat cushion is medically

	appropriate for a member who has a current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; OR has absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift. A positioning seat cushion, positioning back cushion and positioning accessory is medically appropriate for a member who has any significant postural asymmetries. An adjustable or non-adjustable combination skin protection and positioning seat cushion is medically appropriate for a member who meets the criteria for both a skin protection seat cushion and a positioning seat cushion. If the member cannot reposition him/herself or be repositioned at least every 2 hours, a seat cushion will not prevent the development of pressure ulcers.
Seat elevators	Not covered.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: *E0950-E1298, E1399, E2201-E2398, E2601-E2621, K0001-K0195, K0462, K0669, K0813-K0899*

The following documentation is required to establish medical necessity:

Medical records that indicate the member's disease process or injury that necessitates use of the wheelchair, physician's plan of treatment and length of time the wheelchair will be medically necessary, predicted outcomes, and physician's involvement in supervising the use of the prescribed item, **AND**

An evaluation (must be completed by a professional independent from the vendor supplying the equipment) either in a specialized seating/mobility clinic or by a physician and therapist who are knowledgeable about the consequences of long-term disability and the prescription of power operated wheelchairs.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

For policy titled, "Wheelchairs"

Senior Director of Health Affairs

BCBSNC Matrix Program - Certificate languageMedical Policy Advisory Group - 3/99

MEDLINE and MDConsult literature search from 1995 to Present

Specialty Matched Consultant Advisory Panel - 4/2001

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Region C DMERC. Local Coverage Determination L11451. Wheelchair Options/Accessories. Retrieved June 27, 2006 from http://www.palmettogba.comSpecialty Matched Consultant Advisory Panel- 12/2010

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Specialty Matched Consultant Advisory Panel- 9/2014

For policy retitled, “Wheelchairs and Power Operated Vehicles (Scooters)”

Specialty Matched Consultant Advisory Panel9/2015

Medical Director review 9/2015

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CGS Administrators, LLC; DME MAC, Jurisdiction J-C. Local Coverage Determination L33789, Power Mobility Devices, effective date 7/1/16. Retrieved July 6, 2016 from https://www.cms.gov/medicare-coverage-database

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Medical Director review 9/2019

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Specialty Matched Consultant Advisory Panel 9/2020

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Specialty Matched Consultant Advisory Panel 9/2022

Medical Director review 9/2022

Specialty Matched Consultant Advisory Panel 9/2023

Medical Director review 9/2023

Policy Implementation/Update Information

For policy titled, "Wheelchairs"

6/94 Original policy issued9/96 Reaffirmed

10/96 Revised: Added instruction on handling those cases in which electric and manual wheelchairs are purchased. See Also: BCBSA Medical Policy Reference Manual on Durable Medical Equipment, UMP Allied Health section, p. E0100.0.

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8/97	Revised. Added DME Supplier information and Source as contract language.
3/99	Reaffirmed - Medical Policy advisory Group
8/99	Reformatted, Combined Manual Wheelchairs and Electrical Wheelchair; added Medical Term Definitions.
2/00)	Coding system change.
2/01	No change in criteria. Reaffirm. Coding system change.
4/01	Specialty Matched Consultant Advisory Panel review. Added statement, "There was an evaluation, either in a specialized seating/mobility clinic or by a physician and therapist who are knowledgeable about the consequences of long-term disability and the prescription of motorized wheelchairs." to criteria concerning when electric wheelchairs are covered.
4/02	Format changes.
10/02	Specialty Matched Consultant Advisory Panel review. No changes to policy. System coding changes.
8/12/04	Benefits Application and Billing/Coding sections updated for consistency. Individual codes listed for code ranges, E1210-E1213, E1220-E1223, E1240-E1298, and K0010-K0014 under Billing/ Coding section. Added codes, K0650, K0651, K0652, K0653, K0654, K0655, K0656, K0657, K0658, K0659, K0660, K0661, K0662, K0663, K0664, K0665, K0666, K0667, K0668, and K0669 to policy.
9/09/04	Specialty Matched Consultant Advisory Panel review 08/27/2007 with no changes made to policy criteria. References added. Statement added in description to indicate that Power operated vehicles are addressed in a separate policy. Clarification made to "When Wheelchairs Are Covered" to say that it must be prescribed by a physician within the scope of his/her license. Added statement to 2c, "This evaluation must be completed by a professional as indicated above independent from the vendor supplying the equipment." Coding descriptions removed.
1/20/05	First quarter 2005 HCPCS codes E1229, E1239, E2205, E2206, E2291, E2292, E2293, E2294, E2368, E2369, E2370, E2601, E2602, E2603, E2604, E2605, E2606, E2607, E2608, E2609, E2610, E2611, E2612, E2613, E2614, E2615, E2616, E2617, E2618, E2619, E2620, E2621 added to Billing/Coding section of policy. Policy number added in key word section of policy.
2/16/06	Added statement to the section When Wheelchairs Are Not Covered that reads "For electrical or mechanical features that enhance basic equipment and that usually serve a convenience function." Added CPT code E2300 to Billing/Coding section of policy.
8/28/06	Information added to Description for clarity. In the section When Wheelchairs Are Covered, added phrase "Wheelchairs are considered medically necessary when used by the member for mobility in the performance of activities of daily living in his/her residence and when the criteria outlines below are met." Added item 1.c. "the member has the ability to self-propel his/her wheelchair." Added information to item 2 regarding criteria for coverage of electrically operated wheelchairs. Added item 4: "Wheelchairs that are specially adapted for children are medically necessary when the child is non-ambulatory and either requires more support than a regular wheelchair provides or is too small for a standard pediatric wheelchair." In the section When Wheelchairs Are Not Covered, deleted "upgrades for racing or sports" and added statement regarding noncovered options or accessories that are primarily for the purpose of allowing the member to perform leisure, recreation or sports activities. Also added statement "wheelchairs with stair climbing ability are considered not medically necessary." A table was added to Policy Guidelines section of special features or customizations with the usual indications for consideration when determining the

