# Medical Policy

Northwood

# Manual Wheelchair Bases

## Description

A manual wheelchair is characterized by a cross-brace frame (allows folding), built-in or removable arm rests, swing-away footrests, a mid- to high-level back, two large wheels (usually 20-26") with push rims, two small wheels in the front (castors) and push handles to allow non-occupants to propel the chair. Most standard wheelchairs require an individual to propel the wheelchair or a caregiver that is able to provide assistance with the device.

## Policy

Manual wheelchairs are considered **reasonable and necessary** when a Member has mobility limitations that can not be sufficiently resolved by the use of an appropriately fitted cane or walker.

## Policy Guidelines

### Medicare members coverage criteria

Refer to Medicare's Medical policy L33788 and policy article 52497 for coverage criteria.

### Non-Medicare member coverage criteria:

### GENERAL COVERAGE CRITERIA

A manual wheelchair for use inside the home (E1037, E1038, E1039, E1161, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0008, K0009) is covered if:

- Criteria A, B, C, D, and E are met; and
- Criterion F or G is met.

A. The member has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

   1. Prevents the member from accomplishing an MRADL entirely, or
   2. Places the member at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or

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

B. The member's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

C. The member's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided. Any obstacles must be addressed and documented in the home assessment.

D. Use of a manual wheelchair will significantly improve the member's ability to participate in MRADLs and the member will use it on a regular basis in the home.

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

F. The member has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

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

H. **For NH Medicaid members only**: DME that is appropriate for use in the member's home may also be used in the community (Manual Wheelchairs/Power Wheelchairs).

A complete manual wheelchair base includes:

- A complete frame
- Propulsion wheels
- Casters
- Brakes
- A sling seat, seat pan which can accommodate a wheelchair seat cushion, or a seat frame structured in such a way as to be capable of accepting a seating system
- A sling back, other seat back support which can accommodate a wheelchair back cushion, or a back frame structured in such a way as to be capable of accepting a back system
    - Standard leg and footrests
- Armrests

- Safety accessories (other than those separately billable in the Wheelchair Accessories Local Coverage Determination)

ADDITIONAL CRITERIA FOR SPECIFIC MANUAL WHEELCHAIRS (E1037, E1038, E1039, E1161, K0002, K0003, K0004, K0005, K0006, K0007, K0008)

In addition to the general manual wheelchair criteria above, the specific criteria below must be met for each manual wheelchair. If the specific criteria are not met, the manual wheelchair will be denied as not reasonable and necessary.

A transport chair (E1037, E1038 or E1039) is covered as an alternative to a standard manual wheelchair (K0001) and if basic coverage criteria A-E and G above are met.

A standard hemi-wheelchair (K0002) is covered when the member requires a lower seat height (17" to 18") because of short stature or to enable the member to place his/her feet on the ground for propulsion.

A lightweight wheelchair (K0003) is covered when a member meets both criteria (1) and (2):

1. Cannot self-propel in a standard wheelchair in the home; and
2. The member can and does self-propel in a lightweight wheelchair.

A high strength lightweight wheelchair (K0004) is covered when a member meets the criteria in (1) or (2):

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

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

An ultra-lightweight manual wheelchair (K0005) is covered for a member if criteria (1) or (2) is met and (3) and (4) are met:

1. The member must be a full-time manual wheelchair user.

2. The member must require individualized fitting and adjustments for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a K0001 through K0004 manual wheelchair.

3. The member must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP), such as a PT or OT, or treating practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The LCMP may have no financial relationship with the supplier (Exception: If the supplier is owned by a hospital, the PT, OT, or practitioner working in the inpatient or outpatient hospital setting may perform the specialty evaluation.)

4. The wheelchair is provided by a Rehabilitative Technology Supplier (RTS) that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

A heavy-duty wheelchair (K0006) is covered if the member weighs more than 250 pounds or the member has severe spasticity.

