

LCD for Wheelchair Seating (L15845)

Contractor Information

Contractor Name

[NHIC, Corp.](#)

Contractor Number

16003

Contractor Type

DME MAC

LCD Information

LCD ID Number

L15845

LCD Title

Wheelchair Seating

Contractor's Determination Number

WCS

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CMS National Coverage Policy**Primary Geographic Jurisdiction**

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

LCD Information

Oversight Region

Region I

DME Region LCD Covers

Jurisdiction A

Original Determination Effective Date

For services performed on or after 07/01/2004

Original Determination Ending Date

Revision Effective Date

For services performed on or after 12/01/2009

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

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" is defined by the following indications and limitations of coverage and/or medical necessity.

A general use seat cushion (E2601,E2602) and a general use wheelchair back cushion (E2611-E2612) is covered for a patient who has a manual wheelchair or a power wheelchair with a sling/solid seat/back which meets Medicare coverage criteria. If the patient does not have a covered wheelchair, then the cushion will be denied as not medically necessary. If the patient has a POV or a power wheelchair with a captain's chair seat, the cushion will be denied as not medically necessary.

If a general use seat and/or back cushion is provided with a power wheelchair with a sling/solid seat/back, total payment for those items (cushion(s) plus the wheelchair) will be based on the allowance for the least costly medically appropriate alternative – e.g., the code for the comparable power wheelchair with Captain's Chair, if that code exists. (See Power Mobility Device policy for additional information.)

If the patient has a POV or a power wheelchair with a captain's chair seat, a separate seat and/or back cushion will be denied as not medically necessary.

A skin protection seat cushion (E2603, E2604, K0734, K0735) is covered for a patient who meets both of the following criteria:

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1. The patient has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the patient meets Medicare coverage criteria for it; and
2. The patient has either of the following:
 - a. Current pressure ulcer (ICD-9-CM codes 707.03, 707.04, 707.05) or past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface; or
 - b. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1), other spinal cord disease (336.0-336.3), multiple sclerosis (340), other demyelinating disease (341.0-341.9), cerebral palsy (343.0-343.9), anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9), post polio paralysis (138), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.0-330.9), Alzheimer's disease (331.0), Parkinson's disease (332.0), muscular dystrophy (359.0, 359.1), hemiplegia (342.00 – 342.92, 438.20-438.22), Huntignton's chorea (333.4), idiopathic torsion dystonia (333.6), athetoid cerebral palsy (333.71).

A positioning seat cushion (E2605, E2606), positioning back cushion (E2613-E2616, E2620, E2621), and positioning accessory (E0955-E0957, E0960) is covered for a patient who meets both of the following criteria:

1. The patient has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the patient meets Medicare coverage criteria for it; and
2. The patient has any significant postural asymmetries that are due to one of the diagnoses listed in criterion 2b above or to one of the following diagnoses: monoplegia of the lower limb (344.30-344.32, 438.40-438.42) due to stroke, traumatic brain injury, or other etiology, spinocerebellar disease (334.0-334.9), above knee leg amputation (897.2-897.7), osteogenesis imperfecta (756.51), transverse myelitis (323.82).

A headrest (E0955) is also covered when the patient has a covered manual tilt-in-space, manual semi or fully reclining back on a manual wheelchair, a manual fully reclining back on a power wheelchair, or power tilt and/or recline power seating system.

If the patient has a POV or a power wheelchair with a captain's chair seat, a headrest or other positioning accessory will be denied as not medically necessary.

A combination skin protection and positioning seat cushion (E2607, E2608, K0736, K0737) is covered for a patient who meets the criteria for both a skin protection seat cushion and a positioning seat cushion.

If a skin protection seat cushion, positioning seat cushion, or combination skin protection and positioning seat cushion is provided for a patient who does not meet the stated coverage criteria, but the coverage criteria for another type of cushion are met, payment will be based on the allowance for the least costly medically appropriate alternative; if the criteria for a another type of seat cushion are not met, the provided cushion will be denied as not medically necessary.

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If a positioning back cushion is provided for a patient who does not meet the stated coverage criteria, but the coverage criteria for a general use back cushion are met, payment will be based on the allowance for the least costly medically appropriate alternative, E2611 or E2612; if the criteria for a general use back cushion are not met, the provided cushion will be denied as not medically necessary.

If a positioning accessory is provided and the criteria are not met, the item will be denied as not medically necessary.

A custom fabricated seat cushion (E2609) is covered if criteria (1) and (3) are met. A custom fabricated back cushion (E2617) is covered if criteria (2) and (3) are met:

1. Patient meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion;
2. Patient meets all of the criteria for a prefabricated positioning back cushion;
3. There is a comprehensive written evaluation by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), which clearly explains why a prefabricated seating system is not sufficient to meet the patient's seating and positioning needs. The PT or OT may have no financial relationship with the supplier.

If a custom fabricated cushion is provided for a patient who does not meet the stated coverage criteria, but the coverage criteria for another type of cushion are met, payment will be based on the allowance for the least costly medically appropriate alternative; if the criteria for another type of cushion are not met, the custom fabricated cushion will be denied as not medically necessary.

A seat or back cushion that is provided for use with a transport chair (E1037, E1038) will be denied as not medically necessary.

The effectiveness of a powered seat cushion (E2610) has not been established. Claims for a powered seat cushion will be denied as not medically necessary.

A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion which has not received a written coding verification from the Pricing, Data Analysis and Coding (PDAC) contractor or which does not meet the criteria stated in the Coding Guidelines section (see Policy Article) will be denied as not medically necessary.

