



WHEELCHAIR BENEFIT COVERAGE STANDARD: MANUAL WHEELCHAIR BASES, POWER MOBILITY DEVICES, WHEELCHAIR SEATING AND WHEELCHAIR OPTIONS AND ACCESSORIES

Note: Capitalized terms within this Benefit Coverage Standard, which do not refer to the title of a benefit, program or organization, have the meaning specified within the *Definitions* section.

BRIEF COVERAGE STATEMENT

Durable medical equipment (DME) and disposable medical supplies (supplies) are a Health First Colorado benefit for the treatment or therapy of an illness or physical condition when safe and suitable for use in a non-institutional setting.

This Wheelchair Benefit Coverage Standard is supplemental to the Durable Medical Equipment and Disposable Medical Supplies section of the Colorado Medical Assistance Program rule under 10 C.C.R. 2505-10, Section 8.590.

Pages one through 15 of this Benefit Coverage Standard apply to all services described within the standard. Beginning on page 16, coverage is divided into the following benefit categories:

MANUAL WHEELCHAIR BASES (MWBS)

MWBs are a DME benefit for members with neurological, orthopedic, cardiopulmonary, or other conditions that affect their ability to sit or ambulate safely, timely, and functionally. The appropriate type of wheelchair is determined by assessment and evaluation of body size, medical, functional needs, basic and instrumental activities of life (ADLs or IADLs), and physical condition.

POWER MOBILITY DEVICES (PMDS)

PMDs include power operated medical vehicles (POVs) and power wheelchairs (PWCs). PMDs are a DME benefit for members with neurological, orthopedic, cardiopulmonary, or other conditions that affect their ability to sit or ambulate safely, timely, and functionally. PMDs are considered when alternative types of maneuverability controls are needed for ambulation for members who have limited functional strength, coordination, or endurance in their arms and torso. The appropriate type of wheelchair is determined by assessment and evaluation of body size, medical and functional needs, basic and instrumental activities of daily living (ADLs or IADLs) and physical condition.

WHEELCHAIR SEATING

Wheelchair seating includes devices which serve to support a seated or reclined position on a mobility base, to provide postural support, injury prevention, pain alleviation or skin protection. Many members who use wheelchairs require specific wheelchair seating products to address Impairments in body structures or functions such as decreased muscle strength, paralysis, abnormal muscle tone, limited range of motion, orthopedic asymmetries and poor sitting balance. Wheelchair seating devices include both primary and secondary support surfaces. Primary support surfaces include the seat cushion and back support and enable the individual to sit in the mobility system. Secondary supports are typically used to provide support or protection to the extremities (legs, arms, and head), or to help maintain a very specific posture or position of a certain body segment or area, such as the upper torso, buttocks/thighs or extremities.

Secondary support surfaces can be integrated into the primary seat and back supports to provide additional positioning functions, or they may be separate items attached to the wheelchair frame or primary supports via special hardware. Separate secondary supports include, but are not limited to, items such as a head support, lateral trunk supports, medial thigh supports, anterior shoulder straps, pelvic belts, and ankle straps.

WHEELCHAIR OPTIONS/ACCESSORIES (WO/AS)

WO/As include additional wheelchair components that are not provided as standard on a MWB or PMD. WO/As are a DME benefit for members with neurological, orthopedic, cardiopulmonary or other conditions that affect their ability to sit or ambulate safely and functionally. The appropriate WO/As are determined by assessment and evaluation of the client's medical and functional needs and physical condition. WOAs are covered when the member meets coverage criteria for a MWB or PMD and the WO/As are required for the member to complete ADLs or IADLs in the home, community, or any non-institutional setting in which ADLs or IADLs take place.

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SERVICES ADDRESSED IN OTHER BENEFIT COVERAGE STANDARDS

- Outpatient Physical Therapy and Occupational Therapy Services

ELIGIBLE PROVIDERS

RENDERING PROVIDERS

Rendering Provider refers to all accredited DME suppliers and pharmacies that use the DME-supply provider type. All Rendering Providers must be enrolled with Health First Colorado. Pharmacies must use the supply provider type for all DME-supply claims.

With the exception of pharmacies that receive less than 5.0% of total revenue from DME, suppliers must maintain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) accreditation through an authorized Centers for Medicare and Medicaid Services (CMS) accreditation organization. For more information on DMEPOS accreditation, please visit the CMS website here: www.cms.gov

PRESCRIBING PROVIDERS

The State of Colorado limits prescriptive authority to certain board-licensed professions. For the purposes of this Benefit Coverage Standard, prescribing provider refers to any of the following provider types:

- Physicians (MDs and DOs)
- Physician Assistants (PAs)
- Nurse Practitioners (NPs)

Note: Physical therapists (PTs) and occupational therapists (OTs) do not have prescriptive authority in Colorado; however, this does not preclude them from providing services related to proper assessment and fitting of wheelchairs and related items described in this coverage statement.

ELIGIBLE PLACE OF SERVICE

As outlined in 10 C.C.R. 2505-10, Section 8.590.2.B of the Colorado Medical Assistance Program rules, members enrolled in Health First Colorado are eligible to receive equipment and supplies through the DME and Supplies benefit as an outpatient service.

Rendering Providers are required to include coding that indicates the place of service when submitting claims. The eligible place of service for DME and supplies is not an indication of client's physical location at the time services are rendered but, rather, an indication of where

member resides. Members residing in a hospital or other facility must be provided necessary equipment and supplies by the facility, not through the DME benefit.

ELIGIBLE MEMBERS

Wheelchairs and wheelchair-related items are a covered benefit for Health First Colorado members who have a neurological, orthopedic, cardiopulmonary or other condition that affects their ability to sit or ambulate safely and functionally.

SPECIAL PROVISION: EXCEPTION TO POLICY LIMITATIONS FOR MEMBERS AGED 20 AND YOUNGER

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is the Health First Colorado program benefit for members ages 20 and younger. Under federal EPSDT requirements, the state Health First Colorado agency must cover medically necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan. Service limitations on scope, amount, duration, frequency, or other specific criteria described in this Benefit Coverage Standard may be exceeded or may not apply to EPSDT members if the requested service meets the requirements set forth in the EPSDT section of Colorado Medical Assistance Program rule under 10 C.C.R. 2505- 10, Section 8.280.

EPSDT does not require the state Health First Colorado agency to provide any service that is:

- Unsafe, ineffective, or experimental/investigational.
- Not generally recognized as an accepted method of medical practice or treatment.

COVERED SERVICES AND LIMITATIONS

Wheelchairs and wheelchair-related requests are reviewed on a case-by-case basis. Approval is based on documentation submitted by the eligible provider. In general, items will be considered for coverage if client's condition or diagnosis is such that, without the recommended item, member would be unable to sit or ambulate safely and functionally. Specific information on covered services and limitations are indicated in each of the four subparts of this Benefit Coverage Standard, which include MWBs, PMDs, Wheelchair Seating and WO/As.

Wheelchairs and wheelchair-related items are provided after all necessary evaluations, assessments, and documentation requirements have been completed, and medical necessity has been established as indicated in this Benefit Coverage Standard and its subparts.

PRIOR AUTHORIZATION REQUIREMENTS

Prior Authorization is required for purchase of all wheelchairs and wheelchair-related items as outlined in the Durable Medical Equipment (DME) & Supplies Billing Manual with notice of updates in Provider Bulletins; both found on the Department of Health Care Policy & Financing website at colorado.gov/hcpf.

The Prior Authorization Request (PAR) must be accompanied by documentation (see *Documentation Requirements* section), which is used by the Health First Colorado Utilization Management contractor to establish medical necessity. A physician, physician assistant or nurse practitioner who has seen member in the past year must sign the documentation indicating agreement with the recommendation. PARs must include the manufacturer, make, and model of the equipment. A quoted amount must be submitted with the PAR for all purchases or repairs.

The PAR is a determination of coverage based on medical necessity; approval does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, detailed provider information, all required attachments included, etc.). Please refer to the Durable Medical Equipment (DME) & Supplies Billing Manual and the current Fee Schedule (found at colorado.gov/hcpf) for billing information).

Note: Medical necessity is defined in 10 C.C.R 2505-10, Section 8.076.1.8 of the Colorado Medical Assistance Program rules.

DOCUMENTATION REQUIREMENTS

There are two levels of documentation requirements associated with PARs for wheelchairs and wheelchair-related items:

1. **Basic documentation requirements:** Basic documentation requirements apply to all wheelchairs and wheelchair-related items that require a PAR, as indicated in each of the subparts of this Benefit Coverage Standard. This level of documentation does not require a Specialty Evaluation.
2. **Specialty Evaluation documentation requirements:** Some Complex Rehabilitation Technology (CRT) items require Specialty Evaluation documentation, which provides further details in order to establish medical necessity. Items that require a Specialty Evaluation are outlined in the DME Billing Manual and must include both the basic and Specialty Evaluation documentation. If not required, a Specialty Evaluation may be submitted if either the therapist, ordering physician, supply provider, member or Health First Colorado Utilization Management contractor feel that the additional documentation will assist with establishing medical necessity.

BASIC DOCUMENTATION REQUIREMENTS (NO SPECIALTY EVALUATION REQUIRED):

MEDICAL NECESSITY DOCUMENTATION

All medical necessity documentation, as described below, requires the signature of the ordering physician, indicating that he or she agrees with the recommendation(s) and has evaluated the member within the past 12 months of signing and dating the required paperwork.

Note: Basic documentation for repair and replacement of wheelchair parts and accessories does not require the signature of the ordering physician.

All PARs must be accompanied by a letter of medical necessity that includes all of the following information:

- Client's name, date of birth, residence address, height and weight, and all relevant medical diagnoses.
- A summary of client's current medical condition, prognosis, and previous and current treatments that are pertinent to the requested item.
- Length of anticipated need for the requested item.
- A brief description of client's Impairment in functional mobility, which establishes that the member has a Mobility Limitation and that the requested item is medically necessary.
 - Documentation must contain a brief description of the Impairments in Body Functions or structures that rule out use of one type of item (for example, a scooter) over another (for example, a manual wheelchair).
- A description of how member will operate the MWB, PMD, and WO/As. This description must include a statement summarizing the client's mental and physical abilities and limitations, as they pertain to client's ability to operate the requested equipment appropriately for the duration of recommended use and in the environments in which it will routinely be used.
- If applicable, a brief description of client's seating and positioning needs, and how these will be adequately met by the recommended MWB, PMD, Seating and WO/As.
- If applicable, a brief description of where the equipment is to be used (e.g., home, school, place of work, neighborhood, rural, city, train,), including the accessibility of client's residence or non-institutional setting. Medical professional must attest to the capability of member or caregiver to properly operate the equipment in all applicable environments.

Note for DME Suppliers: Any PAR for equipment that will be transported in a vehicle should be accompanied by a description of how that equipment will be transported.

- A brief description of any anticipated changes in client's physical size, medical or functional status -which may require modifications to the equipment, and how the equipment should accommodate the client's needs over time.

Note for DME suppliers: When possible, equipment submitted for prior authorization should be capable of modification to meet the needs for anticipated improvement or deterioration of functional mobility.

- Any additional documentation required for the other components of the wheelchair that are indicated in the *Covered Services and Limitations* section of each subpart of this Benefit Coverage Standard.

ADDITIONAL DOCUMENTATION

Medical necessity documentation should be accompanied by a detailed description of all manually priced items that are requested, including manufacturer's retail pricing or invoice information with itemized pricing, including the description of the specific base, any attached seating system components, and any attached accessories.

SPECIALTY EVALUATION DOCUMENTATION REQUIREMENTS:

Specialty Evaluation is required for:

- A new CRT wheelchair or a replacement CRT wheelchair after the fifth year mark for adults and third year mark for children.
- A new custom contoured seating system or modification.
- An addition of power seating or alternative drive control to a wheelchair.

A Specialty Evaluation must be performed by a licensed or certified medical professional (such as a PT, OT, or physician) who:

- Has no Financial Relationship with the DME provider; and who
- Has a scope of services that includes specific training or experience in CRT wheelchairs or CRT wheelchair seating evaluations.

Note: Financial Relationship is defined in 10 C.C.R 2505-10, Sections 8.590.1 of the Colorado Medical Assistance Program rules.

INDEPENDENT DOCUMENTATION OF THE SPECIALTY EVALUATION

In addition to the Basic Documentation Requirements previously listed, the licensed medical professional must provide the following documentation demonstrating the medical necessity of each item that requires a specialty evaluation:

- Date(s) of Specialty Evaluation; name and signature of licensed/certified medical professional completing the evaluation and assessment.
- A signed statement attesting that the person performing the assessment has no financial relationship with the DME provider.

