Status
Active

**Medical and Behavioral Health Policy**
Section: Allied Health
Policy Number: VII-04
Effective Date: 01/22/2014



# WHEELCHAIRS

**Description:** A wheelchair is durable medical equipment (DME) used by a patient with severe impairment of functional mobility. Without the use of a wheelchair, the patient would otherwise be severely limited or unable to perform routine mobility related activities of daily living (MRADLs).

**Manual wheelchairs** are either self-propelled or pushed by another person. Types of manual wheelchairs include standard, hemi-wheelchairs for patients of short stature, lightweight, high-strength, heavy duty or extra heavy duty. The type of wheelchair required is determined by assessment of the patient's size, medical needs, and physical abilities.

**Powered devices** include wheelchairs that are propelled and operated electrically and power operated vehicles (POVs). Power wheelchairs (PWCs) are classified by the Centers for Medicare and Medicaid Services (CMS) into one of five groups based on the medical condition causing the patient's mobility limitations, patient size and required functionality options such as power tilt and recline seating. Group 1 includes standard PWCs. Group 2 and Group 3 PWCs include both single and multiple powered options and have additional features such as power tilt/recline, drive-control interfaces, and options for patients who require a ventilator mounted on the chair. Group 4 PWCs have high-power and maneuvering capabilities such as curb climbing, higher speed capability and range per battery charge. Group 5 PWCs are designed for pediatric patients. Criteria for coverage of power wheelchairs in some of these groups requires a specialty evaluation be performed by a licensed/certified medical professional, such as a physical therapist, occupational therapist, or physician who has specific training and experience in rehabilitation wheelchair evaluation. POV's have limited seat modification capabilities and include power scooters with tiller steering and other power operated vehicles.

**Custom wheelchair bases** are those that have been uniquely constructed for specific patients because required specifications are not available in an already manufactured base. Customization of the frame must be completed

at the factory for the wheelchair base to be considered custom. The application or use of customized parts or accessories does not result in the wheelchair base being considered custom.

**Features**

The following is a list of characteristics of the various models of wheelchairs:

| MODEL | WEIGHT | SEAT WIDTH | SEAT DEPTH | SEAT HEIGHT | BACK HEIGHT | ARM STYLE |
|---|---|---|---|---|---|---|
| **STANDARD** | Greater than 36 lbs | 16" – narrow 18" – adult | 16" | Greater than or equal to 19" and less than or equal to 21" | Non-adjustable 16" – 17" | Fixed or detachable |
| **STANDARD HEMI (LOW SEAT)** | Greater than 36 lbs | 16" - narrow 18" – adult | 16" | 17" - 18" | Non-adjustable 16" – 17" | Fixed or detachable |
| **LIGHT-WEIGHT** | Less than or equal to 36 lbs | 16" or 18" | 16" | Greater than or equal to 17" and less than 21" | Non-adjustable 16" – 17" | Fixed or detachable |
| **HIGH STRENGTH LIGHT-WEIGHT** | Less than 34 lbs | 14" 16" or 18" | 14" – child 16" – adult | Less than or equal to 17" and less than 21" | Sectional or adjustable 15" – 19" | Fixed or detachable |
| **ULTRA LIGHT-WEIGHT** | Less than 30 lbs | 14" 16" or 18" | 14" – child 16" – adult | Less than or equal to 17" and less than 21" | Varies | Fixed or detachable |
| **HEAVY DUTY** | Varies | 18" | 16" or 17" | Greater than 19" and less than 21" | Non-adjustable 16" – 17" | Fixed height, detachable |
| **EXTRA HEAVY DUTY** | Varies | 18" | 16" or 17" | Greater than 19" and less than 21" | Non-adjustable 16" – 17" | Fixed height, detachable |
| **MOTORIZED / POWER** | Varies | 14" – 18" | 16" | Greater than or equal to 19" and less than or equal to 21" | Sectional 16" or 18" | Fixed height, detachable |

All models have fixed or swing-away detachable footrests and all footplate extensions are 16" – 21". Heavy duty and extra heavy duty models have reinforced back and seat upholstery. Heavy duty models can support a patient weighing greater than 250 pounds. Extra heavy duty models can support a patient weighing over 300 pounds.

