Clinical Policy: Custom Mobility Seating and Systems

Reference Number: TX.CP.MP.599 Coding Implications
Last Review Date: 01/23 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

A custom wheeled mobility system is a professionally manufactured device that provides motorized or manual wheeled mobility and body support specifically for individuals with impaired mobility that includes but not limited to: specialized seating positioning components, manual seating options, adjustable frame and other complex or specialized accessories. These requests require a seating assessment with measurements including specifications for exact mobility and seating equipment and all necessary accessories.

This policy applies to the following products: STAR, STAR Health, STAR Kids, STAR+PLUS, MMP, and CHIP.

Policy/Criteria:

I. Documentation Requirements

A. A completed order with all the following;
   1. Signed and dated by a physician, nurse practitioner, or physician assistant familiar with the member.
   2. Dated no more than 90 days prior to the date of the requested prior authorization or the initiation of service.
   3. Diagnosis that results in the need for the custom wheeled mobility device.

B. A completed wheelchair seating assessment performed by an assistive technology professional (ATP) or qualified rehabilitation professional (QRP) **and** physical therapist (PT), occupational therapist (OT), or physician. The therapist or physician must be familiar with the member or must be the treating provider. The assessment must include all the following:
   1. Member's height and weight.
   2. Member's clinical presentation, including but not limited to muscle tone, postural control, range of motion, transfer capability, current and past medical history, history of skin breakdown, physical limitations (such as strength and balance), recent or expected changes in member's status, current functional mobility, orthopedic conditions, ambulatory status and/or potential and level of assist, level of wheelchair dependence and cognitive functional status.
   3. Distance member can ambulate; if member can ambulate more than ten feet, documentation must indicate why member requires the requested seating system.
   4. Environmental assessment documented by therapist to include where the member resides, whether ramps needed/available, where the wheelchair (WC) will be used, how the WC will be transported, where the WC will be stored, and other durable medical equipment (DME) equipment the member utilizes.

5. If member has a current seating system, therapist or physician must document description of current seating system to include make, model, serial number, age and why the system is no longer meeting the member's needs documented by the therapist and why the current system cannot be modified to meet the member's needs.
6. Therapist or physician must document the following:
    a. Make and model of the requested system
    b. Medical necessity of the requested seating system and accessories.
    c. How the family will be trained in the use of the equipment.

Note: the provider who performs the assessment must not be employed by the equipment supplier.

C. A measurement worksheet completed by ATP/QRP, therapist, or physician.
D. Additional documentation required for powered mobility:
    1. In home accessibility assessment performed by ATP/QRP documenting accessibility of the member's residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions).
    2. Level of assist required to safely operate chair documented by therapist or physician.
    3. First time power wheelchair users must complete a trial with the requested equipment. Documentation by therapist or physician must include duration of trial and objective measures demonstrating the trial was successful and member is able to independently operate the power wheelchair.
E. MSRP or quote(s) from manufacturer(s) of the requested seating system, including all components and accessories.

    Note: Handwritten alterations (crossing out of information or changing values) of the invoice render the invoice invalid.

F. Documentation demonstrates the equipment is medically necessary and reasonably required to correct or ameliorate the member's disability, condition, or illness. Although a DME item may serve a useful medical purpose, realistically feasible alternatives, and equipment that the member currently utilizes must be considered. The most medically appropriate equipment will be considered.

    Note: Rental or purchase will be assessed on a case-by-case basis. Purchase will be considered when more cost effective than a rental.

II. General Criteria for all Mobility Systems

All custom mobility systems require the general criteria be met. Each unique system requires the specific criteria to be met. It is the policy of Superior HealthPlan that custom mobility may be **medically necessary** for the following indications:

A. Date member was last seen by the physician must have been within six months from service start date.
B. Wheelchairs, components and accessories must be submitted using the most appropriate procedure code that describes the item.
C. Member is unable to ambulate ten feet due to a physical impairment or neurological impairment.

D. Mobility related ADL/primary role function cannot otherwise be achieved by a lower-level device.
E. Provider must submit documentation demonstrating potential for member growth as follows:
   1. For members 12 years of age and younger, the wheelchair frame must adjust for a minimum of 3 inches of growth potential in width and depth and demonstrate the frame will adjust for anticipated growth for at least 5 years.
   2. For members 13 years of age through 17 years of age, the wheelchair frame must adjust for a minimum of 2 inches of growth potential in width and depth and demonstrate the frame will adjust for anticipated growth for at least 5 years.
   3. For members 18 years of age and older, the wheelchair frame must adjust for a minimum of 1 inch in depth and 2 inches in width and demonstrate the frame will adjust for anticipated growth for at least 5 years.
   4. For manual and power mobility, frames must also accept a 20 percent change in weight.