- A brief description of the Specialty Evaluation process that was completed, including a summary of the pertinent assessment findings and outcomes in the following assessment areas that apply:
 - Functional mobility, including transfers
 - Sitting balance/postural alignment
 - Existence and severity of postural asymmetries
 - Sensory function, if impaired
 - Neuromusculoskeletal function (movement, muscle tone, coordination)
 - Mat exam (joint range of motion, deformities, orthopedic Impairment), addressing the existence and severity of orthopedic deformities.
- Any observed equipment trials/simulations.
- Information on any recent changes in client's physical or functional status, and any expected or potential surgeries that will improve or further limit mobility.
- A summary of the type of mobility equipment that will best meet client's medical and functional needs, and an explanation of the activities of daily living that will be possible with this equipment that would not be possible with a lower level or lower cost item.
- If applicable, information regarding client's seating and positioning needs.
- If a tilt seat function is recommended, documentation supporting the necessity of a tilt seat function in order to meet client's medical or functional needs.
- If member has a progressive disability, documentation indicating how the item is expected to accommodate the client's needs over time.

Note: All medical necessity Specialty Evaluation documentation, as described above, requires the signature of the ordering physician, indicating that he or she agrees with the recommendation and has evaluated the member within the past 12 months of signing and dating the required paperwork.

ADDITIONAL SPECIALTY EVALUATION DOCUMENTATION

DME suppliers must provide the following additional documentation when submitting a PAR for item(s) that require a Specialty Evaluation:

- A description of the client's current mobility and seating equipment, how long the member has been using the current equipment, and why it no longer meets the member needs.
- If information regarding the client's seating and positioning needs is supplied by medical professional in the medical necessity documentation, as listed above, such documentation should be accompanied by specific seating equipment and accessories recommendations to meet those needs.
- If a member is expected to grow, documentation that illustrates wheelchair has a growth potential.

NON-COVERED SERVICES AND GENERAL LIMITATIONS

Items for coverage are reviewed on a case-by-case basis using documentation that is submitted.

Approval decisions are based on the equipment that is the least costly alternative to meet the client's medical and functional needs. Approval will not be granted for equipment that is solely intended to allow the member to engage in leisure, recreational or social activities if this equipment is more costly than wheelchair seating which meets the client's medical and basic functional needs.

The Colorado Medical Assistance Program pays for some secondary or back-up equipment, when there is a medical necessity and the services are not duplicative (i.e., being used for the same purpose as items already utilized by the client). Please see the *Primary, Secondary and Back-Up Mobility Devices* section on page 8 for details.

Any item that has not received a written coding verification from the Pricing, Data Analysis, and Coding (PDAC) contractor may be denied as not reasonable and necessary and will be reviewed on a case-by-case basis.

REPLACEMENT

Health First Colorado covers replacement of medically necessary items when:

- There is a change in the client's condition which warrants a new device; or
- Reasonable wear and tear renders the item nonfunctional, it is not cost-effective to repair, and there is coverage for the specific item available under the plan.

Members age 21 and older are eligible for wheelchair replacement every five years. However, early replacement will be considered with documentation that demonstrates a medical or functional need, and why repairs or modifications to the current wheelchair are not sufficient.

Members age 20 and younger, while they are continuing growth and physical development, are eligible for wheelchair replacement every three years. However, early replacement will be considered with documentation that demonstrates a medical or functional need, and why repairs or modifications to the current wheelchair are not sufficient.

Regardless of age:

- Prior authorization documentation should include detailed information on evidence of need due to a change in the type or severity of the client's Impairments in Body Structures or Functions, or significant change in body size or weight.
- Equipment requested should accommodate current needs as well as anticipated future needs or have the ability to be modified to accommodate changes when changes in the client's condition are foreseeable.

Projected repairs should not exceed the cost of new equipment.

Note: In the case of unforeseen changes in a client's medical or physical condition, exceptions to the replacement guidelines defined above will be made on a case-by-case basis.

Additional criteria for determining when circumstances justify a replacement include:

- The equipment is stolen. An official police report must be submitted with the replacement request, attached to the PAR. The request for replacement must also include a statement that the theft was not covered by auto or homeowner's insurance or that it is in the process of litigation.
- The equipment is damaged or destroyed in a motor vehicle accident. An official police report must be submitted with the replacement request. The request for replacement must also include a statement that the damage was not covered by auto insurance or is in the process of litigation.
- The equipment has been damaged beyond repair in some manner, and is not the result of member Misuse (see *Definitions*). The request for replacement must include an itemized price breakdown showing the cost to repair the wheelchair. The equipment must not be thrown away prior to the replacement decision.

Note 1: All policies and prior approval requirements that apply to the purchase of the original wheelchair also apply to replacements.

Note 2: Rendering Providers are required to complete services of repair and replacement in a timely manner, and advise the member on the estimated completion time.

PRIMARY, SECONDARY, AND BACK-UP MOBILITY DEVICES

The PMD or MWB that a member uses the majority of the time in accommodated and Non-Accommodated Environments to meet their daily medical and functional needs is referred to as their Primary Mobility Device. Purchase of a Primary Mobility Device is approved after medical necessity for the device has been evaluated, assessed and well-documented by an appropriate provider.

A Secondary Mobility Device is a PMD, MWB, stroller or walking aid that the member uses routinely a minority of time in situations in which they are unable to use their Primary Mobility Device to meet their medical and functional need. While the client's Secondary Mobility Device is not used as frequently as their Primary Mobility Device, the member requires it on a routine basis in accommodated and Non-Accommodated Environments in order to perform ADLs or IADLs which cannot be performed using the Primary Mobility Device. Decisions regarding purchase of a Secondary Mobility Device are made on a case-by-case basis after medical necessity for the device has been evaluated, assessed and well-documented by an appropriate provider.

Duplicate services are not provided. If a member uses a PMD as the Primary Mobility Device, Health First Colorado will not pay for another PMD to be used as the Secondary Mobility Device.

Likewise, if a member uses a MWB as the Primary Mobility Device, Health First Colorado will not pay for the purchase of another MWB to be used as the Secondary Mobility Device. If the member uses a stroller as the Primary Mobility Device, Health First Colorado will not pay for another stroller to be used as the Secondary Mobility Device. A stroller can serve as a Secondary Mobility Device to either a PMD or an MWB.

This policy is not intended to limit access to a Secondary Mobility Device for any member. In cases where a member is not able to use a MWB, an additional PMD may be covered. This may be due to an inability to self-propel and/or because the member is not able to transfer in and out of a manual wheelchair. The member's caregiver status may also be considered in determining medical necessity of a secondary PMD. Medical necessity of an additional PMD will be determined on an individual basis.

A back-up mobility device is a client-owned PMD or MWB that is used infrequently as a back-up to the Primary Mobility Device, or Secondary Mobility Device, when either device requires repair or maintenance. Health First Colorado does not pay for the purchase of a back-up mobility device.

Health First Colorado may either pay for repair or modifications to an existing client-owned back-up device, or the rental of a back-up device for members who require only a Primary Mobility Device. However, medical or functional need for a back-up mobility device must be established and be the least costly alternative. Repairs, rental, or modifications to a back-up mobility device are provided after medical necessity has been evaluated, assessed and well-documented by an appropriate provider (See *Repair and Rental* sections for more details).

WHEELCHAIR SEATING AND WO/AS FOR PRIMARY, SECONDARY, AND BACK-UP MOBILITY DEVICES

If a member owns a Primary Mobility Device and a Secondary Mobility Device, Health First Colorado may approve the purchase of a wheelchair seating system and WO/As for each device if the provider demonstrates items are medically necessary to enable the member to perform activities of daily living at home and in the community. Duplicate services will not be approved (i.e. purchase of two wheelchair seating systems for the same MWB or PMD).

In limited situations, Health First Colorado may pay for repair, modifications, or replacement of wheelchair seating and WO/As used in an existing client-owned back-up mobility device (see *Primary, Secondary and Back-up Mobility Devices* section), if the medical or functional need for the back-up mobility device is established. Repairs, modifications, or replacement of the wheelchair seating and WO/As on a back-up mobility device are provided after medical necessity has been evaluated, assessed and well-documented by an appropriate provider, and there are no other less costly options to meet the client's medical and basic functional needs (See the Repair and Rental sections for more details).

WHEELCHAIR BENEFIT COVERAGE STANDARDSUBPART 1: MANUAL WHEELCHAIR BASES

COVERED SERVICES AND LIMITATIONS

MWBs will be considered for coverage if the client's condition or diagnosis is such that, without an MWB, he or she would be unable to sit or ambulate safely, timely, or functionally. MWB requests for coverage are reviewed on a case-by-case basis, based on documentation that is submitted. Approval decisions are based on documentation of the equipment that is the most appropriate and least costly option available to meet the client's medical and basic functional needs.

Eligible members may receive one new MWB to be used:

- As their primary mode of mobility; or
- As a Secondary Mobility Device to a PMD.

If a member owns a PMD, Health First Colorado may approve the purchase of a secondary MWB if:

- The provider demonstrates medical necessity, and
- A secondary MWB is required to enable the member to meet his or her activities of daily living ADLs or IADLs at home and in the community, which cannot be completed with the use of their PMD.

In addition, if a member owns a PMD or MWB, Health First Colorado may approve the purchase of a stroller or Transport Chair if:

- The provider demonstrates medical necessity; and
- A stroller or Transport Chair is required to enable the member to meet their activities of daily living ADLs or IADLs at home and in the community, which cannot be completed with the use of their PMD or MWB.

Members are only eligible for one Primary Mobility Device and one Secondary Mobility Device when medically necessary. Requests for an additional wheelchair to be used solely as a back-up, in case the primary or secondary device requires repair, will be denied as not medically necessary if the patient's primary wheelchair is adequate to meet the client's medical need (See *Primary, Secondary and Back-up Wheelchair* section for further clarification).

BASIC COVERAGE CRITERIA FOR A MWB

A member is eligible for a MWB if the following basic coverage criteria are met:

- The member has a Mobility Limitation that significantly impairs the client's ability to participate in ADLs or IADLs, in customary locations in the home and in the community, or in any non-institutional setting, in which routine life activities take place;
- The client's Mobility Limitation cannot be sufficiently and safely resolved by the use of an ambulatory device, such as a cane, crutches or a walker;
- The client's home and community provides adequate access, maneuvering space, and surfaces for use of the MWB that is provided;
- Use of a MWB will significantly improve the client's ability to participate in activities of daily living, and the member will use it on a regular basis in the home or community;
- The member has expressed a willingness to use the MWB that is provided in the home or community; **and**
 - The member has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home or community during a typical day; **or**
 - The member has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

All MWB recommendations must demonstrate that the member meets the criteria in the *Basic Coverage Criteria* section for a MWB (as outlined above) and the criteria outlined in the appropriate MWB category below, to substantiate the client's functional and medical need.

STANDARD MANUAL WHEELCHAIR

A Standard Manual Wheelchair is a folding wheelchair that weighs more than 36 lbs., has a weight capacity of 250 lbs. and a seat-to-floor height of 19 inches or greater. Limited seat depths and widths are available. Most features on a Standard Manual Wheelchair base are fixed, including arm supports. Lower leg/foot supports are adjustable in length. A Standard Manual Wheelchair does not have features to accommodate specialized seating or positioning, and a limited number of options and accessories are available.

A STANDARD MANUAL WHEELCHAIR IS COVERED IF:

- The member requires a MWB for short term use (less than three months), or infrequently (less the once a week); **and**
- The member does not require adjustability of the wheelchair frame to address their seating/postural or functional needs.

STANDARD HEMI (LOW SEAT) WHEELCHAIR

A Standard Hemi Manual Wheelchair is a folding wheelchair that has a low seat-to-floor height of less than 19 inches. Availability and adjustability of features are similar to a Standard Manual Wheelchair.

A STANDARD HEMI-WHEELCHAIR IS COVERED IF:

- The member is of short stature and requires a lower seat height (less than 19 inches but greater than 17 inches) to facilitate transfers into, and out of, the wheelchair, or to allow the member to accomplish activities of daily living at home or in the community; **or**
- The member requires a shorter seat-to-floor distance so that their feet reach the floor and the member may foot propel the MWB.

LIGHTWEIGHT MANUAL WHEELCHAIR

A Lightweight Manual Wheelchair is a folding wheelchair that typically weighs between 34 and 36 pounds and has similar features to a Standard or Hemi Manual Wheelchair. A Lightweight Manual Wheelchair is available in multiple seat widths and depths. Most features on this wheelchair have limited adjustability including: front and rear seat-to-floor heights, back support height, arm support height, and rear wheel placement. A variety of options and accessories are available.

A LIGHTWEIGHT MANUAL WHEELCHAIR IS COVERED IF:

- The member will use a manual wheelchair part-time (i.e., intermittently) for more than three months or is expected to be a full-time manual wheelchair user for less than one year; and
- The member requires a size or feature available on a Lightweight Manual Wheelchair, that is not available on a less costly or lower level MWB, to accommodate seating, positioning, or functional mobility needs, in order to accomplish activities of daily living; **and**
 - The member is capable of independently propelling a Lightweight Wheelchair to meet their basic activities of daily living at home or in the community; **or**
 - The member is not capable of independently propelling a Lightweight Wheelchair, but has identified seating needs that can only be accommodated with the available features on a Lightweight Wheelchair; **or**
 - The member requires the removable rear wheel feature to allow safe stowing of the wheelchair in a vehicle.

HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR

A High Strength Lightweight Wheelchair is a folding wheelchair that weighs between 30 and 34 pounds and has similar features as a Lightweight Manual Wheelchair, with the exception of having a lifetime warranty on side frames and cross braces. Most features on this chair are adjustable and have adjustable position castor housing. There is greater adjustability of the rear axle plate and rear wheel placement as compared to a standard lightweight wheelchair. A variety of configurations, options, and accessories are available.

A HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR IS COVERED IF:

- The member will use a manual wheelchair part-time (i.e. intermittently) for more than three months, or is expected to be a full time manual wheelchair user for less than one year; and

- The member requires a size or feature available on a High Strength Lightweight Manual Wheelchair, that is not available on a less costly or lower level MWB, to accommodate seating, positioning, or functional mobility needs, in order to accomplish activities of daily living; **and**
 - The member is capable of independently propelling a High Strength Lightweight Wheelchair to meet their activities of daily living at home or in the community; **or**
 - The member is not capable of independently propelling a Lightweight Wheelchair, but has identified seating and positioning needs that can only be accommodated with the available features on a High Strength Lightweight Wheelchair; **or**
 - The member requires the removable rear wheel feature to allow safe stowing of the wheelchair in a vehicle.

ULTRA LIGHTWEIGHT WHEELCHAIR

An Ultra Lightweight Wheelchair is available in folding and rigid styles and weighs less than 30 pounds. Ultra Lightweight Wheelchairs vary from highly adjustable to custom configured with minimal adjustability, and are designed to meet highly individualized postural support and functional mobility needs.

AN ULTRA LIGHTWEIGHT WHEELCHAIR IS COVERED IF:

- The member is expected to use a manual wheelchair on a regular basis for one year or longer; **and**
- The member requires a specific configuration or feature available on an Ultra Lightweight Manual Wheelchair, that is not available on a less costly or lower level MWB, to accommodate seating, positioning, or functional mobility needs in order to accomplish activities of daily living; **and**
 - The member is able to independently self-propel an Ultra Lightweight Wheelchair to meet their activities of daily living at home or in the community, and routinely performs advanced wheelchair skills, such as wheelies; routinely encounters non-accommodated terrain; or independently stows their wheelchair in a vehicle on a regular basis; **or**
 - The member is a marginal self-propeller and an Ultra Lightweight Wheelchair is the lightest weight option that can facilitate independent mobility and function; **or**
 - The member is not capable of independently propelling an Ultra Lightweight Wheelchair, but has identified seating and positioning needs that can only be accommodated with the available features on an Ultra Lightweight Wheelchair.

HEAVY DUTY WHEELCHAIR

A Heavy Duty Manual Wheelchair has a weight capacity between 250 and 350 pounds and is reinforced to accommodate increased user weight.

A HEAVY DUTY WHEELCHAIR IS COVERED IF:

- The member meets the weight requirements for the specific wheelchair requested; **or**

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- The member does not meet the weight requirement, but needs a heavy duty wheelchair to accommodate his/her width; **and**
- The member is able to independently self-propel the Heavy Duty Wheelchair to accomplish their activities of daily living at home or in the community; **or**
- The member is not capable of independently propelling a Heavy Duty Wheelchair, but has identified seating and positioning needs that can only be accommodated with the available features on a Heavy Duty Wheelchair; **or**
- The member has severe spasticity.

EXTRA HEAVY DUTY WHEELCHAIR

An Extra Heavy Duty Manual Wheelchair has a weight capacity greater than 350 pounds and is reinforced to accommodate increased user weight.

AN EXTRA HEAVY DUTY WHEELCHAIR IS COVERED IF:

- The member meets the weight requirements for the specific wheelchair requested; **and**
 - The member is able to independently self-propel the Heavy Duty Wheelchair to accomplish their activities of daily living at home or in the community; **or**
 - The member is not capable of independently propelling a Heavy Duty Wheelchair, but has identified seating and positioning needs that can only be accommodated with the available features on a Heavy Duty Wheelchair; **or**
 - The member has severe spasticity.

Note: A member who does not meet the weight requirement but needs an Extra Heavy Duty Wheelchair to accommodate their width, can qualify.

CUSTOM MANUAL WHEELCHAIR/BASE

A Custom Manual Wheelchair/Base has been uniquely constructed or substantially modified to meet the needs for a specific client. To be considered customized, there must be Customization of the frame for the wheelchair base. A need to add standard components or accessories to a wheelchair, a need for an unusually large or small wheelchair, or the use of a different material in the construction, is not considered Customization.

A CUSTOM MANUAL WHEELCHAIR/BASE IS COVERED IF:

- The member is expected to use a manual wheelchair full time for one year or longer; **and**
- The member requires a specific configuration or feature available on a custom manual wheelchair, that is not available on a less costly or lower level MWB, to accommodate seating, positioning, or functional mobility needs in order to accomplish activities of daily living; **and**
 - The member is able to independently self-propel the Custom Manual Wheelchair to meet their activities of daily living at home or in the community; **or**

- The member is not capable of independently propelling a Custom Manual Wheelchair, but has identified seating and positioning needs that can only be accommodated with the available features on a Custom Manual Wheelchair.

STANDARD RECLINING WHEELCHAIR

A Standard Reclining Wheelchair has similar features to a Standard or Hemi Manual Wheelchair. In addition, the back of the wheelchair can move independently of the seat to provide a change in orientation by opening the seat-to-back support angle, allowing the member to assume a more recumbent position. The adjustable back support can either be maintained in a static position or it can be dynamic, allowing the member to move into full recline and back to the upright position. Recline mechanisms on manual wheelchairs utilize a manually activated hydraulic system that is typically managed by a caregiver.

A STANDARD RECLINING WHEELCHAIR IS COVERED IF:

- The member needs to perform ADLs or IADLs (including intermittent catheterization for bladder management) in a reclined position; **or**
- The member has significant trunk or hip musculoskeletal deformity, or abnormal tone, and must be reclined to maintain postural control or spinal alignment; **or**
- The member has trunk or lower extremity casts or braces that require the reclining feature for positioning; **or**
- The member is at increased risk of developing pressure sores with prolonged upright position and is unable to perform a functional weight shift; **or**
- The member has respiratory, digestive or cardiac dysfunction that is functionally improved with the recline feature; **or**
- The member has a need to rest in a recumbent position two or more times per day and has an inability to transfer between bed and wheelchair without assistance; **and**
 - The member is not at high risk for skin breakdown due to shear; **and**
 - There is a caregiver available to operate the manual recline.

ADULT SIZED TILT-IN-SPACE WHEELCHAIR

An Adult Sized Tilt-in-Space Wheelchair has a seat width of 15 inches or greater and includes a mechanism to allow the entire seat to pivot on the frame, while maintaining a static seat-to-back support angle. The tilt function on a manual Tilt-in-Space Wheelchair allows the individual to move into a tilted position and to return to an upright position. Different mechanisms for tilt activation are available, dependent on the specific wheelchair. The criteria below refer to manual Tilt-in-Space Wheelchairs only.

AN ADULT SIZED TILT-IN-SPACE WHEELCHAIR IS COVERED IF:

- The member is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; **or**

- The member has an Impairment of speech, cardiovascular, respiratory, or digestive function that is functionally improved with the tilt feature; **or**
- Adjustable tilt is needed to manage orthostatic hypotension related to an Impairment of cardiovascular, respiratory, or neuromusculoskeletal functions; **or**
- Adjustable tilt is needed to ensure the member can be transferred and positioned into, and out of, the wheelchair safely by a caregiver; **or**
- Adjustable tilt is needed to ensure the member can perform transfers into, and out of, the wheelchair independently, or re-position their body within the system with independence; **or**
- Adjustable tilt is needed to achieve or maintain a safe and healthy body alignment, and maintain postural stability, due to an Impairment of neuromusculoskeletal functions or movement related functions (e.g. Impairment of joint mobility, muscle strength, muscle tone, muscle endurance or motor coordination); **or**
- Adjustable tilt is needed to ensure the member is adequately positioned to perform or participate in basic or instrumental ADLs, such as eating, meal preparation, access to communication device, grooming/hygiene, etc.; **or**
- The member requires frequent changes in orientation in space throughout the day to manage chronic, severe pain.

Note: A manual wheelchair with combination tilt and recline seat functions allows the entire seat to pivot on the frame while maintaining a constant seat-to-back support angle and it also allows the back support to recline posteriorly, opening the seat to back support angle. A manual wheelchair with combination tilt and recline seat functions will be covered if a client's needs are not adequately met by tilt or recline alone, and the member meets the above stated criteria for both a Standard Reclining Wheelchair and a Tilt-in-Space Wheelchair.

MANUAL STANDING WHEELCHAIR

A Manual Standing Wheelchair includes a mechanism to allow the wheelchair user to move from a sitting position to a standing position requiring passive hip and knee extension. Chair weight, weight capacity, adjustments, and availability of accessories vary by specific wheelchair.

A MANUAL STANDING WHEELCHAIR SYSTEM IS COVERED IF:

- The member is an independent manual wheelchair propeller; **and**
- The member is able to demonstrate independent operation of the manual standing seat function;
and
- The member is not at high risk for skin breakdown due to shear; **and**
 - Use of a Manual Standing Wheelchair reduces the need for outside caregiver assistance and enables the member to perform activities of daily living in the home or community they would otherwise not be able to perform without the device; **or**
 - A medically prescribed standing program has been recommended which will benefit the client's Body Structures and function (including, but not limited to: maintaining vital

organ capacity, bone mineral density, circulation, and range of motion; reducing tone and spasticity; and reducing the occurrence of pressure sores and skeletal deformities); and

- The member is unable to independently transfer to an appropriately prescribed stand-alone standing frame; and
- The member does not have access to a caregiver for assistance with transfers.

PEDIATRIC MANUAL WHEELCHAIR

A Pediatric Manual Wheelchair has a seat width, or depth, 14 inches or less, and adjustable features that can accommodate specialized seating and positioning needs. Varied options for rear wheel size and configuration provides the member with the ability, or potential, to self-propel. There is adjustability to grow the frame size, to accommodate growth of the client, over the expected lifetime of the wheelchair.

A PEDIATRIC MANUAL WHEELCHAIR IS COVERED IF:

- The member is a child or requires a wheelchair width or depth, of 14 inches or less ; **or**
- The member requires adjustability in the wheelchair frame to accommodate specialized seating and positioning equipment or the member requires growth feature; **and**
- The member spends more than two hours per day in the wheelchair; **and**
 - The member can safely propel, or has the potential to self-propel the pediatric wheelchair to accomplish their ADLs or IADLs at home and in the community; **or**
 - The member is not capable of independently propelling a pediatric wheelchair, but has identified seating and positioning needs that can only be accommodated with the available features on a pediatric wheelchair.

TILT-IN-SPACE PEDIATRIC MANUAL WHEELCHAIR

A Pediatric Sized Tilt-in-Space Wheelchair has a seat width or depth of 14 inches or less and includes a mechanism to allow the entire seat to pivot on the frame, while maintaining a static seat-to-back support angle. A Tilt-in-Space seat function on a manual wheelchair allows the individual to move into a tilted position and to return to an upright position. Different mechanisms for tilt activation are available, dependent on the specific wheelchair. They include:

- Manual tilt activation by the wheelchair user;
- Manual tilt activation by a caregiver;
- Power tilt activation by the wheelchair user; **and**
- Power tilt activation by a caregiver.

A PEDIATRIC SIZED TILT-IN-SPACE MANUAL WHEELCHAIR IS COVERED IF THE MEMBER MEETS THE BASIC CRITERIA FOR PEDIATRIC MANUAL WHEELCHAIR, AND:

- The member is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; **or**

- The member has an Impairment of speech, cardiovascular, respiratory, or digestive function that is functionally improved with the tilt feature; **or**
- Adjustable tilt is needed to manage orthostatic hypotension related to an Impairment of cardiovascular, respiratory, or neuromusculoskeletal functions; **or**
- Adjustable tilt is needed to ensure the member can be transferred and/or positioned into, and out of, the wheelchair safely by a caregiver; **or**
- Adjustable tilt is needed to ensure the member can perform transfers into, and out of, the wheelchair independently, or re-position their body within the system with independence; **or**
- Adjustable tilt is needed to achieve or maintain a safe and healthy body alignment, and/or maintain postural stability, due to an Impairment of neuromusculoskeletal functions and/or movement related functions (e.g. Impairment of joint mobility, muscle strength, muscle tone, muscle endurance or motor coordination); **or**
- Adjustable tilt is needed to ensure the member is adequately positioned to perform or participate in basic or instrumental ADLs, such as eating, meal preparation, grooming/hygiene, etc.; **or**
- The member requires frequent changes in orientation in space throughout the day to manage chronic, severe pain.

