

Clinical Policy: Standard Manual Wheelchair or Standard Power Wheeled Mobility Systems

Reference Number: TX.CP.MP.519

Last Review Date: 11/19

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The purpose of this policy is to provide guidelines for authorization of standard manual wheelchair or standard powered wheeled mobility system. This policy applies to the following products: STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP.

A standard manual wheelchair is a non-customized chair mounted on four wheels, incorporating a non-adjustable frame, a sling or solid back and seat, and arm rests, that does not require specialized seating. Appropriate adaptations requested for member safety may include the following: swing-away detachable footrests versus fixed footrests, detachable arms, arm troughs, pelvic seat belts, brake extensions, and rear anti-tip or rollback equipment. In addition, a member who is transported or seated in the wheelchair (e.g., for a van ride) may require a removable headrest and/or other options for transportation safety purposes.

A standard powered wheeled mobility system is a manufactured device that provides motorized wheeled mobility and body support specifically for individuals with impaired mobility that may include but is not limited to: seating positioning components, manual seating options, and an adjustable frame that does not require customized seating.

Policy/Criteria

I. It is the policy of Superior HealthPlan that Standard Manual Wheelchairs are **medically necessary** when all the following general and specified criteria are met:

A. General Criteria

1. Mobility-related ADL/primary role function cannot be met due to mobility limitation that cannot be safely met by an alternative or less restrictive mobility device.
2. Mobility-related ADL/primary role function can be met safely and efficiently using non-customized manual wheelchairs.
3. Member or caregiver is able to safely and effectively propel standard wheelchair (WC).
4. Member weight \leq 250 lbs. (excludes standard heavy duty/extra heavy duty WC).
5. The member does not require specialty-seating components.
6. The member is not expected to need powered mobility within the next five-year period.
7. The WC must be able to accommodate a 20 percent change in the member's height or weight.

B. Standard Manual Wheelchairs

Standard WC may be considered **medically necessary** when general criteria are met.

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Note: *Standard manual WC requests must be initially rented for six months prior to purchase. After six months of rental, the clinician can approve purchase of the standard WC. If provider requests purchase prior to initial six month rental period, clinician must send to the medical director for secondary review.*

C. Standard Hemi Wheelchairs

A standard hemi WC may be considered **medically necessary** when general criteria and one of the following criteria are met:

1. The member requires a low seat-to-floor height.
2. The member must/may use his/her feet to propel the wheelchair.

D. Standard Reclining Wheelchairs

A standard reclining WC may be considered **medically necessary** when general criteria and at least one of the following criteria are met:

1. The member is at high-risk for development of a pressure ulcer, spends two or more hours per day in the WC, and is unable to perform a functional weight shift.
2. The member requires assisted-ventilation while in a reclining position.
3. The member needs to perform mobility-related activities of daily living (MRADL's) in a reclining position.
4. The member has significant edema of the lower extremities and proper leg elevation for venous return can only be achieved in a WC with reclining function.
5. The member has severe spasticity which prevents her/him from utilizing a standard, upright WC.
6. The member has excess extensor tone of the trunk muscles.
7. The member has quadriplegia.
8. The member has a fixed hip angle.
9. The member requires intermittent catheterization for bladder management and is unable to independently transfer from the WC to the bed.
10. The member has trunk or lower extremity casts or braces that require the reclining feature for positioning.

E. Standard Lightweight Wheelchair

1. Standard lightweight wc may be considered **medically necessary** when above general criteria and all of the following criteria are met:
2. The member is unable to propel a standard WC at home due to significantly decreased upper extremity strength, poor trunk control, or a cardiopulmonary or cardiovascular condition that limits endurance.
3. The member is capable of independently propelling a lightweight WC.
4. The WC allows the member to accomplish his/her MRADL's at home.

F. Standard High-Strength Lightweight Wheelchair

Standard high-strength lightweight WC may be considered **medically necessary** when above general criteria and all of the following criteria are met:

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1. The member is unable to propel a standard WC at home due to significantly decreased upper extremity strength, poor trunk control, or a cardiopulmonary or cardiovascular condition which limits endurance.
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 hours per day in the WC.
3. The member engages in frequently performed activities that require a high-strength capacity system that cannot otherwise be completed using a standard WC.