   Note: If the requested device does not accommodate member's growth, the therapist or physician must submit documentation that demonstrates why growth is not necessary.
F. Purchased DME is anticipated to last a minimum of five years, DME is not considered medically necessary when used as a restraint or requested for the convenience of the member or caregiver.

III. Specific Criteria for Custom Manual Wheelchairs

A. Criteria for Ultra-Lightweight Manual Wheelchair (K0005)

An ultra-lightweight manual wheelchair is **medically necessary** when the documentation requirements in section I is submitted and criteria in section II are met ***and*** all the following criteria are met:

1. Member has a documented medical condition that cannot be accommodated by the seating or features available on a standard, lightweight, or high-strength lightweight wheelchair.
2. Member has a permanent or progressive condition and requested equipment is required for long term use.
3. Will spend six or more hours a day in wheelchair.
4. Able to independently propel manual wheelchair for functional distances.

Note: Criterion #4 does not apply if the members primary mobility device is a custom power wheelchair and the request is for a custom manual wheelchair as a backup device.

B. Criteria for Tilt-in-Space Wheelchair (E1161)

A tilt-in-space wheelchair is **medically necessary** when the documentation requirements in section I is submitted and criteria in section II are met ***and*** all the following criteria are met:

1. Member has a documented medical condition that cannot be accommodated by the seating or features available on a standard, lightweight, or high-strength lightweight wheelchair, or standard recline wheelchair.
2. Permanent or progressive condition and required for long term use.
3. Member is unable to propel a manual wheelchair.
4. Member will spend six or more hours a day in wheelchair.
5. Requested system must have the capability to accommodate custom seating.
6. Member has a documented diagnosis or condition that requires a tilt-in-space feature by meeting one of the following:
    a. Documented weak upper extremity (UE) strength or a progressive disorder that will lead to weak upper extremities.
    b. At risk for skin breakdown or history of skin breakdown due to inability to reposition body in a chair to relieve pressure areas.
    c. Hemodynamic instability that requires tilt for stabilization.

C. Criteria for Pediatric Manual Mobility Systems (E1235, E1236, E1237, E1238)
A pediatric manual wheeled mobility system is defined as a manual standard or custom wheelchair (including those optimally configured for propulsion or custom seating) that has a seat width or depth of less than 15 inches. A pediatric manual wheelchair is **medically necessary** when the documentation requirements in section I is submitted and criteria in section II are met ***and*** all the following criteria are met:

1. Member has a documented medical condition that is permanent or progressive and the requested equipment is required for long term use.
2. Height or weight is greater than what can be accommodated by a standard manual wheelchair or stroller.
3. Seating system frame will be fully adjustable in depth and width to accommodate growth for 5 years (see section II E as reference).
4. Member will spend six or more hours a day in the wheelchair.
5. Requested system will allow for self-propulsion.
6. Requested system must have the capability to accommodate custom seating.
7. Member demonstrates control, strength, coordination, and cognition to independently and safely propel manual wheelchair for functional distances **or** member has a documented medical condition that limits their ability for self-propulsion but requires a component, feature or seating that is not available on a standard, lightweight, or high-strength lightweight manual wheelchair.

D. Criteria for Pediatric Tilt-in-Space Wheelchair (E1231, E1232, E1233, E1234)
A pediatric manual tilt-in-space is **medically necessary** when the documentation requirements in section I is submitted and criteria in section II are met ***and*** all the following criteria are met:

1. Member has a documented medical condition that cannot be accommodated by the seating or features available on a standard, lightweight, or high-strength lightweight wheelchair, or standard recline wheelchair.
2. Permanent or progressive condition and required for long-term use.

3. Height or weight is greater than what can be accommodated by a standard manual wheelchair or stroller.
4. Seating system frame will be fully adjustable in depth and width for growth for five years (see section II H as reference).
5. Member will spend six or more hours a day in the wheelchair.
6. Requested system must have the capability to accommodate custom seating.
7. Member has the following conditions that require a tilt in space feature (not including age-appropriate functional mobility, strength, and milestones):
    a. Documented weak upper extremity strength or a disease that will lead to weak upper extremities.
    b. At risk for skin break or history of skin breakdown due to inability to reposition body in a chair to relieve pressure areas.
    c. Hemodynamic instability that requires tilt for stabilization.