BASIC ADAPTIVE STROLLERS

A Basic Adaptive Stroller is a dependent mobility base with small rear wheels which prevents the client's ability to independently self-propel. There are a wide range of sizes available accommodating very young children to grown adults. Seating/positioning features, if available, are integrated into the device; it is not designed to accept separate specialized seating or positioning components. A basic stroller has limited adjustability of frame size and features and limited adjustability to grow the frame size to accommodate growth of the member over the expected lifetime of the mobility base. A basic stroller generally weighs less and is easier to fold than a pediatric manual wheelchair, making it appropriate for transportation and stowage needs.

A BASIC ADAPTIVE STROLLER IS COVERED IF:

- The member spends less than two hours per day in the stroller; **and**
 - The member is not capable of independently propelling a pediatric wheelchair, and does not have complex seating and positioning needs; **or**
 - The member requires mobility assistance because they have identified Impairments in Body Structure or Function that result in the client's inability to ambulate functionally in the home and/or community, due to pain and/or fatigue; **or**
 - The member requires caregiver-dependent mobility in the home and/or community for safety reasons; **or**
 - The member requires a Secondary Mobility Device to a PMD or a MWB, to provide access in the home and/or community, to meet routine transportation, accessibility, and stowage needs.

TRANSPORT AND ROLLABOUT CHAIRS: ADULT, PEDIATRIC, AND HEAVY DUTY SIZED
Transport and Rollabout Chairs have casters of at least five inches in diameter and are intended for intermittent, dependent transport of a non-ambulatory person. Transport and Rollabout Chairs have limited adjustability and do not accept specialized seating supports, and therefore are not intended to provide long term continual postural support.

Note: The wide range of chairs with smaller casters, which are found in general use in homes, offices, and institutions for many purposes, do not meet the definition of durable medical equipment, in that they are not related to the care or treatment of members with an Impairment of Body Structure or Function.

ADULT AND PEDIATRIC TRANSPORT CHAIRS, AND ROLLABOUT CHAIRS ARE COVERED IF:

- The member will spend less than two hours per day in the mobility device; **and**
- The member is unable to self-propel a MWB or PMD and the member has a caregiver who is willing and able to operate the Transport Chair or Rollabout Chair; **or**
- The member requires mobility assistance because they have identified Impairments in Body Structure or Function resulting in the member being a non-functional ambulator in the home and/or community, due to pain and/or fatigue; **or**
- The member requires dependent mobility in the home and/or community for safety reasons; **or**
- The member requires a Secondary Mobility Device to a PMD or a MWB to provide access in the home and/or community to meet routine transportation, accessibility, and stowage needs.

WHEELCHAIR BENEFIT COVERAGE STANDARDSUBPART 2: POWER MOBILITY DEVICES

COVERED SERVICES AND LIMITATIONS

PMDs will be considered for coverage if the client's condition or diagnosis is such that, without the PMD, the member would be unable to access their home or community environments safely, or entirely. PMD requests for coverage are reviewed on a case-by-case basis and approval is based on documentation submitted by the eligible provider.

PMDs refer to two categories of mobility devices, Power Operated Vehicles (POVs) and PWCs. Each of these categories offer varying degrees of mobility options designed to accommodate individual needs. Approval for PMDs is based on thorough assessment and documentation of the equipment that is the most appropriate and least costly option available to meet the client's medical and functional needs.

PMD CATEGORIES

The PMD categories for coverage include:

- Group 1 POV
 - Standard
 - Heavy Duty
 - Very Heavy Duty
- Group 2 POV
 - Standard
 - Heavy Duty
 - Very Heavy Duty
- Group 1 PWCs:
 - No Power Seating Option
- Group 2 PWCs:
 - No Power Seating Option
 - Single Power Seating Option
 - Multiple Power Seating Option
- Group 3 PWCs:
 - No Power Seating Option

- Single Power Seating Option
- Multiple Power Seating Option
- Group 4 PWCs:
 - No Power Seating Option
 - Single Power Seating Option
 - Multiple Power Seating Option
- Group 5 PWCs:
 - Single Power Seating Option
 - Multiple Power Seating Option

BASIC COVERAGE CRITERIA FOR A PMD

In addition to the criteria outlined in the following pages for specific POV or PWC recommendations, all PMD recommendations must be accompanied by the following assessment documentation, demonstrating that the member meets the basic coverage criteria for a PMD.

- The member has a Mobility Limitation that significantly impairs the client's ability to participate in ADLs and IADLs, in the home, or any non-institutional setting, in which routine life activities take place.
- The client's Mobility Limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
- The member does not have sufficient upper extremity function to self-propel an Optimally Configured Manual Wheelchair in the home or community to perform ADLs or IADLs during a typical day, including but not limited to:
 - Limitations of strength, endurance, range of motion, or coordination;
 - Presence of pain, or deformity;
 - Absence of one or both upper extremities.
- The member has sufficient mental and physical capabilities (i.e., adequate range of motion, coordination, trunk control, appropriate judgment, cognitive skills, vision, and perceptual abilities) to safely operate the PMD being requested. If the member is age 20 years or younger, they demonstrate the potential to develop sufficient mental and physical capabilities with practice.
- The client's home or non-institutional community setting provides adequate access between rooms, maneuvering space, and surfaces for the operation of the PMD being requested.
- The client's condition is such that the requirement for a PMD is long-term, and the need is anticipated to be more than six months.

- PMDs are not medically necessary if the underlying condition is reversible and the medical justification does not support a long-term need. (Example: Requests for PMDs following lower extremity surgery, which limit ambulation, do not support medical necessity criteria for a powered mobility device.)
- If a member requires a PMD for less than six months, the PMD can be rented.
- Use of a PMD will significantly improve the client's ability to participate in ADLs or IADLs, and the member will use it on a regular basis in the home and/or community.
- The member has expressed a willingness to use the PMD that is provided in the home and/or community setting.
- The member does not exceed, and is not at risk of exceeding, the weight capacity of the recommended PMD.
- The recommended PMD should be intended for long-term use and capable of modification to meet the needs of anticipated improvement, deterioration, or change in height or weight, for the lifetime of the device.

Note 1: If the member is dependent on a caregiver for mobility in a wheelchair, and the primary caregiver is unable to adequately push the member in an Optimally Configured Manual Wheelchair, a PWC may be provided, if the caregiver is available, capable, and willing to safely operate the PWC being requested and assure it is cared for. A POV and a Group 4 PWC are deemed as not medically necessary in these situations and will be denied.

Note 2: All PMD recommendations must demonstrate that the member meets the criteria in the Basic PMD Coverage Guidelines outlined above, and the following criteria outlined in the appropriate PMD category, to substantiate the client's functional and medical need. Documentation should also include justification that indicates why a lower level or less costly PMD is not appropriate.

COVERAGE CRITERIA FOR POWER OPERATED VEHICLES

GROUP 1 POWER OPERATED VEHICLES

Group 1 POVs have the ability to operate primarily in Accommodated Environments. A typical user must be able to operate the Tiller Steering System, sit with good postural stability in Van Captain Seating, and transfer into, and out of, the device with independence. Group 1 POVs are intended primarily for use on smooth, flat surfaces.

A GROUP 1 POV IS COVERED IF:

- The member is able to maintain postural stability in Van Captain Seating while operating the POV; and
- The member is able to operate a Tiller Steering System; and
- The member is able to safely transfer into, and out of, the POV independently; and
- The member performs ADLs or IADLs primarily in Accommodated Environments; **and**

- Based on diagnosis, prognosis, symptomatology (including rate of change of functional skills), the member is unlikely to require a change in steering mechanism, electronic adjustability, or postural support, for the lifetime of the device.

GROUP 2 POWER OPERATED VEHICLES

Group 2 POVs have the ability to operate in both accommodated and Non-Accommodated Environments. A typical user must be able to operate the Tiller Steering System, sit with good postural stability in Van Captain Seating, and transfer into, and out of, the device with independence. Some Group 2 POVs can accommodate a power seat elevator. These devices are intended for extensive use in indoor and outdoor environments, and over a variety of terrain.

A GROUP 2 POV IS COVERED IF:

- The member is able to maintain postural stability in Van Captain Seating while operating the POV; and
- The member is able to operate a Tiller Steering System; and
- The member is able to safely transfer into and out of the POV independently; and
- The member performs ADLs or IADLs in both accommodated and Non-Accommodated Environments for extended distance travel; **and**
- Based on diagnosis, prognosis, symptomatology (including rate of change of functional skills), the member is unlikely to require a change in steering mechanism, electronic adjustability, or postural support, for the lifetime of the device.

COVERAGE CRITERIA FOR PWCS

GROUP 1 PWCS

Group 1 PWCs have the ability to operate in Accommodated Environments only, traversing low level surfaces with minimal environmental barriers, such as thresholds of approximately .75 inches. Group 1 PWCs are appropriate for members with good postural stability who are unable to operate a Tiller Steering System and/or who cannot independently transfer into, or out of, a POV. Group 1 PWCs are operated with a Standard Proportional Joystick, have No Power Seating Options, and are intended primarily for indoor use.

A GROUP 1 PWC IS COVERED IF:

- The member is unable to operate a POV safely and/or independently; and
- The member performs ADLs or IADLs in Accommodated Environments; and
- The member is able to operate a standard joystick; and
- The member is able to maintain postural stability in Van Captain Seating while operating the wheelchair; and
- The member is able to maintain skin integrity through postural shifts, and therefore does not need a mechanical method of pressure relief; **and**

- Based on diagnosis, prognosis, symptomatology (including rate of change of functional skills), the member is unlikely to require a change in steering mechanism, electronic adjustability, or postural support, for the lifetime of the device.

GROUP 2 PWCS

Group 2 PWCs have the ability to operate in Accommodated Environments for long distance travel, traversing thresholds no greater than 1.5 inches in height. In general, Group 2 PWCs have limited adaptability for upgrades beyond the initial design and coding parameters. Some Group 2 PWCs can accommodate upgrades in specialty seat cushions and back supports, or Tilt-in-Space seating systems; however, the options available are limited and not always available. Group 2 PWCs may be inappropriate for members who have significant seating and positioning needs, or who are expected to experience a change or progression in medical condition that would require additional seating or positioning functions. Group 2 PWCs can be operated with a Standard Proportional Joystick, and are intended for daily mobility, primarily indoors.

A GROUP 2, NO POWER SEATING OPTION PWC IS COVERED IF:

- The member is able to operate a standard joystick; and
- Based on diagnosis, prognosis, symptomatology (including rate of change of functional skills), the member is unlikely to require a change in steering mechanism, electronic adjustability, or postural support, for the lifetime of the device; **and**
- A Group 1 PWC does not meet the client's environmental or seating needs because either:
 - The primary use is for ADLs or IADLs taking place in Accommodated Environments, and infrequent use in Non-Accommodated Environments; **or**
 - The member has an Impairment in Body Structures or Functions and requires a seating and positioning system, other than Van Captain Seating, which cannot be accommodated by a Group 1 PWC.

A GROUP 2, SINGLE POWER SEATING OPTION PWC IS COVERED IF:

- The member meets all of the coverage guidelines for a Group 2, No Power Seating Option wheelchair; **and**
- The member requires a power tilt seating system, as outlined in the coverage guidelines, for Power Tilt/Recline.

GROUP 3 PWCS

Group 3 PWCs have the ability to operate in accommodated and Non-Accommodated Environments for extended distances, traversing thresholds and curbs of approximately 2.25 inches in height. In general, Group 3 PWCs are designed for those who have specific, unique medical and functional needs that require an individually configured device with a specialized seating system and possibly a power tilt and/or power recline system. Group 3 PWCs can be operated with a Standard Proportional Joystick, or can be upgraded to accommodate an Alternate

Control System, such as head control, sip and puff, switch control, etc. These PWCs will accommodate modifications to the seating configuration, drive control method, and electronics to meet the needs of members whose functional needs are expected to change within the lifetime of the chair due to their diagnosis, prognosis, or other symptomatology. This group of mobility devices is intended for daily mobility indoors and outdoors, primarily on smooth paved surfaces.

A Group 3, No Power Seating Option PWC is covered if:

- The primary use is for ADLs or IADLs that take place in Accommodated and Non-Accommodated Environments; **or**
- The member has an Impairment in Body Structures or Functions that requires an individually configured seating system that cannot be accommodated by a Group 2 PWC or other lower level PWC; **or**
- The member has a diagnosis, prognosis, or other symptomatology that will likely cause a change in the client's functional abilities over the lifetime of the chair, requiring modifications to the seating configuration, drive control method, or chair electronics.

A GROUP 3, SINGLE POWER SEATING OPTION PWC IS COVERED IF:

- The member meets all of the coverage guidelines for a Group 3, No Power Seating Option PWC; **and**
- The member requires either an Alternate Control System or a power seating system because:
 - The member is unable to operate a Standard Proportional Joystick and must use an Alternate Control System such as head control, sip and puff, switch control, etc.; **or**
 - The member requires a power tilt **or** power recline seating, as outlined in the coverage guidelines for Power Tilt/Recline.

