

## Corporate Medical Policy

### Wheelchairs

<b>File Name:</b>	wheelchairs
<b>Origination:</b>	1/2000
<b>Last CAP Review:</b>	9/2011
<b>Next CAP Review:</b>	9/2012
<b>Last Review:</b>	9/2011

#### Description of Procedure or Service

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Mobility assistance may be required for a variety of reasons and for varying durations because the etiology of the disability may be due to a congenital cause, injury, or disease. Some members may need mobility assistance on a short-term basis, while those with chronic conditions or enduring disabilities may require mobility assistance on a permanent basis. This policy discusses 2 types of wheelchairs: manually operated and electrically operated types. Manual wheelchairs are used for patients who are unable to walk, but have sufficient upper extremity function to propel a wheelchair. Electric wheelchairs are used for patients who are unable to walk **and also** have upper extremity impairment.

Power operated vehicles (scooters) are addressed under a separate BCBSNC medical policy entitled "Power Operated Vehicles."

***\*\*\*Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

#### Policy

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**Manually and electrically operated wheelchairs will be considered eligible for coverage on an individual consideration basis. BCBSNC may provide coverage for wheelchairs when they are determined to be medically necessary because the medical criteria and guidelines shown below are met.**

**Repair, adjustment or replacement of components, accessories or equipment for covered wheelchairs will be eligible for coverage on an individual consideration basis as well. Reasonable care of the equipment must be documented.**

#### Benefits Application

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This medical policy relates only to the services or supplies described herein. Devices and equipment used for environmental accommodation such as, but not limited to, chair lifts, stair lifts, home elevators, standing frames, and ramps are specifically excluded under most health benefit plans.

Durable medical equipment that serves no medical purpose or that is primarily for comfort or convenience is also excluded under most health benefit plans.

Please refer to the Member's Benefit Booklet for availability of benefits for durable medical equipment.

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Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

See Other Services for **Durable Medical Equipment**. See the BCBSNC Corporate Medical Policy entitled “**Durable Medical Equipment**”. Wheelchairs are considered Durable Medical Equipment (DME). The individual certificate or member benefit should be reviewed to verify eligibility requirements and any prior approval or preauthorization necessary for the rental/purchase of equipment.

- Determination of rental or purchase of DME will be made based on review of diagnosis, severity of illness, and prognosis.
- The DME supplier must meet eligibility and/or credentialing requirements as defined by the BCBSNC Provider Blue Book in order to be eligible for reimbursement.
- **Please also refer to Corporate Medical Policy for Durable Medical Equipment (DME). All criteria stated in the DME medical policy must be satisfied in conjunction with the criteria listed in this policy.**

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## When Wheelchairs are covered

- Wheelchairs are considered medically necessary when used by the member for mobility in the performance of activities of daily living in his/her residence and when the criteria outlined below are met. The determination of rental or purchase will be made based on the review of the patient’s diagnosis, severity of illness, and prognosis.
  - The wheelchair must provide therapeutic benefit to a patient in need because of certain medical conditions and/or illnesses, and;
  - The wheelchair must be prescribed by a physician within the scope of his/her license.
  - Medical necessity of repair, adjustment or replacement of components, accessories or equipment will be based upon review of documented reasonable care of the equipment.
  - **Please also refer to Corporate Medical Policy for Durable Medical Equipment (DME).**
1. Manually operated wheelchairs are eligible for coverage under the following conditions:
    - a. Member has a disease process, injury or disability that would contraindicate weight bearing or ambulation or,
    - b. Member has a disease process, injury or disability in which there is a decrease in neuromuscular function in the lower extremities, and
    - c. The member has the ability to self-propel his/her wheelchair.
    - d. Appropriate diagnoses include, but are not limited to the following:
      - i. Multiple Sclerosis
      - ii. Paraplegia or low level quadriplegia (C6 - T1)
      - iii. Cerebral Palsy
      - iv. Cerebral vascular accident
      - v. Severe congestive heart failure