Coding Information

CPT/HCPCS Codes

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

HCPCS MODIFIERS:

EY - No physician or other licensed healthcare provider order for this item or service

GA - Waiver of liability statement on file

GZ - Item or service expected to be denied as not reasonable and necessary

KX - Requirements specified in the medical policy have been met

Coding Information

HCPCS CODES:

SEAT CUSHIONS:

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

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

E2609 CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE

E2610 WHEELCHAIR SEAT CUSHION, POWERED

K0734 SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH

K0735 SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH

K0736 SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH

K0737 SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH

BACK CUSHIONS:

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

E2614 POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, 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

E2617 CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE

Coding Information

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

POSITIONING ACCESSORIES:

E0955 WHEELCHAIR ACCESSORY, HEADREST, CUSHIONED, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH

E0956 WHEELCHAIR ACCESSORY, LATERAL TRUNK OR HIP SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH

E0957 WHEELCHAIR ACCESSORY, MEDIAL THIGH SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH

E0960 WHEELCHAIR ACCESSORY, SHOULDER HARNESS/STRAPS OR CHEST STRAP, INCLUDING ANY TYPE MOUNTING HARDWARE

E0966 MANUAL WHEELCHAIR ACCESSORY, HEADREST EXTENSION, EACH

E1028 WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE FOR JOYSTICK, OTHER CONTROL INTERFACE OR POSITIONING ACCESSORY

MISCELLANEOUS:

A9900 MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE

E0992 MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT INSERT

E2231 MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE

E2291 BACK, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE

E2292 SEAT, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE

E2293 BACK, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE

E2294 SEAT, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE

E2619 REPLACEMENT COVER FOR WHEELCHAIR SEAT CUSHION OR BACK CUSHION, EACH

K0108 WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED

K0669 WHEELCHAIR ACCESSORY, WHEELCHAIR SEAT OR BACK CUSHION, DOES NOT MEET SPECIFIC CODE CRITERIA OR NO WRITTEN CODING VERIFICATION FROM DME PDAC

ICD-9 Codes that Support Medical Necessity

The presence of an ICD-9 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on Indications and Limitation of Coverage and/or Medical Necessity for other coverage criteria and payment information.

Coding Information

For HCPCS codes E2603, E2604, K0734, K0735:

138	LATE EFFECTS OF ACUTE POLIOMYELITIS
330.0 - 330.9	LEUKODYSTROPHY - UNSPECIFIED CEREBRAL DEGENERATION IN CHILDHOOD
331.0	ALZHEIMER'S DISEASE
332.0	PARALYSIS AGITANS
333.4	HUNTINGTON'S CHOREA
333.6	GENETIC TORSION DYSTONIA
333.71	ATHETOID CEREBRAL PALSY
335.0 - 335.21	WERDNIG-HOFFMANN DISEASE - PROGRESSIVE MUSCULAR ATROPHY
335.23 - 335.9	PSEUDOBULBAR PALSY - ANTERIOR HORN CELL DISEASE UNSPECIFIED
336.0 - 336.3	SYRINGOMYELIA AND SYRINGOBULBIA - MYELOPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE
340	MULTIPLE SCLEROSIS
341.0 - 341.9	NEUROMYELITIS OPTICA - DEMYELINATING DISEASE OF CENTRAL NERVOUS SYSTEM UNSPECIFIED
342.00 - 342.92	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE - UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
343.0 - 343.9	CONGENITAL DIPLEGIA - INFANTILE CEREBRAL PALSY UNSPECIFIED
344.00 - 344.1	QUADRIPLEGIA UNSPECIFIED - PARAPLEGIA
359.0	CONGENITAL HEREDITARY MUSCULAR DYSTROPHY
359.1	HEREDITARY PROGRESSIVE MUSCULAR DYSTROPHY
438.20 - 438.22	HEMIPLEGIA AFFECTING UNSPECIFIED SIDE - HEMIPLEGIA AFFECTING NONDOMINANT SIDE
707.03 - 707.05	PRESSURE ULCER, LOWER BACK - PRESSURE ULCER, BUTTOCK
741.00 - 741.93	SPINA BIFIDA UNSPECIFIED REGION WITH HYDROCEPHALUS - SPINA BIFIDA LUMBAR REGION WITHOUT HYDROCEPHALUS

For HCPCS codes E0956-E0957, E0960, E2605, E2606, E2613-E2617, E2620, and E2621:

138	LATE EFFECTS OF ACUTE POLIOMYELITIS
323.82	OTHER CAUSES OF MYELITIS
330.0 - 330.9	LEUKODYSTROPHY - UNSPECIFIED CEREBRAL DEGENERATION IN CHILDHOOD
331.0	ALZHEIMER'S DISEASE

Coding Information

332.0	PARALYSIS AGITANS
333.4	HUNTINGTON'S CHOREA
333.6	GENETIC TORSION DYSTONIA
333.71	ATHETOID CEREBRAL PALSY
334.0 - 334.9	FRIEDREICH'S ATAXIA - SPINOCEREBELLAR DISEASE UNSPECIFIED
335.0 - 335.21	WERDNIG-HOFFMANN DISEASE - PROGRESSIVE MUSCULAR ATROPHY
335.23 - 335.9	PSEUDOBULBAR PALSY - ANTERIOR HORN CELL DISEASE UNSPECIFIED
336.0 - 336.3	SYRINGOMYELIA AND SYRINGOBULBIA - MYELOPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE
340	MULTIPLE SCLEROSIS
341.0 - 341.9	NEUROMYELITIS OPTICA - DEMYELINATING DISEASE OF CENTRAL NERVOUS SYSTEM UNSPECIFIED
342.00 - 342.92	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE - UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
343.0 - 343.9	CONGENITAL DIPLEGIA - INFANTILE CEREBRAL PALSY UNSPECIFIED
344.00 - 344.1	QUADRIPLEGIA UNSPECIFIED - PARAPLEGIA
344.30 - 344.32	MONOPLÉGIA OF LOWER LIMB AFFECTING UNSPECIFIED SIDE - MONOPLÉGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
359.0	CONGENITAL HEREDITARY MUSCULAR DYSTROPHY
359.1	HEREDITARY PROGRESSIVE MUSCULAR DYSTROPHY
438.20 - 438.22	HEMIPLEGIA AFFECTING UNSPECIFIED SIDE - HEMIPLEGIA AFFECTING NONDOMINANT SIDE
438.40 - 438.42	MONOPLÉGIA OF LOWER LIMB AFFECTING UNSPECIFIED SIDE - MONOPLÉGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
741.00 - 741.93	SPINA BIFIDA UNSPECIFIED REGION WITH HYDROCEPHALUS - SPINA BIFIDA LUMBAR REGION WITHOUT HYDROCEPHALUS
756.51	OSTEOGENESIS IMPERFECTA
897.2 - 897.7	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL AT OR ABOVE KNEE WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) BILATERAL (ANY LEVEL) COMPLICATED
For HCPCS codes E2607, E2608, K0736, K0737, <u>either</u> 1) One of the following ICD-9 codes	
138	LATE EFFECTS OF ACUTE POLIOMYELITIS
330.0 - 330.9	LEUKODYSTROPHY - UNSPECIFIED CEREBRAL DEGENERATION IN CHILDHOOD
331.0	ALZHEIMER'S DISEASE

