

Local Medical Review Policies (LMRPs)

Motorized/Powered Wheelchair Bases

HCPCS CODES:

The appearance of a code in this section does not necessarily indicate coverage.

K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lightweight portable motorized/power wheelchair
K0014	Other motorized/power wheelchair base
K0460	Power add-on, to convert a manual wheelchair to motorized wheelchair, joystick control

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCES: Coverage Issues Manual 60-6, 60-9

DEFINITIONS:

Motorized/power wheelchairs (K0010, K0011, K0012) are characterized by:

Seat Width	14" - 18"
Seat Depth	16"
Seat Height	≥ 19 and ≤ 21 "
Back Height	Sectional 16" or 18"
Arm Style	Fixed height, detachable
Footplate Extension	16" - 21"
Footrests	Fixed or swingaway detachable

In addition, a lightweight power wheelchair (K0012) is characterized by:

Weight < 80 lbs. without battery
Folding back or collapsible frame

Wheelchair "poundage" (lbs.) represents the weight of the usual configuration of the wheelchair without frontriggings.

COVERAGE AND PAYMENT RULES:

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, "reasonable and necessary" are defined by the following coverage and payment rules.

A power wheelchair is covered when all of the following criteria are met:

- 1) The patient's condition is such that without the use of a wheelchair the patient would otherwise be bed or chair confined, and;
- 2) The patient's condition is such that a wheelchair is medically necessary and the patient is unable to operate a wheelchair manually and;

3) The patient is capable of safely operating the controls for the power wheelchair.

A patient who requires a power wheelchair usually is totally nonambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease/condition.

If the documentation does not support the medical necessity of a power wheelchair but does support the medical necessity of a manual wheelchair, payment is based on the allowance for the least costly medically appropriate alternative. However, if the power wheelchair has been purchased, and the manual wheelchair on which payment is based is in the capped rental category, the power wheelchair will be denied as not medically necessary.

Options that are beneficial primarily in allowing the patient to perform leisure or recreational activities are noncovered.

A power wheelchair is covered if the patient's condition is such that the requirement for a power wheelchair is long term (at least six months).

Payment is made for only one wheelchair at a time. Backup chairs are denied as not medically necessary. One month's rental of a wheelchair is covered if a patient-owned wheelchair is being repaired.

Reimbursement for the wheelchair codes includes all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement also includes support services, such as emergency services, delivery, set-up, education, and on-going assistance with use of the wheelchair.

CODING GUIDELINES:

Wheelchairs with individualized features which meet the needs of a particular patient are billed by selecting the correct code for the wheelchair base and then using appropriate codes for wheelchair options and accessories. (Refer to the Wheelchair Options and Accessories policy.) If the frame of the wheelchair is modified in a unique way to accommodate the patient, bill the code for the wheelchair base and bill the modification with code K0108 (wheelchair component or accessory, not otherwise specified).

Codes K0010 - K0014 are not used for manual wheelchairs with add-on power packs. Use the appropriate code for the manual wheelchair base provided (K0001 - K0009) and code K0460.

Codes E1210 - E1220 should only be used to bill for maintenance and service for an item for which the initial claim was paid to the local carrier prior to the transition to the DMERC.

A supplier wanting to know which code to use to describe a particular product should consult the Wheelchair Base Product Classification List published by the DMERC. Questions concerning the coding of items not on the list should be directed to the Statistical Analysis DMERC (SADMERC). For wheelchair bases not on the list, suppliers should use their knowledge of the product and the information in the Definition section of this policy to determine the correct code until a determination is published by the DMERC or they receive a response to a coding inquiry.

DOCUMENTATION:

For an item to be considered for coverage and payment by Medicare, the information submitted by the supplier must be corroborated by documentation in the patient's medical records that Medicare coverage criteria have been met. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals, or test reports. This documentation must be available to the DMERC upon request.

A certificate of medical necessity, which has been filled out, signed, and dated by the treating physician, must be kept on file by the supplier. The CMN for power wheelchairs is HCFA Form 843. This applies to the power add-on code K0460 as well as to the power wheelchair bases K0010-K0014.

The initial claim must include a copy of the CMN, if filed in hard copy. If the claim is filed electronically, the information on the CMN must be transcribed exactly into the GU0 record. (See the DMEPOS National Standard Format Matrix for details.) If additional medical necessity information is included, this would be transcribed into the HA0 record.

Power wheelchairs described by codes K0011 and K0014 are eligible for Advance Determination of Medicare Coverage (ADMC) only when a power tilt and/or power recline seating system or a non-joystick control device (e.g., head control, sip and puff, switch control) is ordered. Refer to the ADCM chapter in the Supplier Manual for details concerning the ADCM process. When billing K0014, the claim must include documentation indicating the brand name and model name/number of the base, and a statement documenting the medical necessity of this base for the particular patient including why another base (K0010-K0012) was not acceptable.

Accessories to the wheelchair base should be billed on the same claim. If additional claim forms are needed, charges should be carried over and the total should be entered on the last page.

Refer to the Supplier Manual for more information on orders, CMNs, medical records, and supplier documentation.

EFFECTIVE DATE:

Claims for dates of service on or after January 1, 2002.

This is a revision of a previously published policy.