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- vi. Fracture femur, hip, pelvic and/or bilateral lower extremity
2. Electrically operated wheelchairs are eligible for coverage under the following conditions:
  - a. A manually operated wheelchair is determined to be inadequate to address the member's need for mobility in his/her home and
  - b. The member is capable of safely operating the controls of an electrically operated wheelchair and
  - c. There was an evaluation (must be completed by a professional independent from the vendor supplying the equipment) either in a specialized seating/mobility clinic or by a physician and therapist who are knowledgeable about the consequences of long-term disability and the prescription of electrically operated wheelchairs and
  - d. Member has a condition in which there is a disease process, injury, or disability:
    - i. which contraindicates weight bearing or ambulation **Or**
    - ii. which results in decreased neuromuscular function in all four extremities **AND** the member requires support of the trunk.
3. Appropriate covered supplies for both the manually and electrically operated wheelchairs require proper documentation of medical necessity and may include, but are not limited to the following:
  - i. Roho cushions
  - ii. Pads and supports for the trunk of the body
  - iii. Abduction and adduction pads
  - iv. Head rests, head extensions
  - v. Anti-tippers
  - vi. Shelf or rack for Ventilator
4. Wheelchairs that are specially adapted for children are considered medically necessary when the child is non-ambulatory and either requires more support than a regular wheelchair provides, or is too small for a standard pediatric wheelchair.

## **When Wheelchairs are not covered**

1. Wheelchairs that fail to meet the medical criteria above are considered not medically necessary.
2. Wheelchairs with stair climbing ability (e.g., iBOT 3000) are considered not medically necessary.
3. Seat elevators for manually and electrically operated wheelchairs are considered not medically necessary when used solely for the convenience of the insured or the insured's family/caretaker.

The following examples of personal convenience items are considered non-covered supplies under most benefit plans for both the manually and electrically operated wheelchair.

This list includes, but is not limited to:

- a. Trays (attached to the front of the wheelchair)
- b. Tie-downs
- c. Personal back packs
- d. Patient lifts, ceiling lifts, access ramps.
- e. Any option or accessory that is primarily for the purpose of allowing the member to perform lei

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sure, recreation or sports activities

f. Electrical or mechanical upgrades that do not serve a medical purpose.

## Policy Guidelines

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- **All wheelchairs are subject to medical necessity review.**
- See Billing/Coding and Physician Documentation for documentation requirements.
- Wheelchairs require a prescription to rent or purchase before they are eligible for coverage.
- Payment of eligible fees will begin on the day the device is delivered, set-up, and ready for use by our member at the location needed.
- **Purchase of both a manual and an electric wheelchair within the same 12 month benefit period:** If a member meets the medical necessity criteria and purchases both a manual and an electric wheelchair within the same 12 month benefit period, the Plan will allow up to the assigned allowance for an electric wheelchair only. The amount previously allowed for the manual chair will be deducted from the allowance for the electric wheelchair.

*The following table contains a list of special features or customizations, including the usual indications considered when determining the wheelchair needs of a member. Non-standard features of a wheelchair are considered medically necessary only when the member's condition meets the criteria for the item. This is not an all-inclusive list.*

**Table 1 :**

<b>Feature</b>	<b>Usual Indications</b>
Lightweight	Member cannot propel self in a standard wheelchair but can and does propel self in a lightweight wheelchair.
Ultra lightweight	Member cannot propel self in a standard or lightweight wheelchair but can and does propel self in an ultra lightweight wheelchair.
Hemi wheelchair	Member has paralysis in one arm and/or leg and propels self in the wheelchair; OR is of short stature and requires lower seat height (17"-18") that enables member to place his/her feet on the ground for propulsion.
Full or Semi-Reclining	Member is a quadriplegic; OR Has trunk or lower extremity casts/braces that require special positioning; OR Has a fixed hip angle; OR Has excess extensor tone of the trunk muscles. A full or semi-reclining back option for prophylaxis of sacral decubiti without a prior history of skin breakdown is considered not medically necessary.
Heavy Duty	Member weighs more than 250 pounds; or has severe spasticity.
Extra Heavy Duty	Member weighs more than 300 pounds.
Wide Heavy Duty	Member's hip width is greater than 18 inches.

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Arm trough	Member has quadriplegia, hemiplegia, or uncontrolled arm movement.
Back Support	Member requires trunk and upper body support. Considerations when determining appropriate back support include: neurological impairments, flexible asymmetrical/symmetrical deformities or fixed asymmetrical/symmetrical deformities.
Adjustable arm height option	Member requires an arm height that is different than that available using non-adjustable arms AND the member spends at least 2 hours per day in a wheelchair.
Crutch and can holder	Not medically necessary.
Detachable arms	Member transfers from wheelchair to bed/chair by "sliding over" and cannot walk or stand and pivot to transfer.
Detachable, swing-away foot rests	Not eligible for separate reimbursement. Should be billed separately only when they are replacement parts.
Hook-on headrest extension	Member has weak neck muscles and needs headrest for support; OR meets the criteria for and has a reclining back on the wheelchair.
Reinforced back or seat upholstery	When used with an electrically operated wheelchair AND the member weighs more than 200 pounds. When used in conjunction with heavy duty or extra heavy duty wheelchair bases, is not eligible for separate reimbursement. Reinforced back and seat upholstery are not medically necessary if used in conjunction with other manually operated wheelchairs.
Elevating Leg Rests	Member has musculoskeletal condition, cast or brace that prevents 90 degrees of knee flexion; OR Below the knee amputation in the early rehabilitation phase; OR Meets the criteria for and has a reclining wheelchair; OR Has significant lower extremity edema that requires having an elevating leg rest.
Safety belt/pelvic strap	Member has weak upper body muscles, upper body instability or muscle spasticity requiring belt/strap to maintain proper positioning.
Seat Cushions	A solid seat insert is covered when the member spends at least 2 hours per day in a wheelchair that meets coverage criteria. An adjustable or non-adjustable skin protection seat cushion is medically appropriate for a member who has a current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; OR has absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift. A positioning