Coding Information

332.0	PARALYSIS AGITANS
333.4	HUNTINGTON'S CHOREA
333.6	GENETIC TORSION DYSTONIA
333.71	ATHETOID CEREBRAL PALSY
335.0 - 335.21	WERDNIG-HOFFMANN DISEASE - PROGRESSIVE MUSCULAR ATROPHY
335.23 - 335.9	PSEUDOBULBAR PALSY - ANTERIOR HORN CELL DISEASE UNSPECIFIED
336.0 - 336.3	SYRINGOMYELIA AND SYRINGOBULBIA - MYELOPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE
340	MULTIPLE SCLEROSIS
341.0 - 341.9	NEUROMYELITIS OPTICA - DEMYELINATING DISEASE OF CENTRAL NERVOUS SYSTEM UNSPECIFIED
342.00 - 342.92	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE - UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
343.0 - 343.9	CONGENITAL DIPLEGIA - INFANTILE CEREBRAL PALSY UNSPECIFIED
344.00 - 344.1	QUADRIPLEGIA UNSPECIFIED - PARAPLEGIA
359.0	CONGENITAL HEREDITARY MUSCULAR DYSTROPHY
359.1	HEREDITARY PROGRESSIVE MUSCULAR DYSTROPHY
438.20 - 438.22	HEMIPLEGIA AFFECTING UNSPECIFIED SIDE - HEMIPLEGIA AFFECTING NONDOMINANT SIDE
741.00 - 741.93	SPINA BIFIDA UNSPECIFIED REGION WITH HYDROCEPHALUS - SPINA BIFIDA LUMBAR REGION WITHOUT HYDROCEPHALUS
Or 2) A combination of ICD-9 code 707.03, 707.04, or 707.05 AND one of the following ICD-9 codes:	
323.82	OTHER CAUSES OF MYELITIS
334.0 - 334.9	FRIEDREICH'S ATAXIA - SPINOCEREBELLAR DISEASE UNSPECIFIED
344.30 - 344.32	MONOPLÉGIA OF LOWER LIMB AFFECTING UNSPECIFIED SIDE - MONOPLÉGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
438.40 - 438.42	MONOPLÉGIA OF LOWER LIMB AFFECTING UNSPECIFIED SIDE - MONOPLÉGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
756.51	OSTEOGENESIS IMPERFECTA
897.2 - 897.7	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL AT OR ABOVE KNEE WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) BILATERAL (ANY LEVEL) COMPLICATED

Coding Information

For HCPCS code E2609

138	LATE EFFECTS OF ACUTE POLIOMYELITIS
323.82	OTHER CAUSES OF MYELITIS
330.0 - 330.9	LEUKODYSTROPHY - UNSPECIFIED CEREBRAL DEGENERATION IN CHILDHOOD
331.0	ALZHEIMER'S DISEASE
332.0	PARALYSIS AGITANS
333.4	HUNTINGTON'S CHOREA
333.6	GENETIC TORSION DYSTONIA
333.71	ATHETOID CEREBRAL PALSY
334.0 - 334.9	FRIEDREICH'S ATAXIA - SPINOCEREBELLAR DISEASE UNSPECIFIED
335.0 - 335.21	WERDNIG-HOFFMANN DISEASE - PROGRESSIVE MUSCULAR ATROPHY
335.23 - 335.9	PSEUDOBULBAR PALSY - ANTERIOR HORN CELL DISEASE UNSPECIFIED
336.0 - 336.3	SYRINGOMYELIA AND SYRINGOBULBIA - MYELOPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE
340	MULTIPLE SCLEROSIS
341.0 - 341.9	NEUROMYELITIS OPTICA - DEMYELINATING DISEASE OF CENTRAL NERVOUS SYSTEM UNSPECIFIED
342.00 - 342.92	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE - UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
343.0 - 343.9	CONGENITAL DIPLEGIA - INFANTILE CEREBRAL PALSY UNSPECIFIED
344.00 - 344.1	QUADRIPLEGIA UNSPECIFIED - PARAPLEGIA
344.30 - 344.32	MONOPLÉGIA OF LOWER LIMB AFFECTING UNSPECIFIED SIDE - MONOPLÉGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
359.0	CONGENITAL HEREDITARY MUSCULAR DYSTROPHY
359.1	HEREDITARY PROGRESSIVE MUSCULAR DYSTROPHY
438.20 - 438.22	HEMIPLEGIA AFFECTING UNSPECIFIED SIDE - HEMIPLEGIA AFFECTING NONDOMINANT SIDE
438.40 - 438.42	MONOPLÉGIA OF LOWER LIMB AFFECTING UNSPECIFIED SIDE - MONOPLÉGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
707.03 - 707.05	PRESSURE ULCER, LOWER BACK - PRESSURE ULCER, BUTTOCK
741.00 - 741.93	SPINA BIFIDA UNSPECIFIED REGION WITH HYDROCEPHALUS - SPINA BIFIDA LUMBAR REGION WITHOUT HYDROCEPHALUS
756.51	OSTEOGENESIS IMPERFECTA

Coding Information

[897.2 -](#) TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL AT OR
[897.7](#) ABOVE KNEE WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF LEG(S)
(COMPLETE) (PARTIAL) BILATERAL (ANY LEVEL) COMPLICATED

For HCPCS codes E0955, E2601, E2602, E2611, E2612, and E2619:
Not Specified

For codes E2610 and K0669:
None

Diagnoses that Support Medical Necessity

Refer to previous section.

ICD-9 Codes that DO NOT Support Medical Necessity

For the specific HCPCS codes indicated above, all ICD-9 codes that are not specified in the preceding section.

For HCPCS codes E2610 and K0669, all ICD-9 codes

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

For the specific HCPCS codes indicated above, all diagnoses that are not specified in the previous section.

For HCPCS codes E2610 and K0669, all diagnoses.