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

A manual wheelchair with tilt in space (E1161) is covered if the member meets the general coverage criteria for a manual wheelchair above, and if criteria (1) and (2) are met:

5. The member must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP), such as a PT or OT, or treating practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The LCMP may have no financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, the PT, OT, or practitioner working in the inpatient or outpatient hospital setting may perform the specialty evaluation.)

1. The wheelchair is provided by a Rehabilitative Technology Supplier (RTS) that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.


# Manual Wheelchair Bases

A custom manual wheelchair base (K0008) is covered if, in addition to the general coverage criteria above, the specific configuration required to address the member's physical and/or functional deficits cannot be met using one of the standard manual wheelchair bases plus an appropriate combination of wheelchair seating systems, cushions, options or accessories (prefabricated or custom fabricated), such that the individual construction of a unique individual manual wheelchair base is required.

If K0008 is used to describe a prefabricated manual wheelchair base, even one that has been modified in any fashion, the claim will be denied for incorrect coding. Refer to the CODING GUIDELINES section of the related Policy Article for additional information about correct coding of K0008.

Manual wheelchair bases (K0001 K0002, K0003, K0004, K0005, K0006, K0007, K0008, K0009) include construction of any type of material, including but not limited to, titanium, carbon, or any other lightweight high strength material. Suppliers must not bill HCPCS code K0108 in addition to the base wheelchair for construction materials or for a "heavy duty package" reflecting the type of material used to construct the manual wheelchair base. Billing for construction material is considered incorrect coding – unbundling.

A custom manual wheelchair is not reasonable and necessary if the expected duration of need is less than three months (e.g., post-operative recovery).

If the manual wheelchair will be used inside the home and the coverage criteria are not met, it will be denied as not reasonable and necessary.

If the manual wheelchair base is not covered, then related accessories will be denied as not reasonable and necessary.

**MISCELLANEOUS**

Payment is made for only one wheelchair at a time. Backup chairs are denied as not reasonable and necessary. One month's rental for a standard manual wheelchair (K0001) is covered if a member-owned wheelchair is being repaired.

**Important Note:**

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

# Manual Wheelchair Bases

Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded, or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation and Northwood will use the applicable state requirements to determine required quantity limit guidelines.

Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating practitioner in connection with diagnosis and treatment decisions.

Northwood follows all CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), as applicable.

## References

Centers for Medicare and Medicaid Services, Medicare Coverage Database, National Coverage Documents; October 2015. Last accessed and reviewed December 5,2024.

CGS Administrators, LLC. Jurisdiction B DME MAC, Manual Wheelchair Bases. Local Coverage Determination No. L33788; Last accessed and reviewed December 5, 2024.

Noridian Healthcare Solutions, LLC. Jurisdiction A DME MAC, Manual Wheelchair Bases. Local Coverage Determination No. L33788; Last accessed and reviewed December 12, 2023.

**Change/Authorization History**

# Medical Policy

Northwood

## Manual Wheelchair Bases

| Revision Number | Date | Description of Change | Prepared/Reviewed by | Approved by | Review Date: | Effective Date: |
|---|---|---|---|---|---|---|
| A | Nov.2006 | Initial Release | Rosanne Brugnoni | Ken Fasse | n/a | |
| 01 | Jan.2007 | Clarified home assessment criteria. ( c ) Added KX modifier | Susan Glomb | Ken Fasse | | |
| 02 | | Annual Review / no changes | Susan Glomb | Ken Fasse | Dec.2008 | |
| 03 | Oct.01,2009 | Added GA and GZ modifiers to be used at a future date. Revised KX modifier with instructions on use. | Susan Glomb | Ken Fasse | | |
| 04 | | Annual Review/ no changes | Susan Glomb | Ken Fasse | 12-22-09 | |
| 05 | | Annual Review – No changes | Susan Glomb | Ken Fasse | 12-02-10 | |
| 06 | 01-07-11 | Deleted; least costly alternative language for K0002-K0007 | Susan Glomb | Ken Fasse | | |
| 07 | 07-20-11 | Added Important Note to all Medical Policies | Susan Glomb | Dr. B. Almasri | | |
| 08 | 11-22-11 | Annual Review. Added References to Policy | Susan Glomb | Dr. B. Almasri | Nov. 2011 | |
| 09 | 04-04-12 | Added reference to NH Medicaid | Susan Glomb | Dr. B. Almasri | | |
| 10 | 12-6-12 | Annual Review. Changes made to requirement for K0007 to account | Susan Glomb | Dr. B. Almasri | Dec 12 | |