G. Standard Heavy Duty Wheelchair

Standard heavy duty wheelchairs support members weighing 250-300lbs. A heavy duty WC may be considered **medically necessary** for short-term rental or purchase when the member has severe spasticity *or* all the following criteria are met:

1. The member meets criteria for a standard WC.
2. The member weighs between 250 and 300 pounds.

H. Standard Extra Heavy Duty Wheelchair

Standard extra heavy duty wheelchairs support members weighing greater than 300 lbs. An extra heavy duty WC may be **medically necessary** for short-term rental or purchase when all the following criteria are met:

1. The member meets criteria for a standard WC.
2. The member weighs more than 300 pounds.

I. Manual Wheeled Mobility System-Tilt-In-Space

A tilt-in-space manual wheeled mobility system is defined as a manual wheelchair that has the ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining a constant back to seat angle to provide a change of orientation and redistribute pressure from one area (such as the buttocks and the thighs) to another area (such as the trunk and the head). A tilt-in-space manual wheelchair may be considered **medical necessary** for short-term rental or purchase when all of the following criteria are met:

1. The member meets the criteria for a standard manual wheelchair.
2. The member has a condition that meets criteria for a tilt-in-space feature, including but not limited to:
 - a. Severe spasticity
 - b. Quadriplegia
 - c. Excess extensor tone
 - d. Range of motion limitations prohibit a reclining system, such as hip flexors, hamstrings, or heterotopic ossification
 - e. The need to rest in a recumbent position two or more times per day and an inability to transfer between bed and wheelchair without assistance.

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II. It is the policy of Superior HealthPlan that Standard Electric, Power, or Motorized Wheelchairs are **medically necessary** when all the following general and specified criteria are met:

A. General Criteria

Standard electric, power, or motorized wheelchairs may be considered **medically necessary** for rental or purchase when all the following general criteria are met:

1. Mobility-related ADL/primary role function cannot be met due to mobility limitation that cannot be met by a standard manual WC or other assistive device (such as cane or walker) as documented in the seating assessment.
2. Permanent/progressive medical condition
3. Member or caregiver is able to safely and effectively operate a standard electric, power, or motorized wc
4. Required for short-term use for rental up to 12 mo. or long-term use ≥ 12 mo.
5. Home/primary environment will accommodate standard electric, power, or motorized WC as supported by a home assessment ensuring access.

B. Group 1 Power Standard Wheelchair Description

Group 1 standard power wheelchairs are appropriate for intermittent or limited indoor use. They are designed to be used on hard surfaces with minimal surface irregularity. This WC requires a joystick to operate and cannot accommodate powered seating or positioning systems. This WC is not recommended for use by members with a progressive condition. The Group 1 power WC comes with a standard proportional control input that can be integrated or remote, which allows for either a member or caregiver to operate the w/c. Alternative input devices options and seating (e.g., manual elevating leg rests, recline-only backs) can be placed on this WC if the seating system is not a captain's chair. The Group 1 power wc has a minimum top speed of three MPH, a range of five miles, a minimum obstacle climb of 20 mm, and a dynamic stability incline of six degrees.

Group 1 power WC may be considered **medically necessary** for rental or purchase when the above general criteria and all of the specified criteria below are met:

1. Used for intermittent indoor mobility-related ADL
2. Safely and effectively able to use a standard proportional joystick
3. No power seating/positioning options required

C. Group 2 Power Standard Wheelchair Description

Group 2 standard power wheelchairs are for consistent indoor mobility. They are suitable for use on hard surfaces with minimal to moderate surface irregularity. They may be used for level outdoor terrain but are not appropriate for heavy outdoor use. This WC may be upgraded in order to accommodate alternative-control devices (e.g., sip and puff, head array); however, they do not provide the tracking accuracy and ease of use as found in a Group 3 w/c. This w/c can be assembled in the home and may be appropriate when environmental restrictions or stairs exist. A group 2 power WC can accommodate seating and positioning systems (e.g., seat and back cushions, headrests, lateral and medial trunk

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supports, and lateral hip supports). A Group 2 power wc has a minimum top speed of three MPH, a range of seven miles, a minimum obstacle climb of 40 mm, and a dynamic stability incline of six degrees.