General Information

Documentation Requirements

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. 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 and test reports. This documentation must be available upon request.

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request.

For cushions and positioning accessories provided at the time of initial issue of a power wheelchair, once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician's order, the supplier must prepare a written document (termed a detailed product description) that lists the specific base (HCPCS code and either a narrative description of the item or the manufacturer name/model) and all options and accessories that will be separately billed. The supplier must list their charge and the Medicare fee schedule allowance for each separately billed item. If there is no fee schedule allowance, the supplier must enter "not applicable". The physician must sign and date this detailed product description and the supplier must receive it prior to delivery of the PWC. A date stamp or equivalent must be used to document receipt date. The detailed product description must be available on request.

For items provided other than at the time of initial issue of a power wheelchair, there must be a detailed written order which lists each item which will be separately billed and which is signed and dated by the physician. In these situations, the supplier's charges and Medicare allowances do not need to be included. This order must be received prior to delivery of cushion.

General Information

Items delivered before a signed written order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

The ICD-9 code which justifies the need for these items must be included on the claim.

KX MODIFIER:

For a skin protection seat cushion (E2603, E2604, K0734, K0735), a KX modifier should be added to the code if either criterion (a), (b), or (c) is met:

- a. If there is a past history of or current pressure ulcer in the area of contact with the seating surface; or
- b. If there is absent or impaired sensation in the area of contact with the seating surface due to one of the diagnoses listed as a covered diagnosis; or
- c. If there is an inability to carry out a functional weight shift due to one of the diagnoses listed as a covered diagnosis.

For a positioning seat cushion (E2605, E2606), positioning back cushion (E2613-E2616, E2620, E2621), or positioning accessory (E0956-E0957, E0960), a KX modifier should be added to the code if the patient has significant postural asymmetries due to one of the diagnoses listed as a covered diagnosis.

For a headrest (E0955), a KX modifier should be added to the code if one of the coverage criteria specified in the Indications and Limitations of Coverage section has been met.

For a combination skin protection and positioning seat cushion (E2607, E2608, K0736, K0737), a KX modifier should be added to the code if criterion (a) or (b) or (c) is met and criterion (d) is met:

- a. If there is a past history or current pressure ulcer in the area of contact with the seating surface; or
- b. If there is absent or impaired sensation in the area of contact with the seating surface due one of the diagnoses listed as a covered diagnosis for skin protection cushions (except 707.03, 707.04, 707.05); or
- c. If there is an inability to carry out a functional weight shift due one of the diagnoses listed as a covered diagnosis for skin protection cushions (except 707.03, 707.04, 707.05); and
- d. If the patient has significant postural asymmetries due to one of the diagnoses listed as a covered diagnosis for positioning cushions.

For a custom fabricated seat or back cushion (E2609, E2617), a KX modifier should be added to the code if criterion (a) is met and criterion (b), (c), or (d) is met:

- a. For E2609 or E2617, there is a comprehensive written evaluation by a licensed/certified medical professional, such as a PT or OT (who has no financial relationship with the supplier) which explains why a prefabricated seating system is not sufficient to meet the patient's seating and positioning needs; and
- b. For E2609, there is a past history of or current pressure ulcer in the area of contact with the seating surface; or
- c. For E2609, there is absent or impaired sensation in the area of contact with the seating surface or an inability to carry out a functional weight shift due to one of the diagnoses listed

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- as a covered diagnosis for skin protection cushions; or
- d. For E2609 or E2617, the patient has significant postural asymmetries due to one of the diagnoses listed as a covered diagnosis for positioning cushions.

GA AND GZ MODIFIERS:

In all of the situations above describing use of the KX modifier, if all of the coverage criteria have not been met, the GA or GZ modifier must be added to a claim line for the seat or back cushion or positioning accessory. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claim lines billed without a GA, GZ or KX modifier will be rejected as missing information.

MISCELLANEOUS

When billing for a custom fabricated cushion (E2609, E2617), the claim must include the manufacturer and model name/ number of the product (if applicable), or if not, a detailed description of the product that was provided.

Refer to the Supplier Manual for more information on documentation requirements.

Appendices

Utilization Guidelines

Sources of Information and Basis for Decision

Advisory Committee Meeting Notes

Start Date of Comment Period

12/03/2001

End Date of Comment Period

01/21/2002

Start Date of Notice Period

03/01/2004

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Revision History Number

WCS011

Revision History Explanation

Revision Effective Date: 12/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Hemiplegia, Huntington's chorea, idiopathic torsion dystonia, and cerebral palsy to the list of covered conditions for skin protection seat cushions.

Added: Above knee amputations, osteogenesis imperfecta, and transverse myelitis to the list of covered conditions for positioning seat and back cushions and positioning accessories.

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: Corresponding ICD-9 codes.

Moved: 359.0, 359.1 from second group of codes to the first group of codes for E2607, E2608, K0736, K0737.

HCPCS MODIFIERS:

Added: GA, GZ

Revised: KX modifier.

DOCUMENTATION REQUIREMENTS:

Added: Instructions for use of GA and GZ modifiers.

Revision Effective Date: 01/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Replaced: Reference to SADMERC with PDAC.

HCPCS CODES AND MODIFIERS:

Added: E2231

Revised: K0669

11/09/2008 - The description for CPT/HCPCS code K0669 was changed in group 4.

08/10/2008 - This policy was updated by the ICD-9 2008-2009 Annual Update.

03/01/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) LCD L15845 from DME PSC TriCenturion (77011) LCD L15845.

Revision Effective Date: 01/01/2008

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Muscular dystrophy to the list of covered diagnoses for prefabricated skin protection and combination skin protection and positioning seat cushions.

Removed: Instructions concerning solid seat support base (E2618).

HCPCS CODES AND MODIFIERS:

Added: K0108

Deleted: E2618

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: Muscular dystrophy (359.0, 359.1) to the list of covered diagnoses for prefabricated skin protection and combination skin protection and positioning seat cushions.

Removed: E2618

11/10/2007 - CPT/HCPCS code E2618 was deleted from group 4.

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: Duplicate paragraph.

06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia

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and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

Revision Effective Date: 11/15/2006

Implementation of the 10/01/2006 LCD revision has been delayed.