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| | | for appropriateness of coding. | | | | |
| 11 | 05-29-13 | Code K0009 deleted. Code K0008 added Custom Manual Wheelchair/Base with coverage criteria. E1161 criteria changed: Ability to tilt the frame of the wheelchair greater than or equal to 20 degrees from horizontal while maintaining the same back to seat angle. Lifetime warranty on side frames and cross braces. | Susan Glomb | Dr. B. Almasri | | |
| 12 | 12-11-13 | Annual review. No further changes. | Susan Glomb | Dr. B. Almasri | | |
| 13 | 12-4-14 | Annual Review. Added: Items in this policy are subject to the Affordable Care Act (ACA) 6407 requirements | Susan Glomb | Dr. B. Almasri | | |
| 14 | 12-30-14 | Changed narrative for Code: E0986 Manual wheelchair accessory, push-rim activated power assist system. | Susan Glomb | Dr. B. Almasri | | |
| 15 | 12-14-15 | Annual Review. Policy updated with Medicare policy criteria. References | Susan Glomb | Dr. B. Almasri | 12-14-15 | |

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| | | updated. Criteria for MassHealth and MassHealth Care Plus updated to reflect that the DME that is appropriate for use in the member's home may also be used in the community. Manual Wheelchair/Power Wheelchair. | | | | |
| 16 | 12-08-16 | Annual Review. No Changes. | Lisa Wojno | Dr. B. Almasri | December 2016 | |
| 17 | 12-20-17 | Annual Review. Updated DME MAC reference names. | Lisa Wojno | Dr. Cheryl Lerchin | December 2017 | |
| 18 | 12-10-18 | Annual review. Added: Clarification of what is included in a manual wheelchair base code. Added: Clarification of titanium unbundling in manual wheelchair bases. | Carol Dimech | Dr. C. Lerchin | December 2018 | |
| 19 | 12-12-19 | Annual review. Added: Clarification of materials used in construction of manual wheelchair bases. | Carol Dimech | Dr. C. Lerchin | December 2019 | December 2019 |
| 20 | 6-4-20 | Revised: H. Criteria for MassHealth and MassHealth Care Plus to instead | Carol Dimech | Dr. C. Lerchin | 6-4-20 | |

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| | | indicate NH Medicaid updated to reflect that the DME that is appropriate for use in the member's home may also be used in the community. | | | | 6-4-20 |
| 21 | 12-09-20 | Annual review. Per CMS, revised "physician" to "treating practitioner"; revised: Format of HCPCS codes, from 'code spans' to individually listed HCPCS. | Carol Dimech | Dr. C. Lerchin | December 9, 2020 | December 9, 2020 |
| 22 | 12-8-21 | Annual review. Added NCD, LCD verbiage to "Important Note". | Carol Dimech | Dr. C. Lerchin | December 8, 2021 | |
| 23 | 12-7-22 | Annual review. No changes. | Carol Dimech | Dr. C. Lerchin | 12-7-22 | 12-7-22 |
| 24 | 12-12-23 | Annual review. Per CMS, policy updated with information regarding specialty evaluations. Exception: If the supplier is owned by a hospital, the PT, OT, or practitioner working in the inpatient or outpatient hospital setting may perform the specialty evaluation. | Susan Glomb | Dr. C. Lerchin | 12-12-23 | December 2023 |
| 25 | 12-5-24 | Annual review. Per CMS, added to Coverage Criteria C: Any issues to the use of the wheelchair in the home must be | Carol Dimech | Dr. C. Lerchin | 12-5-24 | 12-5-24 |

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| | | addressed and documented in the home assessment. | | | | |