A GROUP 3, MULTIPLE POWER SEATING OPTION PWC IS COVERED IF:

- The member meets all of the coverage guidelines for a Group 3, No Power Seating Option PWC; **and**
- The member requires either a mounted ventilator or a power seating system because:
 - The member has an Impairment of respiratory functioning, and requires a ventilator mounted to the wheelchair; **or**
 - The member needs a power tilt and power recline seating system, as outlined in the coverage guidelines for Power Tilt/Recline.

GROUP 4 PWCS

Group 4 PWCs have the ability to operate in accommodated and Non-Accommodated Environments at high speeds and over rough, varied, and uneven surfaces, which are regularly encountered during extended distance travel. Group 4 PWCs can travel over barriers and thresholds of approximately 2.75 inches in height. Group 4 PWCs are designed for those who have specific, unique, medical and functional needs, which require an

individually configured

device with a specialized seating system and possibly a power tilt and/or power recline system. Group 4 PWCs can be operated with a Standard Proportional Joystick or can be upgraded to accommodate an Alternate Control System, such as head control, sip and puff, switch control, etc. These PWCs accommodate modifications to the seating configuration, drive control method, and electronics to meet the needs of members whose functional needs are expected to change within the lifetime of the chair due to their diagnosis, prognosis, or other symptomatology. This group of mobility devices is intended for extensive daily use in indoor and outdoor environments, over a variety of terrain.

A GROUP 4, NO POWER SEATING OPTION PWC IS COVERED IF:

- The primary use is for:
 - ADLs or IADLs, which take place in Accommodated Environments; and for
 - Extensive use in Non-Accommodated Environments, which include rough, varied, or uneven surfaces that are regularly encountered and that cannot be accommodated by a Group 3 PWC or other lower level PWC; **and** either
 - The member has an Impairment in Body Structures or Functions and requires an individually configured seating system; **or**
 - The member has a diagnosis, prognosis, or other symptomatology that will likely cause a change in the client's functional abilities over the lifetime of the chair, requiring modifications to the seating configuration, drive control method, or chair electronics.

A GROUP 4, SINGLE, POWER SEATING OPTION (PWC) IS COVERED IF:

- The member meets all of the coverage criteria for a Group 4, No Power Seating Option PWC; **and**
- The member requires either an Alternate Control System or a power seating system because:
 - The member is unable to operate a Standard Proportional Joystick and must use an Alternate Control System, such as head control, sip and puff, switch control, etc.; **or**
 - The member requires a power tilt **or** power recline seating, as outlined in the coverage guidelines for Power Tilt/Recline.

A GROUP 4, MULTIPLE POWER SEATING OPTION PWC IS COVERED IF:

- The member meets all of the coverage criteria for a Group 4, No Power Seating Option PWC; **and**
- The member requires either a mounted ventilator or a power seating system because:
 - The member has an Impairment of respiratory functioning, and requires a ventilator mounted to the wheelchair; **or**

- The member needs a power tilt **and** power recline seating system, as outlined in the coverage guidelines for Power Tilt/Recline.

GROUP 5 PWCS

Group 5 PWCs have the ability to operate in accommodated and Non-Accommodated Environments for extended distances. In general, Group 5 PWCs are designed for individuals who have specific, unique, medical and functional needs, which require a small wheelchair base or seating system, or specialized power functions, that are not available on other PWCs. A Group 5 PWC may also accommodate a power tilt and/or power recline system. Group 5 PWCs can be operated with a Standard Proportional Joystick, or can be upgraded to accommodate alternate drive controls, such as head control, sip and puff, switch control, etc. These PWCs will accommodate modifications to the seating configuration, drive control method, and electronics, to meet the needs of members whose functional needs are expected to change within the lifetime of the chair, due to their diagnosis, prognosis, or other symptomatology. This group of mobility devices is intended for daily mobility indoors and outdoors, primarily on smooth paved surfaces.

A GROUP 5, SINGLE POWER OPTION PWC IS COVERED IF:

- The member has developmental or medical needs and requires the special features of a Group 5 PWC which cannot be accommodated by a lower level PWC, such as very low seat to floor height, overall small base size, and/or growth capabilities; and
- The primary use is for ADLs or IADLs taking place in Accommodated Environments and occasional use in Non-Accommodated Environments; **and**
- The member requires either an Alternate Control System or a power seating system because:
 - The member is unable to operate a Standard Proportional Joystick and must use an Alternate Control System, such as head control, sip and puff, switch control, etc.; **or**
 - The member requires a power tilt **or** power recline seating, as outlined in the coverage guidelines for Power Tilt/Recline.

A GROUP 5, MULTIPLE POWER SEATING OPTION PWC IS COVERED IF:

- The primary use is for ADLs or IADLs taking place in Accommodated Environments and occasional use in Non-Accommodated Environments; **and**
- The member has an Impairment in Body Structures or Functions and requires the power seat-to- floor function to meet developmental and/or medical needs.

Note: Refer to the Wheelchair Options/Accessories subpart of this Benefit Coverage Standard for more specific coverage criteria related to the power seat-to-floor function.

COVERAGE CRITERIA FOR POWER TILT OR POWER RECLINE SYSTEMS

Power tilt or power recline systems are covered if:

- The member is at high risk for developing a pressure ulcer and is unable to independently perform a functional weight shift; or

- The member utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed; or
 - The member has an Impairment of speech, cardiovascular, respiratory, or digestive function that is functionally improved with the tilt or recline feature; or
 - Power tilt or recline is needed to manage orthostatic hypotension related to an Impairment of cardiovascular, respiratory, or neuromusculoskeletal functions; or
 - Power tilt or recline is needed to ensure the member can be transferred and/or positioned into, and out of, the wheelchair safely by a caregiver; or
 - Power tilt or recline is needed to ensure the member can perform transfers into, and out of, the wheelchair independently, or independently re-position their body within the system; or
 - Power tilt or recline is needed to achieve or maintain a safe and healthy body alignment, and/or maintain postural stability, due to an Impairment of neuromusculoskeletal and/or movement related functions (e.g. Impairment of joint mobility, muscle strength, muscle tone, muscle endurance or motor coordination); or
 - Power tilt or recline is needed to ensure the member is adequately positioned to perform or participate in ADLs or IADLs, such as eating, meal preparation, grooming/hygiene, etc.;
- or**
- The member requires frequent changes in orientation in space and/or joint position throughout the day to manage chronic, severe pain.

NON-COVERED SERVICES AND GENERAL LIMITATIONS

Duplicate services will not be approved (i.e., purchase of two PMDs coded in the same HCPC category).

All-terrain PMDs are not considered a medical necessity by standard medical practice, and will not be covered.

MWCs and PMDs that have stair-climbing capability are not considered a medical necessity by standard medical practice, and will not be covered.

WHEELCHAIR BENEFIT COVERAGE STANDARDSUBPART 3: WHEELCHAIR SEATING

COVERED SERVICES AND LIMITATIONS

Items for coverage are reviewed on a case-by-case basis and approval is based on documentation submitted by the eligible provider. Wheelchair seating devices will be considered for coverage if the client's condition or diagnosis is such that, without the recommended seating device, the member would be unable to sit in, and use, a MWB or PMD safely and functionally, and without declines in health conditions.

There are different types of wheelchair seating devices available to members, each with varying capabilities designed to accommodate different needs. Approval for wheelchair seating equipment is based on thorough assessment documentation of the equipment that is the most appropriate and least costly option available to meet the client's medical and functional needs.

BASIC COVERAGE CRITERIA FOR WHEELCHAIR SEATING

In addition to the criteria outlined in the following pages for specific wheelchair seating device recommendations, all recommendations must be accompanied by the following assessment documentation, demonstrating that the member meets the basic coverage criteria for the wheelchair seating device:

- The member has a Mobility Limitation that significantly impairs his/her ability to participate in ADLs or IADLs, in customary locations in the home, or in any non-institutional setting in which routine life activities take place; **and**
- The client's Mobility Limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker; **and**
- The member has a MWB or PMD with either a sling seat or back support, or a solid seat and back support pan, which meets Health First Colorado coverage criteria.

WHEELCHAIR SEATING CATEGORIES

- General Use Seat Cushion
- General Use Back Support
- Skin Protection Seat Cushion
- Positioning Seat Cushion
- Positioning Back Support
- Combination Skin Protection and Positioning Seat Cushion
- Custom Contoured Seat Cushion
- Custom Contoured Back Support
- Positioning Accessories

- Lateral Trunk Support, Lateral Thigh/Knee Support or Lateral Pelvic Support
- Medial Thigh/Knee Support
- Anterior Shoulder Strap or Chest Strap
- Anterior Abdominal Support
- Head Support
- Pelvic Belt
- Foot/Ankle Positioners
 - Heel Loop
 - Shoe Holder
 - Toe Loop
 - Leg/Ankle Strap
- Arm Trough
- Skin Protection Cushion for Use in Devices Other Than a MWB or PMD

COVERAGE CRITERIA AND GUIDELINES FOR WHEELCHAIR SEATING DEVICES

For all Wheelchair Seating equipment, with the exception of a Skin Protection Cushion to be Used in Devices Other Than a MWB or PMD, recommendations must demonstrate that the member meets the Basic Wheelchair Seating Coverage Criteria outlined above, as well as the following criteria outlined in the appropriate Wheelchair Seating category to substantiate the client's functional and medical need. Documentation should also include justification that indicates why a lower level or less costly wheelchair seating device is not appropriate.

GENERAL USE SEAT CUSHION AND GENERAL USE BACK SUPPORT

A General Use Seat Cushion is a static, prefabricated cushion with minimal contour that includes a removable cover and has other defined characteristics (see *Definitions*). A General Use Seat Cushion is intended for use by a person who sits in their wheelchair for more than two hours per day, but who is at a low risk of skin breakdown and has minimal positioning needs.

A General Use Back Support is a static, prefabricated cushion that can be planar or minimally contoured, includes a removable cover, and has other defined characteristics (see *Definitions*). A General Use Back Support is intended for use by a person who sits in their wheelchair for more than two hours per day, but who has minimal positioning needs.

A GENERAL USE SEAT CUSHION OR GENERAL USE BACK SUPPORT IS COVERED IF:

- The member will spend more than two hours per day in their wheelchair.

SKIN PROTECTION SEAT CUSHION

Skin Protection Seat Cushions include both nonadjustable Skin Protection Cushions and adjustable Skin Protection Cushions. A Skin Protection Seat Cushion is a prefabricated cushion with moderate contour (minimum loaded contour depth of 40mm) that includes a removable cover and has other defined characteristics (see *Definitions*). A Skin Protection Seat Cushion is

intended for use by a person who uses their wheelchair several hours a day, and is at risk of skin breakdown.

A SKIN PROTECTION SEAT CUSHION IS COVERED IF:

- The member has a history of decubitus ulcers on their buttocks or thighs; **or**
- The member is at high risk for developing a sitting-acquired decubitus ulcer due to absent or impaired sensation; **or**
- The member is at high risk for developing a sitting-acquired decubitus ulcer due to an inability to perform a functional weight shift; **or**
- The member is at high risk for developing a sitting-acquired decubitus ulcer due to other specified Impairments in Body Structures or Functions.

Note: Impairments of Body Structures relevant to the need for a Skin Protection Seat Cushion may include structures of the nervous system (e.g. brain, spinal cord or nerves); structures of the cardiovascular and respiratory systems; structures related to movement (e.g. head or neck region, shoulder region, upper extremities, trunk, lower extremities, or pelvis); and/or structures of the skin. Impairments in Body Functions relevant to the need for a Skin Protection Seat Cushion may include mental functions (e.g. cognition, memory, attention, or sequencing of complex movements); sensory functions and pain; functions of the cardiovascular and respiratory systems; neuromusculoskeletal and movement-related functions (e.g. joint mobility, muscle power, muscle tone, endurance, or the presence of involuntary movements), and/or functions of the skin.

POSITIONING SEAT CUSHION AND POSITIONING BACK SUPPORT

A Positioning Seat Cushion is a static, prefabricated seat cushion that has the same basic features as a general use seat cushion, but with additional support surfaces designed to provide greater contact to the pelvis (anteriorly or laterally) or thighs (medially or laterally), in order to help limit unwanted movement or maintain a desired position. A Positioning Seat Cushion may have materials or components that can be added or removed to help address orthopedic deformities or postural asymmetries. A Positioning Seat Cushion is intended for use by a person who uses their wheelchair full time and has greater positioning needs.

A Positioning Back Support is a static, prefabricated back support that has additional contour depth which may include both posterior and lateral support to the trunk, as well as other defined characteristics (see *Definitions*). A Positioning Back Support may have materials or components that can be added or removed to help address orthopedic deformities or postural asymmetries. A Positioning Back Support is intended for use by a person who uses their wheelchair several hours a day and has greater positioning needs.

A POSITIONING SEAT CUSHION OR A POSITIONING BACK SUPPORT IS COVERED IF:

- The member has postural asymmetries which cannot be self-corrected due to an Impairment in Body Structures or Functions; or
- The member is at risk for developing postural asymmetries, or orthopedic deformities, due to Impairment in Body Structures or Functions.