E. All Inclusive Items for Manual Wheelchair

The initial purchase of all manual wheelchairs and wheeled mobility systems must include the wheelchair base or frame and the following standard components which will not be prior authorized separately:

1. Complete set of standard propulsion and caster wheels, including all of the following:
    a. Propulsion or caster tires of any size, made of solid rubber or plastic
    b. Standard hand rims
    c. Complete wheel lock assembly
    d. Bearings
2. Standard footrest assembly (fixed, detachable, or swing away), including standard footplates, calf rests/pads, and ratchet assembly.
3. Standard armrests (fixed non-adjustable or detachable non-adjustable), including standard foam or plastic arm pads.
4. Standard seat and back upholstery.

IV. Specific Criteria for Custom Powered Mobility

A. Criteria for Group 2 Power Wheeled Mobility Device (K0820-K0831, K0835-K0843)

A group 2 power mobility device is **medically necessary** when the documentation requirements in section I is submitted and criteria in section II are met ***and*** all the following criteria are met:

1. Mobility related ADL cannot be met by a manual wheelchair, other assistive device (such as cane or walker) or a lower-level group power wheelchair.
2. Documentation demonstrates member is physically and cognitively able to independently operate power wheelchair without assistance.
3. In home assessment demonstrates that home/primary environment will accommodate power wheelchair.
4. Requires a control interface not available on a lower-level chair.
5. First time power wheelchair users must complete a trial with the requested equipment. (see I D for reference)

B. Criteria for Group 3 Power Wheeled Mobility Device (K0848-K0864)
A group 3 power mobility device is **medically necessary** when the documentation requirements in section I is submitted and criteria in section II are met ***and*** all the following criteria are met:
1. Mobility related ADL cannot be met by a manual wheelchair, other assistive device (such as cane or walker), or a lower-level group power wheelchair.
2. Documentation demonstrates member is physically and cognitively able to independently operate power wheelchair without assistance.
3. In home assessment demonstrates that home/primary environment will accommodate power wheelchair.
4. The member's mobility limitation is due to a permanent or progressive neurological condition, myopathy, or congenital skeletal deformity.
5. Will consistently use power wheelchair in home and community.
6. First time power wheelchair users must complete a trial with the requested equipment. (see I D for reference)

C. Criteria for Group 4 Power Wheelchair (K0868-K0871, K0877-K0880, K0884-K0886)
A group 4 power mobility device is **medically necessary** when the documentation requirements in section I is submitted and criteria in section II are met ***and*** all the following criteria are met:
1. Mobility related ADL/primary role function cannot be met due to mobility limitation that cannot be met by a manual wheelchair, other assistive device (such as cane or walker), or a lower-level group power wheelchair.
2. Documentation demonstrates member is physically and cognitively able to independently operate power wheelchair without assistance.
3. In home assessment demonstrates that home/primary environment will accommodate power wheelchair.
4. Mobility limitation is due to a permanent or progressive neurological condition, myopathy, or congenital skeletal deformity.
5. Will consistently use power wheelchair in home and community.
6. The enhanced features found on a Group 4 PMD must be medically necessary to meet the member's routine mobility related ADL and will not be approved for leisure or recreational activities.
7. First time power wheelchair users must complete a trial with the requested equipment. (see I D for reference)
8. Documentation must demonstrate consistent use over rugged terrains that cannot be navigated by a group 3 power wheelchair **or** requires a ventilator and requires extra battery for long distances.

D. Criteria for Group 5 Pediatric Power Wheelchair (K0890-K0891)
A group 5 power mobility device is **medically necessary** when the documentation requirements in section I is submitted and criteria in section II are met ***and*** all the following criteria are met:

1. Documentation supports that member has a medical necessity requiring for lower seat to floor height.
2. The member requires growth change in height or weight of more than 20 percent.
3. Meets all criteria for group 3 power wheelchairs above.

E. All Inclusive Items for Power Wheelchairs

Each power wheelchair must include all the following basic components that may not be billed separately:

1. Lap belt or safety belt.

Note: Does not include multiple-attachment-point positioning belts or padded belts.

2. Battery charger, single mode
3. Batteries (initial)
4. Complete set of tires and casters, any type
5. Leg rests
6. Foot rests or foot platform
7. Arm rests
8. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by member weight capacity
9. Controller and input device

Note: Replacement batteries or a replacement battery charger may be considered for reimbursement if they are no longer under warranty.