**Policy:**

**I. Criteria for All Wheelchairs**

**All** of the following criteria must be met for any wheelchair to be considered **MEDICALLY NECESSARY**:

A. The patient has a mobility limitation that significantly impairs his or her ability to participate in mobility related activities of daily living (MRADLs) appropriate to the patient's needs and abilities. These activities include toileting, dressing, personal hygiene and eating, education, working or job training. A mobility limitation is one that:
   1. Prevents the patient from accomplishing the MRADLs entirely,
      **OR**
   2. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs. Weakness and fatigue alone are not considered significant impairments in the ability to participate in MRADLs.

   **AND**

B. The patient has a mobility limitation that cannot be sufficiently resolved by use of an appropriately fitted cane or walker;
   **AND**

C. Features of the wheelchair are based upon the patient's physical and functional capabilities and body size as assessed by a qualified professional or professionals and appropriate to the type of device requested;
   **AND**

D. An assessment of the patient's home demonstrates that the home provides adequate access between rooms, maneuvering space and surfaces for use of the wheelchair provided.

**II. Manual (Non-Motorized) Wheelchair**

A manual (non-motorized) wheelchair may be considered **MEDICALLY NECESSARY** when:

A. The patient has **met the criteria in section I:**
   **AND**

B. The patient meets one of the following:
   1. has sufficient upper-extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided;
      **OR**
   2. A caregiver has been trained and is willing and able to assist with or operate the manual wheelchair when the patient's condition precludes self operation of the manual wheelchair.

**III. Motorized / Power Wheelchair**

Motorized / power wheelchairs may be considered **MEDICALLY NECESSARY** when the patient has met the criteria in section I **and ALL** of the following have been met:

A. A non-motorized wheelchair is determined to be inadequate to address the patient's need for mobility inside and outside the patient's home;
**AND**

B. The patient's condition is such that he/she is unable to operate a non-motorized wheelchair due to lack of upper body strength;
**AND**

C. The patient is capable of safely operating the controls of a motorized/power wheelchair or has a caregiver who cannot push a manual chair but can propel the power chair using an attendant control;
**AND**

D. The patient must be able to safely transfer, or be transferred, in and out of the motorized / power wheelchair and have adequate trunk stability to be able to safely ride in the wheelchair.

**IV. Power-Operated Vehicle (POV) (i.e., Scooter or motorized 3-4 wheeled vehicles)**

A POV may be considered **MEDICALLY NECESSARY** when the patient meets the criteria in section I and **ALL** of the following criteria are met:

A. Patient is unable to self-propel a manual wheelchair;
**AND**

B. Patient is able to safely transfer in and out of the POV;
**AND**

C. Patient is cognitively and physically able to safely maintain stability and position for adequate operation;
**AND**

D. The patient's condition is non-progressive;
**AND**

E. The POV meets the needs of the patient in lieu of a power wheelchair.

**V.** The base of a wheelchair with stair-climbing ability (e.g., iBOT® 4000) may be considered **MEDICALLY NECESSARY** when a patient meets coverage criteria for a wheelchair. The stair climbing features (the 4-wheel, balance, stair and remote functions) are considered an **UPGRADE** and are **NOT COVERED**.

**VI.** Wheelchairs designed for sports or recreational purposes and Medicare Group 4 power wheelchairs are considered **NOT MEDICALLY NECESSARY** as these wheelchairs have additional capabilities that are not necessary for use within the home.

## VII. Wheelchair Features/Customizations

This list is not all-inclusive

A. Light-Weight Wheelchair

A light-weight wheelchair may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Cannot propel himself or herself in a standard wheelchair but can, and does, propel him or herself in a light-weight wheelchair.

B. Ultra Light-Weight Wheelchair

An ultra light-weight wheelchair may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Cannot propel himself or herself in a standard wheelchair but can, and does, propel him or herself in an ultra light-weight wheelchair.

C. Hemi Wheelchair

A hemi wheelchair may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Has paralysis in one arm and/or leg and propels self in the wheelchair **OR** is of short stature that requires lower seat height (17" – 18") that enables the patient to place his/her feet on the ground for propulsion.

D. Full- or Semi-Reclining and Manual or Power Tilt

Recline and manual or power tilt features may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Meets one or more of the following:
   a. Is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift;
      **OR**
   b. Has a fixed hip angle
      **OR**
   c. Utilizes intermittent catheterization for bladder management and is unable to intermittently transfer from the wheelchair to bed;
      **OR**
   d. Power seating is needed to manage increased tone or spasticity.

E. Heavy Duty Wheelchair

A heavy duty wheelchair may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Weighs more than 250 lbs. **OR** has severe spasticity.