Note: Impairments of Body Structures relevant to the need for a Positioning Seat Cushion or Positioning Back Support may include structures of the nervous system (e.g. brain, spinal cord or nerves) and/or structures related to movement (e.g. head or neck region, shoulder region, upper extremities, trunk, lower extremities, or pelvis). Impairments in Body Functions relevant to the need for a Positioning Seat Cushion or Positioning Back Support may include mental functions (e.g. cognition, memory, attention, or sequencing of complex movements); sensory functions and pain; functions of the cardiovascular and respiratory systems, and/or neuromusculoskeletal and movement-related functions (e.g. joint mobility, muscle power, muscle tone, endurance, or the presence of involuntary movements).

COMBINATION SKIN PROTECTION AND POSITIONING SEAT CUSHION

A combination skin protection and Positioning Seat Cushion is a static, prefabricated seat cushion which combines the characteristics of a Skin Protection Seat Cushion and a Positioning Seat Cushion. A combination skin protection and Positioning Seat Cushion is intended for use by a person who uses their wheelchair several hours a day, is at risk of skin breakdown and has greater positioning needs.

A COMBINATION SKIN PROTECTION AND POSITIONING SEAT CUSHION IS COVERED IF:

- The member meets the criteria outlined previously for both a Skin Protection Seat Cushion and a Positioning Seat Cushion.

CUSTOM CONTOURED SEAT CUSHION

A Custom Contoured Seat Cushion is a cushion that has been individually made for a specific client, using techniques designed to create support surface contours, which match the unique body shape of the client. A Custom Contoured Seat Cushion is intended for use by a person who uses their wheelchair several hours a day, and who has significant postural asymmetries, postural instability, and/or skin protection needs, that cannot be adequately addressed with a prefabricated seat cushion.

A CUSTOM CONTOURED SEAT CUSHION IS COVERED IF:

- The member meets all of the criteria for a prefabricated Skin Protection Seat Cushion or Positioning Seat Cushion; **and**
- The member has significant postural asymmetries, orthopedic deformities, postural instability, and/or skin protection needs that cannot be adequately addressed by either a prefabricated Skin Protection Seat Cushion or Positioning Seat Cushion; **and**
- A Specialty Evaluation is performed; **and**
- Documentation clearly indicates why a prefabricated seat cushion cannot adequately meet the client's medical and/or functional needs.

CUSTOM CONTOURED BACK SUPPORT

A Custom Contoured Back Support is a back support that has been individually made for a specific client, using techniques designed to create support surface contours, which match the unique body shape of the client. A Custom Contoured Back Support is intended for use by a

person who uses their wheelchair several hours a day, and who has significant postural asymmetries, postural instability, and/or skin protection needs that cannot be adequately addressed with a prefabricated back support.

A CUSTOM CONTOURED BACK SUPPORT IS COVERED IF:

- The member meets all of the criteria for a prefabricated Positioning Back Support; **and**
- The member has significant postural asymmetries, orthopedic deformities, postural instability, and/or skin protection needs, which cannot be adequately addressed by a prefabricated Positioning Back Support; **and**
- A Specialty Evaluation is performed

POSITIONING ACCESSORIES: LATERAL TRUNK SUPPORT, LATERAL KNEE SUPPORT OR LATERAL PELVIC SUPPORT; MEDIAL THIGH/KNEE SUPPORT; ANTERIOR SHOULDER STRAP OR CHEST STRAP

Positioning accessories include lateral trunk supports, lateral knee supports or lateral pelvic supports, medial knee/thigh supports, anterior shoulder straps, or chest straps. These secondary supports are separate items, designed to attach to the wheelchair frame, seat or back supports. Secondary supports are typically used to provide support or protection to the extremities (legs, arms, and head) or to help maintain a very specific posture or position of a certain body segment such as the trunk, buttocks/thighs, or extremities. They are intended for use by members with more significant postural support or injury protection needs.

A POSITIONING ACCESSORY, SUCH AS A LATERAL TRUNK SUPPORT, LATERAL KNEE SUPPORT, LATERAL PELVIC SUPPORT, MEDIAL KNEE/THIGH SUPPORT, ANTERIOR SHOULDER STRAP OR CHEST STRAP, IS COVERED IF:

- The member has postural asymmetries which cannot be self-corrected due to an Impairment in Body Structures or Functions; **or**
- The member is at risk for developing postural asymmetries or orthopedic deformities due to Impairment in Body Structures or Functions; **or**
- The member is unable to actively maintain a safe and functional position of their trunk and/or lower body due to Impairments in specific Body structures and/or Functions; **or**
- The member is at risk of injury to the body or extremities without the positioning accessory.

HEAD SUPPORT

A head support is a seating support surface intended to contact the posterior and/or lateral aspects of a person's head. It is intended for use by members who cannot maintain a safe and functional head position, or who need support in a reclined or tilted position.

A HEAD SUPPORT IS COVERED IF:

- The member has postural asymmetries or orthopedic deformities in the head/neck region which cannot be self-corrected due to an Impairment in Body Structures and/or Functions; **or**
- The member is unable to actively maintain a safe and functional position of their head due to Impairments in Body Structures and/or Functions; **or**

- The member has a covered manual, or power tilt, and/or recline system on an existing MWB or PMD; **or**
- The member is transported on a bus, public transit vehicle, or private vehicle while sitting in the PMD or MWB, and must have support behind the head to prevent hyperextension injury to the neck when the vehicle comes to a sudden stop.

PELVIC BELT

A pelvic belt is an anterior pelvic support designed to contact the front part of the pelvis or hip area. It is typically intended for use with members who are unable to maintain a safe and functional pelvic position when sitting in their MWB or PMD.

A PELVIC BELT IS COVERED IF:

- The member requires the pelvic belt in order to maintain adequate pelvic positioning and postural stability due to an Impairment in Body Structures and/or Functions; **or**
- The member requires a pelvic belt as a safety measure to prevent a fall from the PMD, MWB, or stroller during use.

FOOT/ANKLE POSITIONERS: HEEL LOOP, TOE LOOP, SHOE HOLDER, LEG/ANKLE STRAP

A heel loop is a flexible, posterior support, or strap, designed to contact the back of the heel to help maintain the client's foot on the foot support.

A toe loop is a flexible, superior support or strap intended to contact the top of the foot in the area of the toes, to help maintain the client's foot in the proper position on the foot support.

A leg/ankle strap is a flexible anterior support intended to contact the front of the ankle in order to help maintain the client's foot on the foot support.

A shoe holder is a foot positioning device that typically has an inferior surface, as well as posterior, lateral, and medial walls. It is intended to maintain the client's foot in a specific position on the foot support.

A HEEL LOOP, TOE LOOP, SHOE HOLDER, OR LEG/ANKLE STRAP IS COVERED IF:

- The member requires the positioning device in order to maintain their foot on the foot support in a position which supports safe and adequate function, due to an Impairment in Body Structures or Functions.

Note: A pelvic belt, anterior shoulder, or chest, strap, ankle strap, heel loop, toe loop, or shoe holder are covered only to treat a client's need for postural support and safety. These items are not covered when used as a physical restraint for the purpose of discipline or the convenience of others.

ARM TROUGHS

An arm trough is a special type of arm support which incorporates posterior, medial, and/or lateral support surfaces. An arm trough provides greater support to the upper extremity than a

standard arm rest pad, and is intended for use by members with muscle weakness, paralysis, or abnormal muscle tone in the upper extremities.

AN ARM TROUGH IS COVERED IF:

- The member is unable to maintain their forearm on a standard flat arm support due to an Impairment in Body Structures or Functions; **and**
- The member requires the additional features of an arm trough for adequate positioning, function and/or safety, which cannot be provided by a standard arm support pad.

SKIN PROTECTION CUSHION FOR USE IN DEVICES OTHER THAN A MWB OR PMD

A Skin Protection Cushion is covered for use with a chair other than a MWB or PMD if all of the following criteria are met:

- All of the *Eligible Members* criteria are met;
- The member has a Mobility Limitation that significantly impairs the client's ability to participate in ADLs or IADLs, in customary locations in the home, or in any non-institutional setting in which routine life activities take place;
- The member sits in another chair, such as a recliner or vehicle seat, for more than two hours per day on a regular basis; **and**
- The member has a history of decubitus ulcers on their buttocks or thighs; **or**
- The member is at high risk for developing a sitting-acquired decubitus ulcer due to absent or impaired sensation; **or**
- The member is at high risk for developing a sitting-acquired decubitus ulcer due to an inability to perform a functional weight shift; **or**
- The member is at high risk for developing a sitting-acquired decubitus ulcer due to other specified Impairments in Body Structures or Functions.

Note: Impairments of Body Structures relevant to the need for a Skin Protection Seat Cushion may include structures of the nervous system (e.g. brain, spinal cord or nerves); structures of the cardiovascular and respiratory systems; structures related to movement (e.g. head or neck region, shoulder region, upper extremities, trunk, lower extremities, or pelvis); and/or structures of the skin. Impairments in Body Functions relevant to the need for a Skin Protection Seat Cushion may include mental functions (e.g. cognition, memory, attention, or sequencing of complex movements); sensory functions and pain; functions of the cardiovascular and respiratory systems; neuromusculoskeletal and movement-related functions (e.g. joint mobility, muscle power, muscle tone, endurance, or the presence of involuntary movements), and/or functions of the skin.

NON-COVERED SERVICES AND GENERAL LIMITATIONS

If a seat cushion or back support is provided for use with a Transport Chair or a PMD with a captain's seat, it is considered a comfort item and will be denied as not reasonable and necessary in this circumstance.

POWERED SEAT CUSHION

The effectiveness of a powered seat cushion has not been established. Claims for a powered seat cushion will be denied as not reasonable and necessary.

WHEELCHAIR BENEFIT COVERAGE STANDARD SUBPART 4: WHEELCHAIR OPTIONS/ACCESSORIES

COVERED SERVICES AND LIMITATIONS

A WO/A will be considered for coverage if the client's condition or diagnosis is such that, without the option or accessory, they would be unable to access their home or community environments safely, or entirely. WO/A requests for coverage are reviewed on a case-by-case basis and approval is based on documentation submitted by the eligible provider. Approval decisions are based on documentation of the equipment that is the most appropriate and least costly alternative to meet the client's medical and functional needs.

BASIC WO/A COVERAGE CRITERIA:

A member is eligible for a WO/A if all of the following basic criteria are met:

- The member has a Mobility Limitation that significantly impairs his/her ability to participate in basic and/or instrumental activities of daily living (ADLs or IADLs), in customary locations in the home or any non-institutional setting in which routine life activities take place;
- The member meets the basic criteria for covered services for a PMD or MWB). Refer to the PMD or MWB subparts in this Benefit Coverage Standard for coverage criteria; **and**
- The member must have a wheelchair, or will be receiving, a wheelchair that meets the coverage criteria established by Medicaid, and the WO/A itself must be medically necessary.

All WO/A recommendations must demonstrate that the member meets the criteria in the Basic WO/A Coverage Criteria outlined above, **and** the criteria outlined in the appropriate WO/A category below, to substantiate the client's functional and medical need.

ADJUSTABLE SEATING COMPONENTS-MANUALLY OPERATED

MANUAL ELEVATING LEGRESTS ARE COVERED IF:

- The member has sufficient motor function to operate the manual elevation mechanism independently or has a caregiver who can operate the elevation mechanism; **and**
 - The member has a musculoskeletal condition or the presence of a cast or brace which limits range of motion at the knee; **or**
 - The member has significant edema of the lower extremities and requires elevation for management of symptoms; **or**

- The member meets the criteria for and has a reclining back support or tilt on their wheelchair.

A MANUAL ELEVATING LEGREST WITH ARTICULATION IS COVERED IF:

- The member meets the criteria for a manual elevating legrest; **and**
 - The member requires even distribution of pressure over the seat surface while legs are elevated, and an increase in pressure on the sacrum and coccyx is caused with non- articulating Elevating Leg Rests; **or**
 - The member must maintain a constant hip angle during elevation of the lower extremities in order to manage spasticity or maintain pelvic alignment.

A MANUAL FULLY RECLINING BACK IS COVERED IF:

- The member is not at high risk for skin breakdown due to shear;
- There is a caregiver available to operate the manual recline; **and**
 - The member needs to perform ADLs or IADLs (including intermittent catheterization for bladder management) in a reclined position; **or**
 - The member has significant trunk or hip musculoskeletal deformity, or abnormal tone, and must be reclined to maintain postural control or spinal alignment; **or**
 - The member has trunk or lower extremity casts or braces that require the reclining feature for positioning; **or**
 - The member is at increased risk of developing sitting acquired decubitus ulcers with prolonged upright positioning and is unable to perform a functional weight shift; **or**
 - The member has respiratory, digestive, or cardiac dysfunction that is functionally improved with the recline feature; **or**
 - The member has a need to rest in a recumbent position two or more times per day and has an inability to transfer between bed and wheelchair without assistance.

