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**Manual or Power Operated Wheelchairs (POW) and Power Operated Vehicles (POV)/Scooters**

**Covered Service:** Yes

**Prior Authorization Required:** Yes for rental or purchase

**Additional Information:** None

**Prevea360 Health Plan Medical Policy:**

**Manual Wheelchair (E1037-E1039, E1161, K0001-K0009)**

1.0 Manual wheelchairs require prior authorization through the Health Services Division and may be considered medically necessary when ALL of the following criteria are met:

1.1 The member has a mobility limitation that significantly impairs their ability to participate in one or more mobility related activities of daily living (MRADL) that would be alleviated by the wheelchair. A mobility limitation is one that:

   1.1.1 Prevents the member from accomplishing a MRADL entirely: OR

   1.1.2 Places the individual at reasonably determined high risk of morbidity or mortality secondary to the attempts to perform an MRADL; OR

   1.1.3 Prevents the member from completing an MRADL within a reasonable time frame

1.2 The member’s mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker; AND

1.3 The member’s home provides adequate access between rooms, maneuvering space, and surfaces for use of a manual wheelchair that is provided (if wheelchair is delivered to an alternate setting (e.g. hospital, skilled nursing home, or provider’s place of business) the provider will verbally confirm); AND

1.4 Use of a manual wheelchair will significantly improve the member’s ability to participate in MRADL’s and the member will use it on a regular basis in the home; AND

1.5 The member has not expressed an unwillingness to use the manual wheelchair that is provided in the home

2.0 Either of the following criteria are met in addition to the criteria in (1.0)
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2.1 The member has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion; or coordination, presence of pain, or deformity; or absence of one or both upper extremities are relevant to the assessment of upper extremity function; OR

2.2 The member has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

3.0 For members who are approved for a power wheelchair or a power operated vehicle (POV), a manual wheelchair requires prior authorization through the Health Services Division and may be considered medically necessary.

4.0 A lightweight wheelchair (K0003) requires prior authorization through the Health Services Division and may be considered medically necessary when ALL the criteria in (1.0) has been met AND:

4.1 The member cannot self-propel in a standard wheelchair but the member can self-propel in a lightweight wheelchair.

5.0 A high strength lightweight wheelchair (K0004) requires prior authorization through the Health Services Division and may be considered medically necessary when ALL the criteria in (1.0) has been met, the duration of need is greater than three (3) months AND either of the following criteria (5.1 and 5.2) are met:

5.1 The member self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair; OR

5.2 The member requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair and spends at least two (2) hours per day in the wheelchair.

5.3 A high strength lightweight wheelchair is rarely reasonable and necessary if the expected duration of need is less than three (3) months (e.g. post-operative recovery)

6.0 An ultra-lightweight manual wheelchair (K0005) requires prior authorization through the Health Services Division and may be considered medically necessary when ALL the criteria in (1.0) has been met and (6.1 OR 6.2) is met AND (6.3 or 6.4) are met:

6.1 The member must be a full-time manual wheelchair user; OR

6.2 The member must require individualized fitting and adjustments for one (1) or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles which cannot be accommodated by any manual wheelchair; AND

6.3 The member must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP), such as a physical therapist (PT) or occupational therapist (OT), or physician who has specific training and
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experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features.

6.4 The wheelchair is provided by a Rehabilitative Technology Supplier (RTS) that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the member.

7.0 A heavy duty wheelchair (K0006) requires prior authorization through the Health Services Division and may be considered medically necessary when (1.0) is met and ANY of the following criteria:

7.1 A heavy duty wheelchair is covered if the member weighs more than 250 pounds or the member has severe spasticity;

7.2 An extra heavy duty wheelchair (K0007) is covered if the member weighs more than 300 pounds;

8.0 A manual wheelchair with tilt in space (E1161) is covered if the member meets the general criteria for a manual wheelchair AND the following:

8.1 The member has an evaluation as indicated in (6.3) and the wheelchair is provided by a supplier as indicated in (6.4)

Power Operated Vehicle (K0800-K0808, K0812)

9.0 A Power Operated Vehicle (POV) (K0800-K0808, K0812) requires prior authorization through the Health Services Division and may be considered medically necessary when ALL of the following criteria are met:

9.1 Member meets ALL of the criteria listed (1.1 and 1.2); AND

9.2 Use of a POV will significantly improve the member’s ability to participate in one (1) or more MRADLS; AND

9.3 Member does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair 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 or both upper extremities are relevant to the assessment of upper extremity function; AND

9.4 Member has a condition that requires a POV long term (at least three months); AND

9.5 The member will not be using the POV solely for leisure or recreational activities; AND

9.6 There is no documentation of the following issues:

9.6.1 That the member’s mental capabilities (e.g. cognition, judgment) or physical capabilities (e.g. vision) prevent safe mobility using a POV in the home; OR
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9.6.2 That the member’s environment does not support the use of a POV.

10.0 POV’s that because of their size and/or other features are generally intended for use outdoors will be denied as not medically necessary. (e.g. Larks).