DOCUMENTATION REQUIREMENTS:

Revised: Instructions for detailed product description.

Revision Effective Date: 10/01/2006

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Least costly alternative statement regarding general use cushions.

Revised: Coverage criteria for all seat/back cushions and positioning accessories to identify their coverage with specific types of power mobility devices.

Revised: Statement concerning coverage of a headrest.

Revised: Wording which describes the clinician who performs the evaluation for a custom fabricated cushion.

Added: Statement concerning coverage of a seat cushion solid support base (E2618).

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Substituted: ICD-9 333.71 for 333.7 in three of the diagnosis sets.

DOCUMENTATION REQUIREMENTS:

Added: Requirement for detailed product description for items provided at the time of issue of a power wheelchair.

Revised: Wording which describes the clinician who performs the evaluation for a custom fabricated cushion.

Revision Effective Date: 07/01/2006

INDICATIONS AND LIMITATIONS OF COVERAGE:

Substituted: New codes for adjustable seat cushions.

HCPCS CODES:

Added: K0734, K0735, K0736, K0737

Discontinued: K0108

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY;

Substituted: New codes for adjustable seat cushions.

Corrected by deleting A9900 in last group.

DOCUMENTATION REQUIREMENTS:

Substituted: New codes for adjustable seat cushions.

Removed: Claim submission requirements for K0108.

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective Date: 10/01/2005

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Coverage criteria for headrests (E0955).

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY

Eliminated: Listing of ICD-9 codes for headrests.

DOCUMENTATION REQUIREMENTS:

Revised: KX modifier requirements for headrests.

Eliminated: Statement that additional documentation may be submitted with a claim if the KX modifier is not used.

SOURCES OF INFORMATION AND BASIS FOR DECISION:

Deleted: List of references.

Revision Effective Date: 04/01/2005

HCPCS CODES AND MODIFIERS:

Added: E2291-E2294

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Revision Effective Date: 01/01/2005

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: References to codes E2620, E2621.

Replaced: K codes with new E codes.

Added: Statements related to adjustable seat cushions.

HCPCS CODES:

Added: Codes E2620, E2621, E2618.

Replaced: K codes with new E codes (E2601-E2617, E2619).

ICD-9 CODES SUPPORTING MEDICAL NECESSITY:

Added: Codes E2620, E2621.

Replaced: K codes with new E codes.

Corrected: Diagnosis set for codes E2607 and E2608.

Added: Statements related to adjustable seat cushions.

DOCUMENTATION REQUIREMENTS:

Added: References to codes E2620, E2621.

Replaced: K codes with new E codes.

Revised: Item (d) under the KX modifier requirements for codes E2607 and E2608.

Added: Statements related to adjustable seat cushions.

Added: Claim submission requirements for custom fabricated cushions.

Revised: Claim submission requirements for K0108.

Revision Effective Date: 10/01/2004

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Acceptable diagnosis codes for decubitus ulcers.

ICD-9 CODES SUPPORTING MEDICAL NECESSITY:

Changed: Acceptable ICD-9 codes for decubitus ulcers from 707.0 to 707.03, 707.04, 707.05.

Corrected: Diagnosis set for K0658 to match the narrative description in the Indications and Limitations of Coverage section.

DOCUMENTATION REQUIREMENTS:

Revised: General requirements in paragraph 1.

Corrected: Code range for positioning accessories.

Revised: Acceptable diagnosis codes for decubitus ulcers.

Revision Effective Date: 07/01/2004

HCPCS CODES:

Added: E0966

DOCUMENTATION REQUIREMENTS:

Revised: Criteria for use of the KX modifier for combination skin protection and positioning seat cushions.

Reason for Change

Last Reviewed On Date

Related Documents

Article(s)

[A17918 - Wheelchair Seating - Policy Article - Effective January 2009](#)

LCD Attachments

There are no attachments for this LCD

Article for Wheelchair Seating - Policy Article - Effective January 2009 (A17918)

Contractor Information

Contractor Name

[NHIC, Corp.](#)

Contractor Number

16003

Contractor Type

DME MAC

Article Information

Article ID Number

A17918

Article Type

Article

Key Article

Yes

Article Title

Wheelchair Seating - Policy Article - Effective January 2009

Primary Geographic Jurisdiction

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

DME Region Article Covers

Jurisdiction A

Original Article Effective Date

07/01/2004

Article Information

Article Revision Effective Date

01/01/2009

Article Text

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

For an item addressed in this policy to be covered by Medicare, a written signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to the receipt of a written order, it will be denied as noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

There is no separate payment for a solid insert (E0992) (see definition in Coding Guidelines) that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion.

There is no separate payment for mounting hardware for a seat or back cushion.

There is no separate payment for a wheelchair seat or back cushion when it is used with a rollabout chair (E1031).

CODING GUIDELINES:

The following definitions of seat cushions include results of simulation testing or human subject testing. See the Testing Methodologies section for technical information about the required testing.

A general use seat cushion (E2601,E2602) is a prefabricated cushion, which has the following characteristics:

1. It has the following minimum performance characteristics:
 - a. Simulation tests demonstrate a loaded contour depth of at least 25mm with an overload deflection of at least 5 mm, or
 - b. Human subject tests demonstrate an average peak pressure index that is less than 125% of that of a standard reference cushion within the area of the ischial tuberosities and sacrum/coccyx; and
2. Following testing simulating 12 months of use:
 - a. Simulation tests demonstrate an overload deflection of at least 5 mm, or
 - b. Human subject tests demonstrate an average peak pressure index that is less than 125% of those of a standard reference cushion within the area of the ischial tuberosities and sacrum/coccyx; and
3. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
4. The cushion and cover meet the minimum standards of the California Bulletin 117 or 133 for flame resistance; and
5. It has a permanent label indicating the model and the manufacturer; and
6. It has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 12 months.