V. STAR+PLUS Nursing Home Residents

STAR+PLUS nursing home members requires all of the following criteria. A member must be:

A. Eligible for and receiving Medicaid services, including dual-eligible NF residents, in a licensed and certified NF that has a Medicaid contract with HHSC;
B. Age 21 or older;
C. For STAR+PLUS nursing home residents Texas HHS STAR+PLUS Handbook will be utilized for criteria. (See addendum A)

Note: For Nursing Facility Dual Eligible Members, prior authorization requests are processed as a Medicaid Benefit. A Medicare denial is not required as it is not a covered service under Medicare.

VI. Options/Accessories

Options and accessories for custom manual and power wheelchairs may be considered on a case-by-case basis when documentation demonstrates the equipment is medically necessary and reasonably required to correct or ameliorate the member's disability, condition, or illness. Although a DME item may serve a useful medical purpose, realistically feasible alternatives and equipment that the member currently utilizes must be considered.

A. Manual Reclining Back (E1014, E1225, E1226) will be considered when ***one*** of the following criteria is met:

1. Wheelchair confined and unable to perform independent pressure relief and unable to transferred out of wheelchair by self or others.

2. Requires catheterization.
3. Trunk or LE casting necessitating hip angle greater than 90 degrees.
4. Abnormal or unstable blood pressure necessitating change in position.

B. Power Reclining Back Option (E1003, E1004, E1005) or Power Tilt (E1002) will be considered when:
1. Criteria for manual reclining back are met ***and*** documentation supports member is unable to use manual option.

C. Combination Power Tilt and Recline (E1006, E1007, E1008) will be considered when documentation demonstrates power tilt or power recline alone is unable to meet the needs of the member ***and two*** of the following are met:
1. Wheelchair confined and unable to perform independent pressure relief and unable to transferred out of wheelchair by self or others.
2. History of pressure sores ***OR*** absent or impaired sensation in area contact with the seating surface.
3. Requires catheterization.
4. Has a progressive disorder leading to poor trunk control and UE weakness.

D. Manual Elevating Leg Rests (E0990) will be considered when ***one*** of the following is met:
1. Inability to flex knee to 90 degrees.
2. Lower extremity edema that requires elevation.
3. Required to maintain proper positioning and reduce sheer during recline.

E. Power Elevating Leg Rests (E1010, E1012) will be considered when:
1. Criteria for manual elevating leg rests are met ***and*** documentation supports member is unable to use manual option.

F. Seat Elevator (E2300) will be considered when ***all*** the following are met:
1. The member does not have the ability to transfer independently.
2. Member will be independent with transfers across unequal seat heights with use of the seat elevator.

G. Dynamic Backrest (E2398), Dynamic Footrest (K0108), Dynamic Headrest (K0108) will be considered when ***all*** of the following are met:
1. Hypertonic and involuntary extensor tone in trunk, UE and LE's due to neurological diagnosis.
2. Documentation supports non dynamic features would cause to multiple repairs and adjustments to chair.

G. Push-Rim Activated Power Assist Wheelchair (PAPAW) System (E0986) will be considered when ***all*** of the following are met:
1. Completion of wheelchair and power wheelchair sections of the assessment form
2. Documentation demonstrates member has the physical and cognitive ability to independently safely operate and control the power wheelchair without assistance.
3. The PAPAW must be medically necessary for the member to perform MRADLs in a typical day. Medical necessity may include but is not limited to:

a. Limitations in upper body strength, endurance, and can include the presence of pain.
b. Prevention of the client from completing an MRADL within a reasonable time frame in their environment.
c. Heightened risk of repetitive strain injuries.

4. A description is required of a trial with the equipment requested during the seating assessment by a therapist, in a variety of environments (or simulations of customary environments), including safety awareness, ability to navigate in the environment, and operate the PAPAW system independently.

VII. Non-Covered Services

The following services are not a covered benefit of Texas Medicaid:

A. Wheelchair accessory, power standing system, any type. (E2301)
B. Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware. (E2231)
C. Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware. (E2331)
D. Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features. (E2295)
E. Special wheelchair seat depth, by upholstery. (E1297)
F. Manual wheelchair accessory, headrest extension, each. (E0966)

Note: Pursuant to the Uniform Managed Care Contract, effective March 1, 2018, requests for Medicaid members over age 20 for DME items via a HCPCS code that is set up as non-covered benefit (NCB) can no longer be denied as a NCB. Rather, a medical necessity review must be performed.