F. Extra Heavy Duty Wheelchair

An extra heavy duty wheelchair may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Weighs more than 300 lbs.

G. Wide Heavy Duty

A wide heavy duty wheelchair may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Has a hip width greater than 18".

H. Back Support

A back support may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Requires trunk or body support due to neurological impairments, flexible asymmetrical / symmetrical deformities or fixed asymmetrical / symmetrical deformities.

I. Adjustable Arm Height Option

An adjustable arm height option may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Requires arm height that is different than that available using non-adjustable arms;
   **AND**
3. Spends at least two hours per day in the wheelchair.

J. Arm Trough

An arm trough may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Has quadriplegia, hemiplegia, or uncontrolled arm movements.

K. Detachable Arms

Detachable arms may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Must transfer from wheelchair to bed/chair by "sliding over" and cannot walk or stand and pivot to transfer.

L. Hook-On Head Rest Extension

A hook-on head rest extension may be considered **MEDICALLY NECESSARY** when the patient:

1. Meets the criteria above for a wheelchair;
   **AND**
2. Has weak neck muscles and needs a head rest for support **OR** patient meets the criteria for and has reclining back on the wheelchair.

M. Reinforced Back Upholstery or Reinforced Seat Upholstery
Reinforced back upholstery or reinforced seat upholstery may be considered **MEDICALLY NECESSARY** when:
1. The patient meets the criteria above for a power wheelchair base;
   **AND**
2. The patient weighs more than 200 lbs.

***Note:*** When used in conjunction with heavy duty or extra heavy duty wheelchair base, the allowance for reinforced upholstery is included in the allowance for the wheelchair base. Reinforced back and seat upholstery if used in conjunction with other manual wheelchair bases is **INELIGIBLE FOR COVERAGE.**

N. Elevating Leg Rests
Elevating leg rests may be considered **MEDICALLY NECESSARY** when the patient:
1. Meets the criteria above for a wheelchair;
   **AND**
2. Meets one or more of the following:
   a. Has a musculoskeletal condition, cast or brace that prevents 90 degrees of knee flexion;
      **OR**
   b. Has a below knee amputation and is in an early rehabilitation phase;
      **OR**
   c. Meets the criteria and has a reclining wheelchair;
      **OR**
   d. Has significant edema of the lower extremities that requires having an elevating leg rest.

O. Safety Belt / Pelvic Strap
A safety belt/pelvic strap may be considered **MEDICALLY NECESSARY** when the patient:
1. Meets the criteria above for a wheelchair;
   **AND**
2. Has weak upper body muscles, upper body instability or muscle spasticity requiring belt/strap to maintain proper positioning.

P. Seat Cushions
- Solid seat insert
  A solid seat insert may be considered **MEDICALLY NECESSARY** when the patient:
  1. Meets the criteria above for a wheelchair;
     **AND**
  2. Spends at least two hours per day in a wheelchair or roll-about chair that meets coverage criteria.
- Adjustable or non-adjustable skin protection seat
  An adjustable or non-adjustable skin protection seat may be considered **MEDICALLY NECESSARY** when the patient:
  1. Meets the criteria above for a wheelchair;
     **AND**

2. Has either of the following:
    a. Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface;
    **OR**
    b. Absent or impaired sensation in the area of contact with the seating surface
    **OR**
    c. Inability to carry out a functional weight shift due to spinal cord injury resulting quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida and childhood cerebral degeneration.

- <u>Positioning seat cushion, positioning back cushion, and positioning accessories</u>
  Positioning seat cushion, positioning back cushion, and positioning accessories may be considered **MEDICALLY NECESSARY** when the patient:
  1. Meets the criteria above for a wheelchair;
     **AND**
  2. Has any significant postural asymmetries that are due to spinal cord injury resulting quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida childhood cerebral degeneration, monoplegia of the lower limb, hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonias, or spinocerebellar disease.
- <u>Adjustable or non-adjustable combination skin protection or positioning seat cushion</u>
  Adjustable or non-adjustable combination skin protection or positioning seat cushions may be considered **MEDICALLY NECESSARY** when the patient:
  1. Meets the criteria above for a wheelchair;
     **AND**
  2. Meets the criteria for both a skin protection seat cushion **and** a positioning seat cushion.