A nonadjustable skin protection seat cushion (E2603,E2604) is a prefabricated cushion, which has the following characteristics:

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1. It has the following minimum performance characteristics:
 - a. Simulation tests demonstrate a loaded contour depth of at least 40 mm with an overload deflection of at least 5 mm, or
 - b. Human subject tests demonstrate an average peak pressure index that is less than 85% of that of a standard reference cushion within the area of the ischial tuberosities and sacrum/coccyx; and
2. Following testing simulating 18 months of use:
 - a. Simulation tests demonstrate an overload deflection of at least 5 mm, or
 - b. Human subject tests demonstrate an average peak pressure index that is less than 85% of those of a standard reference cushion within the area of the ischial tuberosities and sacrum/coccyx; and
3. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
4. The cushion and cover meet the minimum standards of the California Bulletin 117 or 133 for flame resistance; and
5. It has a permanent label indicating the model and the manufacturer; and
6. It has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

An adjustable skin protection seat cushion (K0734, K0735) has all the characteristics of a E2603 or E2604 cushion and is determined to be adjustable by the PDAC.

A positioning seat cushion (E2605, E2606) is a prefabricated cushion that has the following characteristics:

1. It has the minimum structural features described in (a) or (b):
 - a. It has two or more of the following:
 - i. A pre-ischial bar or ridge which is placed anterior to the ischial tuberosities and prevents forward migration of the pelvis,
 - ii. Two lateral pelvic supports which are placed posterior to the trochanters and are intended to maintain the pelvis in a centered position in the seat and/or provide lateral stability to the pelvis,
 - iii. A medial thigh support which is placed in contact with the adductor region of the thigh and provides the prescribed amount of abduction and prevents adduction of the thighs ,
 - iv. Two lateral thigh supports which are placed anterior to the trochanters and provide lateral stability to the lower extremities and prevent unwanted abduction of the thighs.

The feature must be at least 25 mm in height in the pre-loaded state. Included in this definition are cushions which have a planar surface but have positioning features within the cushion which are made of a firmer material than the surface material; or

- b. It has two or more air compartments located in areas which address postural asymmetries, each of which must have a cell height of at least 50 mm, must allow the user to add or remove air, and must have a valve which retains the desired air volume; and
2. It has the following minimum performance characteristics:

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- a. Simulation tests demonstrate a loaded contour depth of at least 25mm with an overload deflection of at least 5 mm, or
 - b. Human subject tests demonstrate an average peak pressure index that is less than 125% of that of a standard reference cushion within the area of the ischial tuberosities and sacrum/coccyx; and
3. Following testing simulating 18 months of use:
- a. Simulation tests demonstrate an overload deflection of at least 5 mm, or
 - b. Human subject tests demonstrate an average peak pressure index that is less than 125% of those of a standard reference cushion within the area of the ischial tuberosities and sacrum/coccyx; and
4. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
5. The cushion and cover meet the minimum standards of the California Bulletin 117 or 133 for flame resistance; and
6. It has a permanent label indicating the model and the manufacturer; and
7. It has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

A positioning cushion may have materials or components that can be added or removed to help address orthopedic deformities or postural asymmetries.

A nonadjustable skin protection and positioning seat cushion (E2607, E2608) is a prefabricated cushion which has the following characteristics:

1. It has the minimum structural features described in (a) or (b):
 - a. It has two or more of the following:
 - i. A pre-ischial bar or ridge which is placed anterior to the ischial tuberosities and prevents forward migration of the pelvis,
 - ii. Two lateral pelvic supports which are placed posterior to the trochanters and are intended to maintain the pelvis in a centered position in the seat and/or provide lateral stability to the pelvis,
 - iii. A medial thigh support which is placed in contact with the adductor region of the thigh and provides the prescribed amount of abduction and prevents adduction of the thighs ,
 - iv. Two lateral thigh supports which are placed anterior to the trochanters and provide lateral stability to the lower extremities and prevent unwanted abduction of the thighs.

The feature must be at least 25 mm in height in the pre-loaded state. Included in this definition are cushions which have a planar surface but have positioning features within the cushion which are made of a firmer material than the surface material; or

- b. It has two or more air compartments located in areas which address postural asymmetries, each of which must have a cell height of at least 50 mm, must allow the user to add or remove air, and must have a valve which retains the desired air volume; and
2. It has the following minimum performance characteristics:
- a. Simulation tests demonstrate a loaded contour depth of at least 40mm with an overload deflection of at least 5 mm, or

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- b. Human subject tests demonstrate an average peak pressure index that is less than 85% of that of a standard reference cushion within the area of the ischial tuberosities and sacrum/coccyx; and
3. Following testing simulating 18 months of use:
 - a. Simulation tests demonstrate an overload deflection of at least 5 mm, or
 - b. Human subject tests demonstrate an average peak pressure index that is less than 85% of those of a standard reference cushion within the area of the ischial tuberosities and sacrum/coccyx; and
4. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
5. The cushion and cover meet the minimum standards of the California Bulletin 117 or 133 for flame resistance; and
6. It has a permanent label indicating the model and the manufacturer; and
7. It has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

An adjustable skin protection and positioning seat cushion (K0736, K0737) has all the characteristics of a E2607 or E2608 cushion and is determined to be adjustable by the PDAC. The adjustability feature only relates to the skin protection properties of the cushion.

A general use back cushion (E2611, E2612) is a prefabricated cushion, which has the following characteristics:

1. It is planar or contoured; and
2. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
3. The cushion and cover meet the minimum standards of the California Bulletin 117 or 133 for flame resistance; and
4. It has a permanent label indicating the model and the manufacturer; and
5. It has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 12 months.

A positioning back cushion (E2613-E2616, E2620, E2621) is a prefabricated cushion which has the following characteristics:

1. For codes E2613-E2616, there is at least 25 mm of posterior contour in the pre-loaded state. A posterior contour is a backward curve measured from a vertical line in the midline of the cushion; and
2. For posterior-lateral cushions (E2615, E2616) and for planar cushions with lateral supports (E2620, E2621), there is at least 75 mm of lateral contour in the pre-loaded state. A lateral contour is a backward curve measured from a horizontal line connecting the lateral extensions of the cushion; and
3. For posterior pelvic cushions (E2613, E2614), there is mounting hardware that is adjustable for vertical position, depth, and angle.
4. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
5. The cushion and cover meet the minimum standards of the California Bulletin 117 or 133 for flame resistance; and
6. It has a permanent label indicating the model and the manufacturer; and
7. It has a warranty that provides for repair or full replacement if manufacturing defects are

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identified or the surface does not remain intact due to normal wear within 18 months.