VIII. Alternative or Back-Up Wheelchair

A. Alternative wheelchair will be considered when ***all*** the following criteria are met:
   1. All requested items meet medical necessity.
   2. Member meets all criteria for the requested device and accessories.
B. A custom manual back up wheelchair will be considered when documentation supports that a standard manual wheelchair will not meet the needs of the member.

IX. Equipment Repairs

Repairs to member-owned equipment may be considered for prior authorization with documentation of **medical necessity**. Documentation should include ***all*** the following:

A. The medical appliance or equipment continues to serve a specific medical purpose.
B. Itemized estimated cost of the repairs.
C. Date of purchase of the item being repaired.
D. Serial number of the item.
E. MSRP from manufacturer for manually priced items.

F. The cause of the damage or need for repairs, and the steps the member or caregiver will take to prevent further damage if repairs are due to an accident or misuse.
G. Criteria and medical necessity for all item(s) being requested are met.

Note: Repair will be considered based on the age of the item and cost to repair it as opposed to purchasing new equipment.

X. Replacement of Mobility System

Request to replace a mobility system within five years of purchase is considered **medically necessary** when documentation of ***all*** the following substantiates the request:

A. Criteria and MN for all item(s) being requested for replacement are met.
B. Loss or irreparable damage has occurred.
C. A copy of the police or fire report, when appropriate.
D. A statement about the measures to be taken to prevent reoccurrence.

XI. Wheelchair Modifications

Wheelchair modifications are **medically necessary** when documentation of ***all*** the following are met:

A. Wheelchair seating assessment and member measurements performed by QRP and therapist or physician are submitted.
B. Criteria and medical necessity for all item(s) being requested are met.
C. Date of purchase and serial number of wheelchair being modified.
D. Cost of purchasing new equipment versus modifying current equipment.
E. Description of the change in the member's condition that necessitates modification.

Note: All modifications within the first six months after delivery are considered part of the purchase price. Adjustments made within the first six months after delivery are considered part of the purchase price. A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months following delivery

XII. Seat and Back Cushions

A cushion is considered custom when dimensions or features requested are not available on general cushions, skin protection cushions, positioning cushions, or skin protection and positioning cushions.

A. General Use Seat and Back Cushions (E2601, E2602, E2611, E2612) will be considered when:
   1. Member has an approved or current authorization for approved manual wheelchair or power wheelchair with a sling or solid seat or back.
B. Skin Protection Seat Cushion (E2603, E2604, E2622, E2623) will be considered when one of the following is met:
   1. Current pressure ulcer or history of a pressure ulcer on the area of contact with the seating surface.

2. Documented diagnosis demonstrating absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift.

C. Positioning Seat Cushion (E2605, E2606) and Positioning Back Cushion (E2613-E2616, E2620, E2621) will be considered when ***all*** the below criteria are met:
   1. Member has an approved or current authorization for approved manual wheelchair or power wheelchair with a sling, solid seat or back.
   2. The member has flexible postural asymmetries **or** is dependent on upon a seating system for mobility.

D. Combination Skin Protection and Positioning Seat Cushion (E2607, E2608, E2624, E2625) cushion will be considered when:
   1. The member has flexible postural asymmetries **and one** of the below are met:
   2. Current pressure ulcer or history of a pressure ulcer on the area of contact with the seating surface.
   3. Documented diagnosis demonstrating absent or impaired sensation in the area of contact with the seating surface.
   4. Inability to carry out a functional weight shift.

E. Custom Fabricated Seat Cushion (E2609) will be considered when **all** the below are met:
   1. Criteria is met for a prefabricated skin-protection and has fixed postural asymmetries or deformity OR therapist/physician documentation indicates why prefabricated seating system is not sufficient to meet the member's seating and positioning needs.
   2. MSRP demonstrates customization is being requested.

F. Custom Fabricated Back Cushion (E2617) will be considered when all the below are met:
   1. The member fixed postural asymmetries or deformity OR therapist/physician documentation indicates why prefabricated seating system is not sufficient to meet the member's seating positioning needs.
   2. MSRP demonstrates customization is being requested.