MANUAL SWING AWAY, RETRACTABLE, OR REMOVABLE HARDWARE IS COVERED IF:

- The member requires the specialized mounting hardware to move a body support device out of the way in order to either:
 - Safely perform independent or assisted transfers; **or**
 - Perform other ADLs or IADLs while in the wheelchair; **or**
 - Allow the client's body to be adequately and safely positioned in the body support system; **or**
- The member requires the specialized mounting hardware to move a non-body support device (such as a joystick, switch, or other control device) out of the way in order to either:
 - Safely perform independent or assisted transfers, **or**
 - Perform other ADLs or IADLs while in the wheelchair.

ADJUSTABLE SEATING COMPONENTS-POWER OPERATED

A POWER ELEVATING LEGREST IS COVERED IF:

- The member does not have sufficient upper extremity function or balance to operate manual elevating legrests; **and**
 - The member has a musculoskeletal condition or the presence of a cast or brace which limits range of motion at the knee; **or**
 - The member has significant edema of the lower extremities that requires elevation for management of symptoms; **or**
 - The member experiences hypotensive episodes that require frequent positioning changes; **or**
 - The member meets the criteria for, and has a reclining back support or tilt on, their wheelchair.

A POWER ELEVATING LEGREST WITH ARTICULATION IS COVERED IF:

- The member meets the criteria for a Power Elevating Legrest; **and**
 - The member requires even distribution of pressure over the seat surface while legs are elevated, and an increase in pressure on the sacrum and coccyx is caused with non- articulating ELR's; **or**
 - The member must maintain a constant hip angle during elevation of the lower extremities in order to manage spasticity or maintain pelvic alignment.

A POWER CENTER MOUNT FOOTREST IS COVERED IF:

- The member meets the criteria for Power Elevating Legrest, or Power Elevating Legrest with articulation; and
 - The use of Power Elevating Legrest, or Power Elevating Legrest with articulation, creates accessibility problem (in the home, workplace, school, vehicle etc.) and such problem is mitigated with the use of a power center mount footrest.

A POWER SEAT ELEVATION SYSTEM IS COVERED IF:

- The member does not have the ability to stand or transfer independently;
 - The member does not have a full time care giver who can provide assistance with transfers;
and
 - The member currently requires assistance with transfers across unequal surface heights and, as a result of having the power seat elevation system, the member will be able to transfer across unequal surface heights unassisted; **or**
- The member has limited range of reach of the upper extremities due to limited joint mobility, limited active range of motion, congenital deformity, and/or short stature, which prohibits independent performance of ADLs or IADLs in the home and/or community;

- The member does not have a full time care giver who can provide assistance with ADLs or IADLs in the home and/or community; **and**
- Provision of a power seat elevator enables the member to accomplish independent performance of ADLs or IADLs in the home and/or community.

A POWER SEAT TO FLOOR FUNCTION IS COVERED IF THE FOLLOWING CRITERIA ARE MET:

- The member is independently mobile on the floor, is of short stature or medically fragile, and requires this feature to independently transfer into, and out of, their wheelchair, and is unable to perform other methods of transfers independently; **and**
- The member will routinely uses the PWC for ADLs or IADLs in Accommodated and/or Non- Accommodated Environments; **or**
- The member requires a power seat-to-floor function to meet specific developmental and/or medical needs due to Impairment in Body Structures or functions.

A POWER STANDING SYSTEM IS COVERED IF:

- Member is an independent PWCs user; **and**
- Member is able to demonstrate independent operation of the power standing seat functions; **and**
- Member is not at high risk for skin breakdown due to shear; **and**
 - Use of a power standing wheelchair reduces the need for outside caregiver assistance and enables the member to perform ADLs or IADLs he/she would otherwise not be able to perform without the device; **or**
 - A medically prescribed standing program has been recommended which will benefit the client's health and function (including, but not limited to: maintaining vital organ capacity, bone mineral density, circulation, and range of motion; reducing spasticity; and reducing the occurrence of decubitus ulcers and skeletal deformity), and the member is unable to independently transfer to an appropriately prescribed stand-alone standing frame and does not have access to a caregiver for assistance with transfers.

A POWER TILT AND/OR RECLINE SYSTEM IS COVERED IF:

- The member is at high risk for developing a pressure ulcer and is unable to independently perform a functional weight shift;
- The member utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed;
- The member has an Impairment of speech, cardiovascular, respiratory, or digestive function that is functionally improved with the tilt or recline feature;
- Power tilt or recline is needed to manage orthostatic hypotension related to an Impairment of cardiovascular, respiratory, or neuromusculoskeletal functions;
- Power tilt or recline is needed to ensure the member can be transferred and/or positioned into, and out of, the wheelchair safely by a caregiver;

- Power tilt or recline is needed to ensure the member can perform transfers into, and out of, the wheelchair independently, or independently re-position their body within the system;
 - Power tilt or recline is needed to achieve or maintain a safe and healthy body alignment, and/or maintain postural stability due to an impairment of neuromusculoskeletal and/or movement related functions (e.g. Impairment of joint mobility, muscle strength, muscle tone, muscle endurance, or motor coordination);
 - Power tilt or recline is needed to ensure the member is adequately positioned to perform or participate in ADLs or IADLs, such as eating, meal preparation, grooming/hygiene, etc.;
- or**
- The member requires frequent changes in orientation in space and/or joint position throughout the day to manage chronic, severe pain.

Note: If a combination of power tilt and recline is recommended, the evaluator must indicate why both seat functions are medically necessary and why power tilt or power recline alone is insufficient to meet the client's medical needs.

POWER TILT FOR A MANUAL WHEELCHAIR WILL BE COVERED IF:

- The member meets the criteria for need of a power tilt system; **and**
- Member is able to demonstrate independent operation of the power tilt seat function; **and**
- The member requires a MWB to meet their mobility needs in the home and/or community to perform ADLs or IADLs during a typical day.

PMD DRIVE CONTROL SYSTEMS

ALTERNATIVE DRIVE CONTROL SYSTEMS ARE COVERED IF:

- The member is unable to operate a PWC using a Standard Proportional Joystick due to an Impairment of Body Structures or Functions; **and**
- The member has adequate cognition and physical abilities required to operate the wheelchair using the recommended alternative drive control system.

AN ATTENDANT CONTROL IS COVERED IN PLACE OF, OR IN ADDITION TO, A CLIENT-OPERATED DRIVE CONTROL SYSTEM IF:

- The member is unable to propel a manual wheelchair or operate a PWC and there is a primary caregiver who is unable to push the member in a manual wheelchair but is able to operate a PWC, when the member is in it, using an Attendant Control.
 - Conditions under which this would be considered medically necessary would include:
 - Size/weight of the member is significantly greater compared to the caregiver; **or**
 - The caregiver has a documented medical condition limiting their ability to push or pull a wheelchair with the member in it; **or**
 - The caregiver has a documented medical condition affecting their endurance or stamina which affects their ability to push a manual wheelchair with the member in it;
- or**

- The member is able to operate the PWC with an alternative drive control system but cannot maneuver the chair safely or effectively in certain environments or situations, and there is a primary caregiver who is able to take control of the wheelchair for safety reasons. Situations in which this would be considered necessary could include, but is not limited to:
 - Accessing tight or restrictive areas, such as a ramp into a motor vehicle or an elevator, which requires precise control of the wheelchair through a proportional drive Attendant Control; **or**
- The member is able to independently operate a PWC, but has a medical condition that affects their ability to safely and effectively operate their PWC at certain times of the day, due to increasing fatigue or other fluctuation in medical condition.

AN EXPANDABLE CONTROLLER IS COVERED IF:

- The member operates their PWC with alternative drive control or a control device other than a Standard Proportional Joystick due to an Impairment in Body Structures or Functions; **or**
- The member requires operation of two or more power seat functions through the joystick; **or**
- The member currently uses a standard joystick but it is anticipated they will require an alternative drive control, due to a progressive condition, within the lifetime of the wheelchair frame.

A REMOTE STOP SWITCH IS COVERED IF:

- The member is a new wheelchair user who is learning to operate a PWC and will require a remote stop switch, for safety, during the learning phase; **or**
- The member has a medical condition and an Impairment in Body Functions or structures that affects their ability to reliably operate a PWC on a consistent basis, and a remote stop switch is required for safety reasons.
- The member is unable to reliably operate a PWC in certain environments and a remote stop switch is required for safety in these specific environments.

OTHER PMD WO/A

An electronic interface to allow a speech generating device (SGD) to be operated by the PWC drive control system is covered if:

- The member uses alternative drive control to independently operate a PWC, **and**
- The member has a covered and medically necessary SGD, **and**
- The member has limited access methods for operating auxiliary devices such as SGDs and computers, due to Impairment in Body Structure and functions, and operation of these auxiliary devices is required for independent performance of ADLs or IADLs in the home and/or community.

POWER SWING AWAY HARDWARE IS COVERED IF:

- The member requires access to a device for health or functional needs while seated in their wheelchair, and swing away hardware is needed to enable the member to both access the device and move the device out of the way; **and**
- The member has a significant level of Impairment in Body Structures or Functions and is not able to independently operate manual swing away hardware; **and**
- The member does not have access to a full time caregiver to assist with positioning of the device during the time in which the member is in the wheelchair; **and**
- The member has the ability to operate the power swing away hardware through an alternative access method.

SPECIALTY REAR WHEEL OPTIONS FOR MWBS

ERGONOMIC HANDRIMS ARE COVERED IF:

- The member does not have sufficient upper extremity function to self-propel an Optimally Configured Manual Wheelchair, with standard hand rims and wheels, in the home and/or community, to perform ADLs or IADLs during a typical day;
 - Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity, or absence of one or both upper extremities, are relevant to the assessment of upper extremity function; **and**
- The member is able to independently and functionally propel, with the addition of Ergonomic Hand Rims, in the home and/or community, to perform ADLs or IADLs during a typical day.

HAND RIMS WITH PROJECTIONS ARE COVERED IF:

- The member does not have sufficient upper extremity function to self-propel an Optimally Configured Manual Wheelchair, with standard hand rims and wheels, in the home and/or community to perform ADLs or IADLs during a typical day;
 - Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity, or absence of one or both upper extremities, are relevant to the assessment of upper extremity function; **and**
- The member is able to independently and functionally propel, with the addition of hand rims, with projections in the home and/or community, to perform ADLs or IADLs during a typical day.

ONE ARM DRIVE CONTROLS ARE COVERED IF:

- The member is unable to propel an Optimally Configured Manual Wheelchair, with standard drive wheels, in the home and/or community to perform ADLs or IADLs during a typical day, due

to an Impairment in movement related functions in one arm (e.g. Impairment of joint mobility, muscle strength, muscle tone, muscle endurance, or motor coordination); **and**

- The member is able to independently and functionally propel with the addition of a one arm drive feature; **and**
- The need is expected to last at least six months.

A PUSH RIM ACTIVATED POWER ASSIST DEVICE OR OTHER POWER ADD-ONS ARE COVERED IF:

- All of the criteria for independent use of a PMD are met; **and**
- The member does not have sufficient upper extremity function to self-propel an Optimally Configured Manual Wheelchair, with standard wheels, in the home and/or community to perform ADLs or IADLs during a typical day;
 - Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity, or absence of one or both upper extremities, are relevant to the assessment of upper extremity function; **and**

THE MEMBER IS ABLE TO INDEPENDENTLY SELF-PROPEL WITH THE ADDITION OF PUSH RIM ACTIVATED POWER ASSIST WHEELS, OR OTHER POWER ADD ONS, AN ARTICULATING VENTILATOR TRAY IS COVERED IF:

- Member is dependent on mechanical ventilator support or another medically required device while the member is utilizing the wheelchair;
- Member uses manual or power tilt and/or recline for positional changes in their wheelchair and articulation is required to maintain an upright position of the medical device.

DEFINITIONS

Note: All terms defined below are not necessarily part of the wheelchair benefit but are mentioned within the body of this Benefit Coverage Standard. These definitions are only applicable within the scope of this Benefit Coverage Standard.

ACCOMMODATED ENVIRONMENT

Ordinary indoor environments and mild outdoor terrain – including smooth, level surfaces (tile or low pile carpet), Americans with Disabilities Act Accessibility Guidelines (ADAAG) compliant ramps (no steeper than 1:12 rise to run ratio), thresholds of less than one inch in height, doorways that accommodate the passage of the wheeled mobility device with an additional one inch of clearance on each side of the device, paved surfaces.

ALTERNATE CONTROL SYSTEM

A type of input device or system, other than a Standard Proportional Joystick, used to operate a PWC. An alternate control system may include proportional input devices (e.g., mini, compact, or short throw joysticks, touch pads, chin control, head control, etc.) or a non-proportional input device (e.g. digital head array, digital switch array, sip n puff, non-proportional joystick, etc.). Alternate control systems can only be used on PWCs that accommodate expandable electronics.

ATTENDANT CONTROL

An attendant control is one which allows the caregiver to drive the wheelchair, instead of the member. The attendant control is usually mounted on one of the rear canes of the wheelchair.