Included in this definition are cushions which have a planar surface but have positioning features within the cushion which are made of a firmer material than the surface material.

A positioning back cushion may have materials or components that may be added or removed to help address orthopedic deformities or postural asymmetries.

A custom fabricated seat cushion (E2609) and a custom fabricated back cushion (E2617) are cushions that are individually made for a specific patient starting with basic materials including:

- a. liquid foam or a block of foam and
- b. sheets of fabric or liquid coating material.

The cushion must be fabricated using molded-to-patient-model technique, direct molded-to-patient technique, CAD-CAM technology, or detailed measurements of the patient used to create a configured cushion. The cushion must have structural features that significantly exceed the minimum requirements for a seat or back positioning cushion. The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface. A custom fabricated cushion may include certain prefabricated components (e.g., gel or multi-cellular air inserts); these components must not be billed separately. If a custom fabricated seat and back are integrated into a one-piece cushion, code as E2609 plus E2617.

If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual patient, the cushion must be billed as a prefabricated cushion, not custom fabricated.

A powered wheelchair seat cushion (E2610) is a battery-powered, prefabricated cushion in which an air pump provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the cushion. One type of powered seat cushion is an alternating pressure cushion.

Pediatric seating system codes E2291-E2294 may only be billed with pediatric wheelchair base codes.

A headrest extension (E0966) is a sling support for the head. Code E0955 describes any type of cushioned headrest.

The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, that is an integral part of the cushion.

A solid insert is a separate rigid piece of wood or plastic which is inserted in the cover of a cushion to provide additional support. If a supplier chooses to bill separately for a solid insert used with a seat cushion use code E0992 whether it is a manual or a power wheelchair. Code A9900 must be used for a solid insert used with a back cushion.

A solid support base for a seat cushion is a rigid piece of plastic or other material which is attached with hardware to the seat frame of a wheelchair in place of a sling seat. A cushion is placed on top of the support base. Use code E2231 for a solid support base that is used with a manual wheelchair. A solid support base is included in the allowance for the power wheelchair codes. There should be no separate billing with power wheelchairs.

If a supplier chooses to bill separately for mounting hardware, either nonadjustable or adjustable, for a seat or back cushion or solid support base, code A9900 must be used.

The only products which may be billed using codes E2601-E2608, E2611-E2616, E2620, E2621, and

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K0734-K0737 and the only brand name products that may be billed using codes E2609 or E2617 are those products for which a written coding verification has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor. Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Request can be found on the PDAC web site or by contacting the PDAC. A Product Classification List with products which have received a coding verification can be found on the PDAC web site.

If a nonpowered, prefabricated seat cushion, a prefabricated back cushion, or a brand name custom fabricated seat or back cushion has not received a written coding verification from the PDAC or if it is determined that the cushion does not meet the criteria for the code, it must be billed with code K0669.

Pediatric size positioning accessories are billed with the codes described in this policy. Codes E1025-E1027 (lateral thoracic and lateral/anterior supports) are invalid for claim submission.

Code E1028 (swingaway or removable mounting hardware upgrade) may be billed in addition to codes E0955-E0957. It must not be billed in addition to code E0960. It must not be used for mounting hardware related to a wheelchair seat cushion or back cushion code.

TESTING METHODOLOGY

There are two testing methods that may be used to document wheelchair seat cushion criteria: the simulation method and the human subject method. Simulation tests are used to measure loaded contour depth and bottoming out. Human subject tests are used to measure peak interface pressure.

Simulation Test

Simulation tests measure loaded contour depth and bottoming out. They use standardized models of the human buttocks known as cushion-loading indenters (CLIs). There are two CLIs that are used for simulation testing, a 25 mm CLI and a 40 mm CLI. Specific design features of acceptable CLIs can be found on the PDAC web site.

Test method for determining 25 mm and 40 mm of contour depth:

1. Place the test cushion on a flat, horizontal surface. Cushions with curved bases must be stable during contour measurement testing.
2. Align the CLI so that it is centered from the sides of the cushion and so that the ischial tuberosities of the models are 11-15 cm from the rear edge of the cushion. The ischial tuberosity portion of the CLI should be aligned with the analogous portion of the test cushion.
3. Load the CLI to 140 Newtons (31 pounds) & wait 5 minutes.
4. Contact of the lateral buttons with the cushion indicates that the cushion has contoured to 25 or 40 mm depending on the CLI used - i.e., that it has passed the test for that trial.
5. Repeat the test two times waiting 5 minutes between trials

A cushion must pass the respective contour test during all trials to meet the minimum criteria specified in the cushion definition section.

Overload test method for measuring bottoming out:

1. Record the height of the CLI from the horizontal surface at the end of the loaded contour

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depth test described above.

2. Add 47 Newtons (10 pounds) to the CLI and record the height from the horizontal surface after 1 minute.
3. Subtract the height at overload (#2) from the height at standard load (#1).
4. Round the value in #3 to the nearest 5mm.
5. Remove the overload weight and repeat the test twice, waiting 5 minutes between tests and measuring the height in #1 and #2 each time.
6. Determine the median of the three values recorded in #4. This is the "overload deflection".

If the overload deflection is greater than or equal to 5mm, then the cushion is determined not to have bottomed out during the test.

Simulated use testing:

There must be simulation of 12 or 18 months of use of the cushion (depending on the cushion type - see Definitions section). Following simulated use, the measurements for loaded contour depth and overload as described above must be repeated.

Test report:

There must be a report of the tests which includes:

1. The name and address of the facility performing the tests and the date(s) of the tests; and
2. The manufacturer and brand name/number of the test cushion; and
3. The weight of the cushion to the nearest 250 gm; and
4. The width and length of the cushion; and
5. The temperature and relative humidity of the room where the tests are conducted; and
6. Identification of which CLI was used (25 mm or 40mm); and
7. The results of the three loaded contour depth tests and the overload deflection test prior to simulated used testing; and
8. A description of the method used to simulate cushion use;
9. A statement specifying the number of months of use that were simulated; and
10. Measurements as described in #7 obtained after simulated use testing; and
11. A statement attesting that the testing methodology described in this policy was followed; and
12. The printed name and signature of the person performing or supervising the tests and the signature date.