1. **Group 2 (no power options) power wheelchair**

May be considered **medically necessary** for rental or purchase when the above general criteria and all of the specified criteria below are met:

- a. Continuous indoor w/c mobility required for mobility–related ADL/primary role function two or more hours per day.
- b. Safely and effectively able to use a standard proportional joystick.
- c. No power seating/positioning options are required.

2. **Group 2 power w/c, single power option w/ power tilt/recline option wheelchair**

May be considered **medically necessary** for rental or purchase when the above general criteria and all of the specified criteria are met:

- a. Continuous indoor w/c mobility required for mobility–related ADL/primary role function two or more hours per day.
- b. Single power option
- c. Required for upgrade to alternative control device/expandable controller
- d. And one of the following:
 - i. Inability to perform independent pressure relief
 - ii. Intermittent catheterization required for bladder management and unable to independently transfer to bed
 - iii. Increased tone/spasticity managed by tilt/recline positioning
 - iv. Reduced/low tone and poor trunk/head control

D. **Group 3 Power Wheelchair Description**

Group 3 power wheelchairs are for continuous use both indoors and outdoors. They are suitable for flat rolling terrain and for use on hard surfaces with moderate surface irregularity. Members with permanent or progressive neurological disorders (e.g., SCI, ALS, MS) or members who require specialty controls or multiple power seat functions may be appropriate for this w/c. Group 3 power wheelchairs can accommodate seating and positioning systems (e.g., seat and back cushions, headrests, lateral trunk and hip support, medial thigh support); and can upgrade to an expandable controller or alternative control device. They have a minimum top speed of 4.5 MPH, a minimum range of 12 miles, a minimum obstacle climb of 60mm, and a dynamic stability incline of 7.5 degrees.

1. **Group 3 power wheelchair (no power option base)** may be considered **medically necessary** for rental or purchase when the above general criteria and all of the specified criteria are met:

- a. Continuous indoor and high demand w/c mobility required for mobility related ADL/primary role function.
- b. Mobility limitation secondary to a neurological condition, myopathy, or skeletal deformity.
- c. No power seating/positioning options required.

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2. **Group 3 power wheelchair, single power option** may be considered **medically necessary** for rental or purchase when the above general criteria and all of the specified criteria are met:
 - a. Continuous indoor and high demand w/c mobility required for mobility-related ADL/primary role function.
 - b. Mobility limitation secondary to a neurological condition, myopathy, or skeletal deformity and one of the following:
 - i. Required for upgrade to alternative control device/expandable controller.
 - ii. Inability to perform independent pressure relief.
 - iii. Intermittent catheterization required for bladder management and unable to independently transfer to bed.
 - iv. Increased muscle tone/spasticity managed by tilt/recline positioning.
 - v. Reduced/low muscle tone and poor trunk/head control.

3. **Group 3 power wheelchair, multiple power option** may be considered **medically necessary** for rental or purchase when the above general criteria and all of the specified criteria are met:
 - a. Continuous indoor and high demand w/c mobility required for mobility related ADL/primary role function.
 - b. Mobility limitation secondary to a neurological condition, myopathy, or skeletal deformity and one of the following:
 - i. Inability to perform independent pressure relief.
 - ii. Intermittent catheterization required for bladder management and unable to independently transfer to bed.
 - iii. Increased muscle tone/spasticity managed by tilt/recline positioning
 - iv. Reduced low muscle tone, poor trunk, and head control.
 - v. Required for ventilator accommodation for a ventilator-dependent member.

E. Group 4 Power Wheelchair Description:

Group 4 power wheelchairs have the most advanced functional capabilities of all the groups (i.e., minimum top speed of six MPH, minimum range of 16 miles per battery charge, minimum obstacle climb of 75 mm, and dynamic stability incline of nine degrees). This chair can handle uneven terrain, hard or soft surfaces, and extreme surface irregularity, thereby making it suitable for frequent and aggressive outdoor or community use.

1. **Group 4 power wheelchair (no power option base)** may be considered **medically necessary** for rental or purchase when the above general criteria and all of the specified criteria are met:
 - a. Continuous high activity w/c mobility required for mobility related ADL/primary role function.
 - b. Mobility limitation secondary to a neurological condition, myopathy, or skeletal deformity.