Power Wheelchairs (PWC) (K0013, K0813-K0891, K0898)

11.0 A power wheelchair requires prior authorization through the Health Services Division and may be considered medically necessary when ALL of the following criteria are met:

11.1 Meets ALL of the criteria listed in (1.1 and 1.2); AND

11.2 The member does not have sufficient upper extremity function to safely self-propel a manual wheelchair in the home to perform MRADLs during at typical day;

11.2.1 Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function

11.2.2 An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-power accessories.

11.3 The member meets EITHER of the following:

11.3.1 The member has the mental and physical capabilities to safely operate the power wheelchair provided; OR

11.3.2 If the member is unable to safely operate the power wheelchair, 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 power wheelchair that is provided

11.4 The member’s weight is less than or equal to the weight capacity of the power wheelchair that is provided; AND

11.5 The member’s home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power chair that is provided; AND

11.6 Use of power wheelchair will significantly improve the member’s ability to participate in MRADL’s and the member will use it in the home or place of residence; AND

11.7 The member has not expressed an unwillingness to use a power wheelchair in the home or place of residence; AND

The member has a condition that requires a power wheelchair long term (at least three (3) months)

12.0 Additional Criteria for Specific Groups of Power Wheelchairs
Coverage of any medical intervention discussed in a Prevea360 Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and to applicable state and/or federal laws.

12.1 **Group 1 PWC** (K0813-K0816) or a **Group 2 PWC** (K0820-K0829) is considered medically necessary if the criteria in (11.0) are met and the PWC is appropriate for the member's weight.

12.2 **Group 2 Single Power Option PWC** (K0835-K0840) is considered medically necessary if the following criteria are met:

12.2.1 The member requires a drive control interface other than a hand or chin-operated standard proportional joystick (e.g. head control, sip and puff, switch control); **OR**

12.2.2 The member meets coverage criteria for a power tilt, or a power recline seating system and the system is being used on the wheelchair; **AND**

12.2.3 The member meets the criteria in (6.3) and (6.4)

12.3 **Group 2 Multiple Power Option PWC** (K0841-K0843) is considered medically necessary if the criteria in (11.0) is met and the following:

12.3.1 The member meets coverage criteria for a power tilt, or a power recline seating system and the system is being used on the wheelchair; **OR**

12.3.2 The member uses a ventilator which is mounted on the wheelchair; **AND**

12.3.3 The member has had an evaluation as indicated in (6.3) and the PWC is provided by a supplier as indicated in (6.4)

12.4 **Group 3 PWC with No Power Options** (K0848-K0855) is considered medically necessary if the criteria in (11.0) are met and the following:

12.4.1 The member's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; **AND**

12.4.2 The member has had an evaluation as indicated in (6.3) and the PWC is provided by a supplier as indicated in (6.4)

12.5 **Group 3 PWC with Single Power Options** (K0856-K0860) or with **Multiple Power Options** (K0861-K0864) is considered medically necessary if the following criteria is met

12.5.1 Group 3: criteria in (11.0) is met and the members mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity

12.5.2 Group 2: Single Power Option (12.1) or Multiple Power Options (12.3) criteria are met.

12.6 **Group 4 PWC** (K0868-K0886) have added capabilities that are not typically needed for use in the home. Coverage will be determined on a case by case basis.
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12.7 Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) is covered if ALL the criteria in (11.0) are met and ALL of the following:

12.7.1 The member is expected to grow in height; AND
12.7.2 The Group 2 Single Power Option (12.2) or Multiple Power Options (12.3) are met

13.0 Custom motorized/power wheelchair base (K0013) will be covered if:

13.1 The meets the general coverage criteria for a power wheelchair (11.0); AND
13.2 The specific configurational needs of the member are not able to be met using wheelchair cushions, or options or accessories (prefabricated or custom fabricated), which may be added to another power wheelchair base.

Push Rim Activated Power Assist Device

13.3 A push-rim activated power assist device (E0986) for a manual wheelchair is covered if ALL of the following criteria are met:

13.3.1 All of the criteria for a power mobility device in (11.0) is met; AND
13.3.2 The member has been self-propelling in a manual wheelchair for at least one year; AND
13.3.3 The member has had an evaluation as indicated in (6.3) and the PWC is provided by a supplier as indicated in (6.4)

Add-Ons to Manual or Power Wheelchairs

14.0 Examples of add-ons to manual or power wheelchairs that may be considered medically necessary if the member has medical conditions or physical characteristics justifying their use include but are not limited to:

- Adjustable arm height options or arm trough
- Elevated leg rests
- Power seating system with or without power elevating leg rests
- Non-standard seat width and/or depth
- Gear reduction drive wheel
- Safety belt/pelvic strap
- Swing-away, retractable, or removable hardware if required for member to perform slide transfer to chair or bed
- Electronic interface if member has a covered speech generating device
- Attendant control if member is unable to operate a manual or power wheelchair, and caregiver is able to operate power wheelchair
- Anti-rollback device if member self-propels
- Manual fully reclining back option
- Lap trays when used to provide trunk support
- Push-rim activated power assist system option for manual wheelchair
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15.0 Batteries and Chargers

15.1 Up to two (2) batteries (E2359, E2361, E2363, E2365, E2371, K0733) at any one time are allowed if required for an approved power wheelchair.

15.2 A non-sealed battery (E2358, E2360, E2362, E2364, E2372) will be denied as not medically necessary.

15.3 A single mode battery charger (E2366) is appropriate for charging a sealed lead acid battery. If a dual mode battery charger (E2367) is provided as a replacement, it will be denied as not medically necessary.

15.4 The usual maximum frequency of replacement for a lithium-based battery (E2397) is one (1) every four (4) years. Only one (1) battery is allowed at any one time.

16.0 Examples of add-ons to manual or power wheelchairs that are considered to be a convenience item and therefore are not medically necessary include (not an all-inclusive list):

- Attendant controls if member is able to operate a manual or power wheelchair
- Canopies
- Swing away, retractable, or removable hardware when not needed for slide transfers
- Lap trays when not used to provide trunk support
- Work or cut out trays
- Vehicle travel safety/tie down restraints

17.0 A second manual wheelchair and/or a second power mode of transportation is considered a convenience item, and therefore is not medically necessary.

18.0 Coverage will be limited to the standard model as determined by our Health Services Division.
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