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wheelchair needs of a member. HCPCS codes and references updated. Specialty Matched Consultant Advisory Panel review 6/28/06. (adn)

10/30/06 CPT Codes in Billing/Coding Section updated. (adn)

03/12/07 Billing/Coding section updated to reflect 2007 HCPCS codes changes. (adn)

8/11/08 Reworded Item 2.c. in the When Wheelchairs Are Covered section to read: "There was an evaluation (must be completed by a professional independent from the vendor supplying the equipment) either in a specialized seating/mobility clinic or by a physician and therapist who are knowledgeable about the consequences of long-term disability and the prescription of electrically operated wheelchairs."This statement was also added to the Billing/Coding/Physician Documentation Information section. Reformatted the section When Wheelchairs Are Not Covered into a numbered list. Added "seat elevators" to Item 3.d. in the Non Covered section and to the Table in the Policy Guidelines section. Specialty Matched Consultant Advisory Panel review 6/19/08. (adn)

3/16/09 Clarified the difference between a shelf and a tray. In the When Covered section, Item 3.vi. a shelf or rack for a ventilator may be medically necessary. In the Not Covered section, Item 3.a. tray (attached to the front of the wheelchair) is a noncovered item. (adn)

6/22/10 Policy Number(s) removed (amw)

4/26/11 Specialty Matched Consultant Advisory Panel review meeting 12/2010. (lpr)

10/11/11 Specialty Matched Consultant Advisory Panel review 9/28/2011. Under “When Covered” deleted reference to IC (Individual Consideration). Under “Benefits Application” added benefit disclaimer. Under “When Not Covered” added not medically necessary statement to #3: Seat elevators for manually and electrically operated wheelchairs are considered not medically necessary when used solely for the convenience of the insured or the insured’s family/caretaker. (lpr)

1/1/2012 Added E0988, E2358-E2359 and E2626-E2633 to Billing/Coding section for 2012 code update. (lpr)

10/16/12 Specialty Matched Consultant Advisory Panel review 9/21/2012. No change to policy statement. Removed HCPCS codes: K0800, K0801, K0802, K0806, K0807, K0808, K0812 due to more appropriate setting in POV policy. Added the codes to the POV(Scooter) corporate medical policy. (lpr)

2/12/13 Deleted HCPCS code E1340 from the Billing/Coding section. (lpr)

10/15/13 Specialty matched consultant advisory panel review 9/18/2013. (lpr)

11/26/13 Replaced the word “electrical” with “power” throughout the document. Added full reclining and tilt in space wheelchair to Table 1 page 4. Under “When Not Covered” section a. Trays: added “used solely for convenience purposes.” and deleted d. “patient lifts,ceiling lifts, access ramp.” Under “ When Covered” section: 1.d.vi. added “complex fracture of single to bilateral lower extremity,” added 1.d.vii. Amputee; added 2.d.iii. “other neurological conditions that seriously compromise functional status, such as, but not limited to, CHF Class 3 and 4, COPD, spinal cord injury, stroke with dense hemiplegia, severe Parkinson’s disease, and ALS.”; 3.i. added “custom cushions such as Roho”; 3.iv. added “other straps that may be required to secure the patient”; added 3.vii “altered controls such as hand, mouth/head controls.” Medical director review 11/2013. (lpr)

10/14/14 Specialty matched consultant advisory panel review 9/2014. No changes to policy statement. (lpr) (td)

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12/30/14 Added code E0986 to billing/coding section. No changes to policy statements. Policy noticed 12/30/2014 for 3/31/2015 effective date. (td)