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- c. Required to accomplish mobility related ADL/primary role function.
 - d. Mobility related ADL/primary role function cannot be met with Group 1–3 power WC.
- 2. Group 4 power wheelchair, single power option may be considered **medically necessary** for rental or purchase when the above general criteria and all of the specified criteria are met:**
- a. Continuous high activity w/c mobility required for mobility–related ADL/primary role function.
 - b. Mobility limitation secondary to a neurological condition, myopathy, or skeletal deformity.
 - c. Required to accomplish mobility-related ADL/primary role function.
 - d. Mobility related ADL/primary role function cannot be met with group 1–3 power w/c.
 - e. And one of the following:
 - i. Required for upgrade to alternative control device/expandable controller.
 - ii. Required for power tilt/recline option.
 - iii. Inability to perform independent pressure relief.
 - iv. Intermittent catheterization required for bladder management and unable to independently transfer to bed.
 - v. Increased muscle tone, spasticity managed by tilt and recline positioning.
 - vi. Reduced low muscle tone, poor trunk, and head control.
- 3. Group 4 power wheelchair, multiple power option may be considered **medically necessary** for rental or purchase when the above general criteria and all of the specified criteria are met:**
- a. Continuous high activity WC mobility required for mobility related ADL/primary role function.
 - b. Mobility limitation secondary to a neurological condition, myopathy, or skeletal deformity.
 - c. Required to accomplish mobility-related ADL/primary role function.
 - d. Mobility related ADL/primary role function which cannot be met with group 1–3 power wc
 - e. And the following:
 - o Required for ventilator accommodation for a ventilator-dependent member.
- F. Group 5 Pediatric Power Wheelchair**
- Group 5 pediatric power wheelchair may be considered **medically necessary** for rental or purchase when the above general criteria and all of the specified criteria are met:
- 1. The member requires special developmental capability (i.e., seat to floor, standing, etc.).
 - 2. And all of the following for *single-PWCs*:
 - a. The member requires a drive control interface other than a hand or chin-operated standard proportional

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- b. Joystick (examples include but are not limited to head control, sip and puff, switch control).
3. And all of the following for *multiple-PWCs*:
 - a. 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).
 - b. The member has a documented medical need for a power tilt and recline seating system and the system is being used on the WC or the member uses a ventilator that is mounted on the WC.

➤ **Growth Accommodations for Group 5 Pediatric Wheelchair**

For Members 12 Years of Age and Under:

1. If the WC frame allows for at least a 3 inch growth potential in both width and depth accept as sufficient growth potential.
2. Growth allowance is acceptable with frame modification or growth kit.

For Members 13 Years of Age through 17 Years of Age:

1. If the w/c frame allows for at least a 2 inch growth potential in both width and depth, accept as sufficient growth potential.
2. Growth allowance is acceptable with frame modification or growth kit.

For Members 18 Years of Age and Over:

1. If the w/c frame allows for at least a 1 inch growth potential in depth and 2 inches in width, accept as sufficient growth potential.
2. Growth allowance is acceptable with frame modification or growth kit.

Providers may submit documentation from therapist and/or physician to justify why recommended growth potential is not necessary for the member. Documentation may address:

1. Member's medical condition and its impact to future seating needs due to physical changes and/or growth.
2. Member's age and its impact to future seating needs due to physical changes and/or growth.
3. Member health status associated with weight gain/loss, or weight stability.

III. Power Operated Vehicles (POV)

POV's, commonly known as "scooters," are three or four wheeled motorized transportation systems for persons with impaired ambulation. A POV comes with a battery or batteries for operation, battery charger, seating system, tiller steering system, non-expandable controller, tires and accessories required for safe operation of the equipment.