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	<p>seat cushion, positioning back cushion and positioning accessory is medically appropriate for a member who has any significant postural asymmetries.</p> <p>An adjustable or non-adjustable combination skin protection and positioning seat cushion is medically appropriate for a member who meets the criteria for both a skin protection seat cushion and a positioning seat cushion. If the member cannot reposition him/herself or be repositioned at least every 2 hour, a seat cushion will not prevent the development of pressure ulcers.</p>
Seat elevators	Not covered.

## Billing/Coding/Physician Documentation Information

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbsnc.com](http://www.bcbsnc.com). They are listed in the Category Search on the Medical Policy search page.

*Applicable service codes: E0950-E1298, E1340, E2201-E2399, E2351, E2358, E2359, E2601-E2621, E2626-E2633, K0001-K0195, K0462, K0658 - K0669, K0800- K0899*

The following documentation is required to establish medical necessity:

Medical records that indicate the member's disease process or injury that necessitates use of the wheelchair, physician's plan of treatment and length of time the wheelchair will be medically necessary, predicted outcomes, and physician's involvement in supervising the use of the prescribed item, **And**

An evaluation (must be completed by a professional independent from the vendor supplying the equipment) either in a specialized seating/mobility clinic or by a physician and therapist who are knowledgeable about the consequences of long-term disability and the prescription of electrically operated wheelchairs.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

## Scientific Background and Reference Sources

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Senior Director of Health Affairs

BCBSNC Matrix Program - Certificate language

Medical Policy Advisory Group - 3/99

MEDLINE and MDConsult literature search from 1995 to Present

Specialty Matched Consultant Advisory Panel - 4/2001

Redford JB. Seating and wheeled mobility in the disabled elderly population. *Archives of Physical*

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*Medicine and Rehabilitation*. 1993 Aug;74(8):877-85.

Specialty Matched Consultant Advisory Panel - 9/2002

Specialty Matched Consultant Advisory Panel - 8/2004

Centers for Medicare & Medicaid Services. National Coverage Determination Manual Section Number 280.3. Retrieved May 8, 2005 from [http://www.cms.hhs.gov/mcd/viewncd.asp?ncd\\_id=280.3](http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=280.3)

Region C DMERC. Local Coverage Determination L11443. Manual Wheelchair Bases. Retrieved June 27, 2006 from <http://www.palmettogba.com>

Region C DMERC. Local Coverage Determination L11444. Motorized/Power Wheelchair Bases. Retrieved June 27, 2006 from <http://www.palmettogba.com>

Region C DMERC. Local Coverage Determination L11451. Wheelchair Options/Accessories. Retrieved June 27, 2006 from <http://www.palmettogba.com>

Specialty Matched Consultant Advisory Panel- 12/2010

Specialty Matched Consultant Advisory Panel- 9/2011

## Policy Implementation/Update Information

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- 6/94 Original policy issued
- 9/96 Reaffirmed
- 10/96 Revised: Added instruction on handling those cases in which electric and manual wheelchairs are purchased  
  
See Also: BCBSA Medical Policy Reference Manual on Durable Medical Equipment, UMP Allied Health section, p. E0100.0.
- 8/97 Revised. Added DME Supplier information and Source as contract language.
- 3/99 Reaffirmed - Medical Policy advisory Group
- 8/99 Reformatted, Combined Manual Wheelchairs and Electrical Wheelchair; added Medical Term Definitions.
- 2/00) Coding system change.
- 2/01 No change in criteria. Reaffirm. Coding system change.
- 4/01 Specialty Matched Consultant Advisory Panel review. Added statement, "There was an evaluation, either in a specialized seating/mobility clinic or by a physician and therapist who are knowledgeable about the consequences of long-term disability and the prescription of motorized wheelchairs." to criteria concerning when electric wheelchairs are covered.
- 4/02 Format changes.
- 10/02 Specialty Matched Consultant Advisory Panel review. No changes to policy. System coding changes.
- 8/12/04 Benefits Application and Billing/Coding sections updated for consistency. Individual codes listed for code ranges, E1210-E1213, E1220-E1223, E1240-E1298, and K0010-K0014 under Billing/Coding section. Added codes, K0650, K0651, K0652, K0653, K0654, K0655, K0656, K0657, K0658, K0659, K0660, K0661, K0662, K0663, K0664, K0665, K0666, K0667, K0668, and K0669 to policy.
- 9/09/04 Specialty Matched Consultant Advisory Panel review 08/27/2007 with no changes made to policy criteria. References added. Statement added in description to indicate that Power operated