Human Subject Tests

The ability to demonstrate that there is an important reduction in interface pressure in comparison with a standard reference cushion when tested with human subjects is the basis for this approach. Human subject tests must be performed by an entity that has received human subject testing approval from an Institutional Review Board approved by the US Department of Health and Human Services. Ten (10) wheelchair users must be studied, at least five of which must be clinically insensate on the body surface contacting the cushion.

Interface pressure measurements are taken with each subject seated on the cushion being tested as well as on a standardized reference cushion (see below). The measurements are obtained with a transducer placed on top of the cushion. Subjects must be seated on the cushion and interface pressure transducer for at least 60 seconds before data is collected. The subject should be positioned in their typical posture as determined by query and independent facility judgment. Three

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measurements are taken on each subject on each cushion separated by a complete unloading of the cushion for at least 60 seconds.

The standard reference cushion must be an uncovered 75 mm (\pm 5mm) thick high resiliency foam with a rated 25% indentation force deflection (IFD) equal to 45 pounds (density range of 2.6-2.9 pounds/cubic ft and IFD range of 40-49 pounds).

There must be a report of the tests which includes:

1. The name and address of the facility performing the tests and the date(s) of the tests; and
2. The manufacturer and brand name/number of the test cushion; and
3. Information about the interface pressure measurement device utilized:
 - a. Manufacturer and brand name
 - b. Date of most recent calibration
 - c. Percent error of measurement at 50 and 100 mm Hg pressure; and
4. Actual 25% IFD and density of the reference cushion (obtained from the foam manufacturer or supplier) and actual thickness of the reference cushion; and
5. Information on each subject (coding subjects to preserve confidentiality) including:
 - a. Age
 - b. Height
 - c. Weight
 - d. Disability
 - e. Buttocks sensation status; and
6. Interface pressure measurements for each subject on the test cushion and on the reference cushion:
 - a. If the transducer covers the entire seating area, the entire map showing the pressure in each cell must be submitted. The anatomical locations (as determined by palpation) of the right and left ischial tuberosities and the sacrum/coccyx must be identified on each map. (Data can be submitted as a hard copy map or utilizing the device software.) or,
 - b. If the transducer only covers a portion of the seat surface, measurements must be taken at the following three locations (as determined by palpation): right and left ischial tuberosities and sacrum/coccyx. The report must identify the anatomical location of each set of measurements. The report must list the pressure in each cell at each specified location. The values for the three locations are considered a single test; and
7. The Peak Pressure Index (PPI) for each subject on the test cushion and on the reference cushion. The PPI is determined as follows:
 - a. For each test, identify the cell in the sacro-ischial zone with the highest pressure;
 - b. Determine the greatest sum of pressures in the identified cell and the adjacent cells in a 9-10 square centimeter area. If there are multiple cells with the same "highest pressure", consider all of them in the determination of the "greatest sum". [Note: A 3 cm by 3 cm square or a 3.5 cm diameter circular area are examples of a 9-10 sq cm area. For example, if using an interface pressure sensing array with a cell size of 1 sq cm, 9 cells (a 3 by 3 array) are used and if using a sensing array with a cell size of 2.5 sq cm, 4 cells (a 2 by 2 array) are used.];
 - c. For each test, calculate the average of the cells with the greatest sum of pressures;
 - d. Calculate the average of the results obtained in step (c) for the 3 tests on the test cushion and the 3 tests on the reference cushion. These values are the PPIs for the subject on each cushion; and

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8. A statement attesting that the testing methodology described in this policy was followed;
and
9. The printed name and signature of the person performing or supervising the tests and the signature date.

To determine if the minimum performance characteristics specified in the Definitions section for a particular type of cushion have been met, calculate the average PPI for the 10 subjects on the test cushion and the average PPI for the 10 subjects on the reference cushion. Divide the average PPI on the test cushion by the average PPI on the reference cushion and multiply the value by 100 to give the percentage comparison of Peak Pressure Indexes. If the comparative pressures are less than the specified values (125% or 85% depending on the cushion), then the minimum performance characteristics with respect to pressure have been met.

Coding Information

No Coding Information has been entered in this section of the article.

Other Information

Other Comments

3/1/2008- In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A17918 from DME PSC TriCenturion (77011) Article A17918.

Revision History Explanation

Revision Effective Date: 01/01/2009

CODING GUIDELINES:

Revised: Guidelines for solid seat support base for manual wheelchair.

Replaced: References to SADMERC with PDAC.

3/1/2008- In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A17918 from DME PSC TriCenturion (77011) Article A17918.

Revision Effective Date: 01/01/2008

CODING GUIDELINES:

Revised: Guidelines for solid seat support base.

06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

Revision Effective Date: 11/15/2006

Implementation of the 10/1/2006 Policy Article revision has been delayed

Revision Effective Date: 10/01/2006

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Moved statement concerning coverage of seat cushion solid support base (E2618) to the LCD.

Deleted statement about separate coverage for headrests because this is now addressed in the LCD.

Revision Effective Date: 07/01/2006

Other Information

CODING GUIDELINES:

Substituted new codes for adjustable seat cushions.

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this article was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective Date: 04/01/2005

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Add nonpayment statement when a headrest is used with a captain's seat.

CODING GUIDELINES:

Added instructions for billing pediatric seating system codes E2291-E2294.

Revision Effective Date: 01/01/2005

CODING GUIDELINES:

Added references to codes E2620, E2621, E2618

Replaced K codes with new E codes

Revised definitions for skin protection seat cushions and for combination skin protection and positioning seat cushions to distinguish nonadjustable from adjustable cushions.

Specified that seat cushions billed with K0108 must have been confirmed by a Coding Verification

Review from the SADMERC

HCPCS CODES:

Eliminated this section from the article as the result of a CMS-directed format change

Revision Effective Date: 10/01/2004

CODING GUIDELINES:

Revised the description of a solid seat insert and solid support base.

Revision effective date: 07/01/2004

CODING GUIDELINES:

Added description of E0966 and E0955

Added K0660 and K0661 (General use back cushions) to the list of codes requiring Coding Verification Review by the SADMERC.

Added E1025-E1027, K0115, and K0116 to the list of codes that are invalid for claim submission to the DMERCs.

HCPCS CODES:

Added: E0966

Related Documents

LCD(s)

[L15845 - Wheelchair Seating](#)