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- IV.** It is the policy of Superior HealthPlan that repairs to member-owned equipment are **medical necessary** for the following indications:
- A. The medical appliance or equipment continues to serve a specific medical purpose and an itemized estimated cost list from the DME provider of the repairs.
 - B. A repair will be considered based on the age of the item and cost to repair it.
 - C. Documentation must include the date of purchase and serial number of the current equipment.
- Note: Clinician can approve repair requests if documentation of medical necessity is submitted.
- V.** It is the policy of Superior HealthPlan that replacement to member-owned equipment may be considered **medically necessary** as needed with documentation from the requesting physician and seating assessment completed by a Qualified Rehabilitation Professional (QRP) specialist for any mobility based requests.
- A. Prior authorization for equipment replacement is considered after five years of the original equipment purchase. The clinician can approve replacement requests if documentation of medical necessity is submitted **and** it has been more than 5 years since the mobility system was purchased, **and** when one of the following occurs:
 1. There has been a significant change in the member's condition such that the current equipment no longer meets the member's needs as documented under a current seating assessment.
 2. The equipment is no longer functional because it is either beyond repair, parts are no longer available, or the repair is not cost-effective, as documented by a qualified repair technician.
 3. The equipment is lost through theft, fire, or vandalism. A copy of the police or fire report should be included.
 4. A medical director review is required when an equipment replacement request occurs within five years of the original purchase.

Background

Definitions:

- **Face-to-Face Exam** - An in-person visit between the ordering physician and the Member must occur before prescription of any powered wheeled mobility systems. A medical evaluation must be performed by the ordering physician that clearly documents the member's functional status with attention to conditions affecting the member's mobility and her/his ability to perform activities of daily living within the home. This may be done all or in part by the ordering provider. If all or some of the medical examination is completed by another medical professional, the ordering provider must sign off on the report and incorporate it into the medical records.
- **A standard manual wheelchair** is defined as a manual wheelchair that:
 - Weighs more than 36 pounds.

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- Does not have features to appropriately accept specialized seating or positioning.
- Has a weight capacity of 250 pounds or less.
- Has a seat depth of between 15 and 19 inches.
- Has a seat width of between 15 and 19 inches.
- Has a seat height of 19 inches or greater.
- Is fixed height only, fixed swing away, or detachable arm rest?
- Is fixed, swing away, or detachable footrest.
- **A lightweight manual wheelchair is defined as a manual wheelchair that:**
 - Has the same features as a standard or hemi manual wheelchair.
 - Weighs 34 to 36 pounds.
 - Has available arm styles that are height adjustable.
- **A high-strength lightweight wheelchair is defined as a manual wheelchair that:**
 - Has the same features as a lightweight manual wheelchair.
 - Weighs 30 to 34 pounds.
 - Has a lifetime warranty on side frames and cross braces.
- **A heavy duty wheelchair is defined as a manual wheelchair that:**
 - Meets the standard manual wheelchair definition.
 - Has a weight capacity greater than 250 pounds.
- **An extra heavy duty wheelchair is defined as a manual wheelchair that:**
 - Meets the standard manual wheelchair definition.
 - Has a weight capacity greater than 300 pounds.
- **A standard hemi (low seat) wheelchair is defined as a manual wheelchair that:**
 - Has the same features as a standard manual wheelchair.
 - Has a seat to floor height of less than 19 inches.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
N/A	

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ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Removed work process attachment from policy. Rephrased work process approval with policy and procedure approval. Updated definitions to include wheelchair descriptions.	12/15	12/15
Updated references and signatories. Grammatical edits. Added STAR Kids to product type. Removed MRSA and CHIP RSA from product type. Removed authorization protocol work process.	12/16	12/16
Updated references and signatories. Deleted revision history prior to 2014. Updated requirements and definitions per the 2017 TMPPM. Included the TMPPM definitions of Group 3-5 power wheelchairs and the growth accommodation requirements.	12/17	12/17
Annual Review. Updated references, signatories, and review date. Deleted revision history prior to 2014. Multiple grammatical and nomenclature changes.	11/18	11/18
Updated to new template from TX.UM.10.19 (TX.CP.MP.519 nomenclature implementation). Updated references.	11/19	11/19

References

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2. Texas Medicaid Provider Procedures Manual (2019) - 2.2.16 Mobility Aids
3. Power Mobility Device Face-to-Face Examination Checklist. MLN Matters Number: SE1112. Department of Health and Human Services. Centers for Medicare & Medicaid Services. Available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf>. Accessed last December 11, 2014.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health



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plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs,



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and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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