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vehicles are addressed in a separate policy. Clarification made to "When Wheelchairs Are Covered" to say that it must be prescribed by a physician within the scope of his/her license. Added statement to 2c, "This evaluation must be completed by a professional as indicated above independent from the vendor supplying the equipment." Coding descriptions removed.

- 1/20/05 First quarter 2005 HCPCS codes E1229, E1239, E2205, E2206, E2291, E2292, E2293, E2294, E2368, E2369, E2370, E2601, E2602, E2603, E2604, E2605, E2606, E2607, E2608, E2609, E2610, E2611, E2612, E2613, E2614, E2615, E2616, E2617, E2618, E2619, E2620, E2621 added to Billing/Coding section of policy. Policy number added in key word section of policy.
- 2/16/06 Added statement to the section When Wheelchairs Are Not Covered that reads "For electrical or mechanical features that enhance basic equipment and that usually serve a convenience function." Added CPT code E2300 to Billing/Coding section of policy.
- 8/28/06 Information added to Description for clarity. In the section When Wheelchairs Are Covered, added phrase "Wheelchairs are considered medically necessary when used by the member for mobility in the performance of activities of daily living in his/her residence and when the criteria outlines below are met." Added item 1.c. "the member has the ability to self-propel his/her wheelchair." Added information to item 2 regarding criteria for coverage of electrically operated wheelchairs. Added item 4: "Wheelchairs that are specially adapted for children are medically necessary when the child is non-ambulatory and either requires more support than a regular wheelchair provides or is too small for a standard pediatric wheelchair." In the section When Wheelchairs Are Not Covered, deleted "upgrades for racing or sports" and added statement regarding noncovered options or accessories that are primarily for the purpose of allowing the member to perform leisure, recreation or sports activities. Also added statement "wheelchairs with stair climbing ability are considered not medically necessary." A table was added to Policy Guidelines section of special features or customizations with the usual indications for consideration when determining the wheelchair needs of a member. HCPCS codes and references updated. Specialty Matched Consultant Advisory Panel review 6/28/06. (adn)
- 10/30/06 CPT Codes in Billing/Coding Section updated. (adn)
- 03/12/07 Billing/Coding section updated to reflect 2007 HCPCS codes changes. (adn)
- 8/11/08 Reworded Item 2.c. in the When Wheelchairs Are Covered section to read: "There was an evaluation (must be completed by a professional independent from the vendor supplying the equipment) either in a specialized seating/mobility clinic or by a physician and therapist who are knowledgeable about the consequences of long-term disability and the prescription of electrically operated wheelchairs." This statement was also added to the Billing/Coding/Physician Documentation Information section. Reformatted the section When Wheelchairs Are Not Covered into a numbered list. Added "seat elevators" to Item 3.d. in the Non Covered section and to the Table in the Policy Guidelines section. Specialty Matched Consultant Advisory Panel review 6/19/08. (adn)
- 3/16/09 Clarified the difference between a shelf and a tray. In the When Covered section, Item 3.vi. a shelf or rack for a ventilator may be medically necessary. In the Not Covered section, Item 3.a. tray (attached to the front of the wheelchair) is a noncovered item. (adn)
- 6/22/10 Policy Number(s) removed (amw)
- 4/26/11 Specialty Matched Consultant Advisory Panel review meeting 12/2010. (lpr)
- 10/11/11 Specialty Matched Consultant Advisory Panel review 9/28/2011. Under "When Covered" deleted reference to IC (Individual Consideration). Under "Benefits Application" added benefit disclaimer. Under "When Not Covered" added not medically necessary statement to #3: Seat elevators for manually and electrically operated wheelchairs are considered not medically necessary when used solely for the convenience of the insured or the insured's family/caretaker. (lpr)

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1/1/2012 Added E0988, E2358-E2359 and E2626-E2633 to Billing/Coding section for 2012 code update. (lpr)

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Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.