Q. <u>Seat Elevation (Lift)</u>
Seat elevation or a seat lift may be considered **MEDICALLY NECESSARY** when the patient:
1. Meets the criteria above for wheelchair base;
   **AND**
2. Meets one or more of the following:

a. Must routinely transfer between uneven surfaces that cannot be adjusted and the seat elevation feature allows them to independently transfer;
**OR**
b. Cannot be safely transferred using a patient lift or standing transfer but can safely be transferred with that seat elevation feature;
**OR**
c. The seat elevation has been demonstrated to allow the patient to independently access areas in the home necessary for completion of ADLs (cupboards/closets, etc.)

R. Strollers / Buggies
Case-by-case review is required for infants, small children or non-ambulatory children with severe impairment.

S. Tray
A tray may be may be considered **MEDICALLY NECESSARY** when:
1. The patient meets the criteria above for wheelchair base;
**AND**
2. The tray is primarily required for support or positioning.

T. The following features are **INELIGIBLE FOR COVERAGE:**
1. Baskets
2. Cane holders
3. Canopies
4. Crutch holders
5. Color upgrades
6. Cup holders
7. Flags
8. High-low chassis or frames
9. Lights
10. Modifications to the home environment to accommodate the device (e.g., widening doors, lowering counters)
11. Motorized lifts used to place the wheelchair in a vehicle
12. Storage devices (e.g., backpacks, seat pouches)
13. Tie-downs for vehicles
14. Transit accessories (e.g., headrest, headrest cover, harness and position belt)
15. Trays that are not required primarily for support or positioning

**Documentation Submission:**

The patient's practitioner must submit documentation to support medical necessity for the wheelchair. This documentation must include **ALL** of the following:

A. The patient's diagnosis, prognosis, and severity of the condition;
**AND**
B. Narrative description including functional impairments that necessitate use of the requested wheelchair and any requested non-standard features.
**AND**

C. Relevant medical records.

**Coverage:**

Blue Cross and Blue Shield of Minnesota medical policies apply generally to all Blue Cross and Blue Plus plans and products. Benefit plans vary in coverage and some plans may not provide coverage for certain services addressed in the medical policies.

Medicaid products and some self-insured plans may have additional policies and prior authorization requirements. Receipt of benefits is subject to all terms and conditions of the member's summary plan description (SPD). As applicable, review the provisions relating to a specific coverage determination, including exclusions and limitations. Blue Cross reserves the right to revise, update and/or add to its medical policies at any time without notice.

For Medicare NCD and/or Medicare LCD, please consult CMS or National Government Services websites.

Refer to the Pre-Certification/Pre-Authorization section of the Medical Behavioral Health Policy Manual for the full list of services, procedures, prescription drugs, and medical devices that require Pre-certification/Pre-Authorization. Note that services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial of claims may result if criteria are not met.

Standard wheelchairs in a skilled nursing facility are included in the per diem charge. Required modifications to a wheelchair or a customized wheelchair that is used exclusively and continuously by the member will be reviewed for medical necessity. Wheelchairs approved outside the facility per diem become the property of the resident, not the facility.

Duplication

If coverage has been provided for a wheelchair, requests for a second chair of the same type (e.g., a second manual chair, stroller or a second power chair) are considered duplicates and are NOT COVERED.

Repairs / Maintenance

Coverage includes batteries and repairs required to keep the device operational. Routine maintenance, however, is not covered.

Replacement

Average useable life of a wheelchair is considered to be approximately five (5) years. Coverage for replacement will be considered when:

- The cost of the repair is in excess of the replacement cost;
- Other extenuating medical circumstances occur which require special consideration; OR

- The current wheelchair no longer meets the patient's needs

If an upgrade in equipment is requested, the patient's functional status (diagnosis, prognosis and severity of condition) must be reviewed for special consideration, in accordance with the justification for medical necessity described above.

In the absence of a medical policy addressing a specific DME item, the medical criteria of the regional DME Medicare Administrative Contractor (MAC) Centers will be used in determining the medical necessity of the item. Those policies are available by accessing the List of LCDs on the CMS Coverage Database.

**Coding:** *The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.*

**HCPCS:**

Multiple codes apply

**Policy History:** **Developed November 17, 1993**

**Most recent history:**
Reviewed October 13, 2010
Reviewed October 12, 2011
Reviewed October 10, 2012
Revised October 9, 2013
Reviewed/Updated, no policy statement changes January 22, 2014.

**Cross Reference:** Durable Medical Equipment (DME), VII-07