Addendum:

Texas HHS STAR+PLUS Handbook

Definitions:

QRP: A QRP directly employed or contracted by the DME provider must be present at and participate in all seating assessments

The QRP is responsible for:

- Being present at and involved in the seating assessment of the member for the rental or purchase of a wheeled mobility system.
- Being present at the time of delivery of the wheeled mobility system to direct the fitting of the system to ensure that the system functions correctly relative to the member.

The QRP performing the fitting will:

- Verify the wheeled mobility system has been properly fitted to the member.

- Verify that the wheeled mobility system will meet the member's functional needs for seating, positioning, and mobility.
- Verify that the member, parent, guardian of the member, and/or caregiver of the member has received training and instruction regarding the wheeled mobility system's proper use and maintenance.

Modification

The addition, replacement, or modification of a custom or specialized feature due to changes in the member's needs, including, but not limited to the following:

- specialized seating or positioning components.
- Custom seating.
- Powered seating options, including, but not limited to, power tilt and/or recline seating systems, seat elevation systems, and power elevating leg rests.
- Specialty driving controls, including, but not limited to, non-standard alternative power drive control systems.

Pediatric sized wheeled mobility system is defined as a wheelchair that has a seat width or depth of less than 15 inches.

Custom ultra-lightweight wheeled mobility system is defined as an optimally configured wheelchair for independent propulsion which cannot be achieved in a standard, lightweight, or high-strength lightweight wheelchair that:

- Meets the high-strength lightweight definition and weighs less than 30 pounds.
- Has one or more of the following features to appropriately accept specialized seating or positioning:
  - Adjustable seat-to-back angle
  - Adjustable seat depth
  - Independently adjustable front and rear seat-to-floor dimensions
  - Adjustable caster stem hardware
  - Adjustable rear axle
  - Adjustable wheel camber
  - Adjustable center of gravity
  - Has a lifetime warranty on side frames and cross braces

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 2021, 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
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes)

HCPCS Codes	Description
K0005	Ultra-lightweight wheelchair
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system
E1161	Adult tilt in space
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system
E1233	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system
K0848-K0855	Power wheelchair, group 3 standard
K0856-K0860	Power wheelchair, group 3 single power option
K0861-K0864	Power wheelchair, group 3 multiple power option
K0868-K0871	Power wheelchair, group 4
K0877-K0880	Power wheelchair, group 4 standard, single power option
K0884-K0886	Power wheelchair, group 4 heavy duty, multiple power option
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0891	Power wheelchair group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
E2601	General use wheelchair seat cushion, width less than 22 inches, any depth
E2602	General use wheelchair seat cushion, width 22 inches or greater, any depth
E2603	Skin protection wheelchair seat cushion, width less than 22 inches, any depth
E2604	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth

HCPCS Codes	Description
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
E2605	Positioning wheelchair seat cushion, width less than 22 inches, any depth
E2606	Positioning wheelchair seat cushion, width 22 inches or greater, any depth
E2607	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth
E2608	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth
E2624	Skin protection and pos
E2625	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
E2609	Custom fabricated wheelchair seat cushion, any size
E2294	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware
E2611	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware
E2612	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware
E2613	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware
E2615	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware
E2616	Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware
E2621	Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware
E2293	Back, contoured, for pediatric size wheelchair including fixed attaching hardware

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
New policy created	01/22	01/22
Annual review. References reviewed. Section I A was updated to include "*nurse practitioner, or physician assistant*" as acceptable ordering providers per 42 CFR 440.70. Added to Section I A that orders must be no more than 90 days. Removed E0986 from the non-covered section and added Section VI H for review criteria of E0986. Clarification added to section IX G "*Criteria and medical necessity for all item(s) being requested are met*.". Clarification added to Section III B 5 "Requested system must have the capability to accommodate custom seating."	01/23	01/23

References

1. Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook, Volume 2: Section - 2.2.17 Mobility Aids, December 2022
2. CP.MP.99 Wheelchair Seating
3. Texas Administrative Code 354.1035
4. Centers for Medicare and Medicaid Services. National Coverage Determination for Durable Medical Equipment Reference List. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=190&ncdver=2&keyword=DME&keywordType=starts&areaId=all&docType=NCD&contractOption=all&sortBy=relevance&bc=1 Accessed on December 16, 2021.
5. Centers for Medicare & Medicaid Services. National Coverage Decision (NCD) for Mobility Assistive Equipment (MAE) NCD# 280.3 https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=219 Effective 05/05/2005, Accessed on December 16, 2021.
6. 42 Code of Federal Regulations 440.70

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

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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,

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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