For policy retitled, "Wheelchairs and Power Operated Vehicles (Scooters)"

2/29/16 Policy retitled, 'Wheelchairs and Power Operated Vehicles (Scooters)". Combined and archived policy titled, "Power Operated Vehicles (Scooters)". Changes to reflect title change made throughout policy. Description section updated. When Covered section updated to include Power Operated Vehicle statements. When Not Covered section updated to include power operated vehicle statements. Billing/Coding section updated to add codes: E1012(effective 1/1/16), E1230, K0800, K0801, K0802, K0806, K0807, K0808, K0812. Policy Guidelines updated. Specialty Matched Consultant Advisory Panel review 9/30/2015. Medical Director review 9/2015. (td)

For policy retitled, "Wheelchairs (Manual and Power Operated)"

10/25/16 Policy title change. Removed "Power Operated Vehicle (Sccoters)" from the Policy Statement. Under Benefit Application section, added statement "Power Operated Vehicles (Scooters) are considered a convenience item and excluded from coverage." When Covered section extensively updated to include the following under the Wheelchair section: "The wheelchair is appropriate for the member's weight;"; added "medically necessary" language to items I and II; updated item IIa and added item IId – "The request is for Group 1, 2, 3, or 5 power wheelchair, and member meets criteria for specific type of power wheelchair being requested (see below)."; changed items 3 and 4 to IV and V. and moved them below item III. Criteria for Specific Types of Power Wheelchairs section. Added item III medically necessary language for Group PWCs, items 1-6; added item VI. in reference to repairs and replacements. Removed criteria for Power Operated Vehicle (Scooters) When Not Covered section updated to include section for Power Wheelchairs (PWC): non-coverage language for Group 2 Single Power Options PWCs and Group 4 PWCs, and removed criteria and reference to Power Operated Vehicles (Scooter). Coding section and references updated. Policy noticed 10/25/2016 for effective date 12/30/16. Specialty Matched Consultant Advisory Panel review 9/2016. Medical Director review 9/2016. (jd)

10/13/17 Specialty Matched Consultant Advisory Panel review 9/2017. Medical Director review 9/2017. (jd)

10/12/18 Specialty Matched Consultant Advisory Panel 9/2018. Medical Director review 9/2018. (jd)

2/11/20 The following codes have been removed from the Billing/Coding section and no longer require PPA effective 10/1/2019: E2610, E2626, E2627, E2628, E2629, E2630, E2631, E2632, E2633, K0010, K0011, K0012, K0013, K0014, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0824, K0826, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0850, K0851, K0852, K0853, K0854, K0855, K0857, K0858, K0859, K0860, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0885, K0886, K0890, K0891, K0898, K0899. Specialty Matched Consultant Advisory Panel 10/2019. Medical Director review 10/2019. (jd)

7/28/20 Item 3 under When Not Covered section - revised statement as follows: " Seat elevators for manually and power operated wheelchairs are considered not medically necessary when used solely for the convenience of the individual or the individual's family/caretaker." Medical Director review 7/2020. (jd)

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10/1/20 Specialty Matched Consultant Advisory Panel 9/2020. Medical Director review 9/2020. (jd)

10/1/21 Specialty Matched Consultant Advisory Panel 9/2021. Medical Director review 9/2021. (jd)

11/30/21 Under the When Covered section, Item III. Criteria for Specific Types of Power Wheechairs (PWC): item #1. Group 1 PWC - removed item c. as follows; " 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." Under the When Not Covered section, added item #4 as follows: " Items used to support activities of daily living (ADLs) that do not address a mobility limitation such as robotic arms (e.g. KINOVA JACO® assistive arm) are considered not medically necessary. Items used for assistance with ADLs are considered to be self-help or convenience items that are not primarily medical in nature. Custodial or self-help care is not covered." Table 1 under Policy Guidelines updated with addition of KINOVA JACO assistive robotic arm along with associated indications. Policy noticed 11/30/21 with effective date of 1/25/22. Medical Director review. 11/2021. (jd)

5/31/22 Off-cycle review. Under the Benefits Application section, revised the statement as follows: **"Note:** Power-operated wheelchairs do not require a rental period prior to purchase. All above criteria must be met for approval." (jd)

10/18/22 References and Billing/Coding section updated. Specialty Matched Consultant Advisory Panel 9/2022. Medical Director review 9/2022. (tm)

10/10/23 Previous code range E2201-E2399 updated to E2201-E2398 under Billing/Coding section. References updated. Specialty Matched Consultant Advisory Panel 9/2023. Medical Director review 9/2023. (tm)

4/1/24 Code changes effective 4/1/24: new code E2298 added and code E2300 deleted. Codes are included in code range E2201-E2398 listed under the Billing/Coding section. (tm)

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