BASIC ACTIVITY OF DAILY LIVING (ADL)

The term basic activity of daily living means an individual's capacity to safely participate in mobility and self-care activities including:

- maintaining and changing body position;
- transferring to or from one surface to another;
- walking;
- moving from place to place using mobility equipment, in a safe and timely manner;
- washing one's self;
- caring for one's body;
- toileting;
- dressing;
- eating;

- drinking;
- looking after one's health; and
- carrying, moving, and handling objects to perform and participate in other activities.

BODY FUNCTIONS

Body functions are the physiological functions of body systems (including psychological functions), which include:

- Mental functions (e.g. cognition, memory, attention, sleep)
- Sensory functions and pain (e.g. seeing, hearing, vestibular, taste, smell, touch)
- Voice and speech functions
- Functions of the cardiovascular, hematological, immunological, and respiratory systems
- Functions of the digestive, metabolic, and endocrine systems
- Genitourinary and reproductive functions
- Neuromusculoskeletal and movement-related functions (e.g. mobility/stability of joints and bones; muscle power, tone and endurance; motor reflexes; voluntary and involuntary movements)
- Functions of the skin and related structures (e.g. protective and repair functions of skin, skin sensation; hair and nails)

BODY STRUCTURES

Body structures are anatomical parts of the body such as organs, limbs and their components, which include:

- Structures of the nervous system (e.g. brain, spinal cord, sympathetic and parasympathetic nervous system)
- The eye, ear, and related structures
- Structures involved in voice and speech (e.g. nose, mouth, larynx, pharynx)
- Structures of the cardiovascular, immunological and respiratory systems
- Structures related to the digestive, metabolic, and endocrine systems
- Structures related to the genitourinary and reproductive systems
- Structures related to movement (e.g. head, neck, shoulder, upper extremity, pelvic region, lower extremity, trunk)
- Skin and related structures (e.g. skin, skin glands, nails, hair)

COMPLEX REHAB TECHNOLOGY (CRT)

Complex Rehab Technology (CRT) means individually configured manual wheelchair systems, PWC systems, adaptive seating systems, alternative positioning systems, standing frames, gait

trainers, and specifically designed options and accessories, classified as Durable Medical Equipment. CRT is individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for ADLs or IADLs including but not limited to: employment. CRT must be medically necessary to promote mobility in the home and community or to prevent hospitalization or institutionalization of the client; are primarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury.

ERGONOMIC HAND RIMS

Ergonomic hand rims provide a modified surface for increased propulsion efficiency for individuals with limited grip strength or dexterity in their hands. These specialty hand rims are also utilized to protect thumbs and fingers from injury when propelling and also allow a more ergonomic grip and to decrease repetitive stress injury to the hands.

EXPANDABLE CONTROLLER

An electronic system that is capable of accommodating one or more of the following additional functions:

- proportional input devices (e.g., mini, compact, or short throw joysticks, touch pads, chin control, head control, etc.) other than a Standard Proportional Joystick
- non-proportional input devices (e.g., sip-and-puff, head array, non-proportional joystick, single switch array)
- operate three or more powered seating actuators through the drive control

An expandable controller may also be able to operate one or more of the following:

- separate display (i.e., for alternative drive controls)
- other electronic devices (e.g., control of an augmentative speech device or computer through the chair's drive control)
- an attendant control

IMPAIRMENTS are problems in body function or structure such as a significant deviation or loss.

INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL)

The term instrumental activity of daily living means an individual's capacity to safely participate in life situations in the home and community, including:

- communicating;
- moving around using transportation;
- acquiring necessities, goods, and services;

- performing household tasks;
- caring for household members and family members;
- caring for household objects;
- engaging in education, work, employment and economic life; and
- participating in community, social, and civic activities.

INTERFACES FOR PWCS

Interfaces are considered medically necessary for persons with medically necessary PWCs, as appropriate depending upon the member's condition and ability to use the interface. The term interface describes the mechanism for controlling the movement of a PWC. Examples of interfaces include, but are not limited to, joystick, sip and puff, chin control, head control, etc.

LEVER-ACTIVATED RETROFITABLE WHEELCHAIR WHEELS

Retrofitable bi-manual, lever-activated, hub-based gear driven brake and reversible clutch transmission wheels (e.g., the Wijit® Tetra™ and Voyager™ Driving and Braking Systems (DBS®)) are activated by a lever mounted to the rear wheel hub that contains the transmission, gears and braking system. By pulling the levers inward towards the body, the brakes will engage. The Wijit Driving and Braking System (DBS) is a totally mechanical alternative propulsion system for manual wheelchairs. This driving and braking system is integrated into the wheel and attached to the wheelchair through its axle. The Wijit is intended to enable users to negotiate slopes and inclines, uneven terrain, and environmental obstacles and resistant surfaces. When compared to use of traditional push-rim wheels, the Wijit DBS is intended to increase the torque supplied to the wheels through leverage and gearing. According to the manufacturer, operators of the Wijit do not have to reach out and follow the push rim while attempting to grab and release a moving wheel. As such, their bodies remain upright most of the time. The manufacturer says this feature will reduce upper extremity injuries that occur with push-rim manual wheelchairs. According to the Centers for Medicare and Health First Colorado Services, HCPCS code E0958, "Manual wheelchair accessory, one-arm drive attachment, each", billed twice, adequately describes this product.

MISUSE

Misuse means gross neglect and/or intentionally harmful utilization of Durable Medical Equipment, Supplies and Prosthetic or Orthotic Devices that results in the need for repairs and replacement. The client's specific and unique medical, physical, and functional needs and capacities for basic and instrumental activities of daily living will be considered before assessing misuse.

MOBILITY LIMITATION

A limitation in mobility that will:

- I. Prevent the member from accomplishing a basic or instrumental activity of daily living (ADL) entirely; **or**
- II. Place the member at a reasonably determined heightened risk of morbidity or mortality or injury secondary to the attempts to perform the basic or instrumental ADL; **or**
- III. Prevent the member from completing a basic or instrumental ADL within a reasonable time frame.

NON-ACCOMMODATED ENVIRONMENT

Indoor environments with thick carpeting or higher than one inch thresholds or transitions between floor surfaces, outdoor environments with non ADAAG compliant ramps (steeper than a 1:12 ratio) or hills in the natural environment, curbs or gravel, grassy surfaces that are not level.

ONE-ARM DRIVE

A One-arm drive allows a manual wheelchair user to self-propel in a forward motion with only one upper extremity. Those who use this option generally use one or more feet at a hemi-height seat level to self-propel.

OPTIMALLY CONFIGURED MANUAL WHEELCHAIR

A manual wheelchair with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories to meet a client's specific medical and functional needs.

POWER ADD-ONS TO MANUAL WHEELCHAIRS

A power add-on is used to convert a manual wheelchair to a motorized wheelchair (e.g., an add-on to convert a manual wheelchair to a joystick-controlled PMD or to a tiller-controlled PMD).

POWER ELEVATING LEGREST

A power elevating legrest involves a dedicated motor and related electronics with or without variable speed programmability, which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s).

PRIMARY MOBILITY DEVICE

The PMD or MWB that a member uses the majority of the time in accommodated and/or non-accommodated environments to meet their daily medical and/or functional needs is referred to as their *primary mobility device*.

SECONDARY MOBILITY DEVICE

A *secondary mobility device* is a PMD, MWB, stroller or walking aid that the member uses routinely a minority of time in situations in which he or she is unable to use their primary mobility device to meet their medical and/or functional need. While the client's secondary mobility device is not used as frequently as their primary mobility device, the member requires it on a routine basis in accommodated and/or non-accommodated environments in order to perform basic and instrumental activities of daily living which cannot be performed using the primary mobility device.

SPECIALTY EVALUATION

A specialty evaluation is an assessment performed by a licensed/certified medical professional (such as a PT, OT, or physician) who has no financial relationship with the Durable Medical Equipment supplier and who has specific training and experience in Complex Rehab Technology wheelchair evaluations. The evaluation includes the physical and functional evaluation, treatment plan, goal setting, preliminary device feature determination, trials/simulations, fittings, function related training, determination of outcomes, and related follow-up. This evaluation is usually performed in conjunction with an equipment supplier who is a RESNA-certified Assistive Technology Professional, and who assists with the home environment accessibility survey, system configuration, fitting, adjustments, programming, and product related follow up.

STANDARD PROPORTIONAL JOYSTICK

A standard proportional joystick is a device typically found on Power Wheelchairs to operate speed and directionality. The stick-like device transforms the user's drive command (i.e., a physical action initiated by the wheelchair user) into a corresponding and comparative movement of the wheelchair, both in direction and in speed. The user can move the joystick within a 360 degree array, and the speed of the chair increases gradually as the stick is moved away from the neutral position, and it slows gradually as the joystick is returned to the neutral position. Therefore, the proportional joystick allows the user to make both a non-discrete directional command and a non-discrete speed command.

SWITCHES FOR PWCS

A switch is an electronic device which turns power to a particular function either "on" or "off". The external component of a switch may be either mechanical or non-mechanical.

Mechanical switches involve physical contact in order to be activated. Examples of the external components of mechanical switches include, but are not limited to, toggle, button, ribbon, etc. Examples of the external components of non-mechanical switches include, but are not limited to, proximity, infrared, etc.

Some PWCs have multiple switches. In those situations, each functional switch may have its own external component or multiple functional switches may be integrated into a single external switch component, or multiple functional switches may be integrated into the wheelchair control interface, without having a distinct external switch component.

A stop switch allows for an emergency stop when a wheelchair with a non-proportional interface is operating in the latched mode (Latched mode is when the wheelchair continues to move without the user having to continually activate the interface.) This switch is sometimes referred to as a kill switch.

TILLER STEERING SYSTEM

The Tiller Steering System is the mechanism used to maneuver a power operated vehicle (POV) or mobility scooter. The tiller is the steering column located at the front of the POV that provides forward/reverse directions, turns, and speed controls. Users turn the POV to the left or right directions by pulling or pushing the handles on the steering columns. The forward, reverse and speed controls are operated using thumb paddles, finger controls, or a switch. To operate a tiller steering system, the user must have a stable and upright posture, and some upper body mobility and strength in the trunk, shoulders, and hands.

VAN CAPTAIN SEATING

Seating typically found on a power operated vehicle (POV), Group 1 PWC, and most Group 2 PWCs. The seating consists of a one or two-piece automotive-style seat with rigid frame, cushioning material in both seat and back sections, covered in cloth, vinyl, leather or upholstery. The seating system is designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swing-away, or detachable. It may or may not have a headrest, either integrated or separate.

MANUAL WHEELCHAIR CODE GROUP DEFINITIONS

STANDARD MANUAL WHEELCHAIR

A Standard Manual Wheelchair is defined as a manual wheelchair that:

- Weighs more than 36 pounds;
- Does not have features to appropriately accept specialized seating or positioning;
- Has a weight capacity of 250 pounds or less;
- Has a seat depth of between 15 and 19 inches;
- Has a seat width of between 15 and 19 inches.
- Has a seat to floor height of 19 inches or greater;
- Has either a fixed, swing away, or detachable arm support with a fixed height only;
- Has either a fixed, swing away or detachable foot support.

STANDARD HEMI (LOW SEAT) WHEELCHAIR

A STANDARD HEMI (LOW SEAT) WHEELCHAIR IS DEFINED AS A MANUAL WHEELCHAIR THAT:

- Has the same features as a standard manual wheelchair, with the following exception:
 - Has a seat to floor height of less than 19 inches.

LIGHTWEIGHT MANUAL WHEELCHAIR

A LIGHTWEIGHT MANUAL WHEELCHAIR IS DEFINED AS A MANUAL WHEELCHAIR THAT:

- Has the same features as a standard or hemi manual wheelchair, with the following exceptions:
 - Weighs 34 to 36 pounds.
 - Has available arm support styles that are height adjustable.

HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR

A HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR IS DEFINED AS A MANUAL WHEELCHAIR THAT:

- Has the same features as a lightweight manual wheelchair, with the following exceptions:
 - Weighs 30 to 34 pounds.
 - Has a lifetime warranty on side frames and cross braces.

AN ULTRA LIGHTWEIGHT WHEELCHAIR IS DEFINED AS A MANUAL WHEELCHAIR THAT:

- Weighs less than 30 lbs.
- Has one or more of the following features to appropriately accept specialized seating or positioning:
 - Adjustable seat-to-back support angle
 - Adjustable seat depth

- Independently adjustable front and rear seat-to-floor height dimensions
- Adjustable caster stem hardware
- Adjustable rear axle
- Adjustable wheel camber
- Adjustable center of gravity
- Lifetime warranty on side frames and cross braces

HEAVY DUTY WHEELCHAIR

A HEAVY DUTY WHEELCHAIR IS DEFINED AS A MANUAL WHEELCHAIR THAT:

- Can support a member weighing more than 250 pounds.

EXTRA HEAVY DUTY WHEELCHAIR

AN EXTRA HEAVY-DUTY WHEELCHAIR IS DEFINED AS A MANUAL WHEELCHAIR THAT:

- Can support a member weighing more than 350 lbs.

CUSTOM MANUAL WHEELCHAIR/BASE

A CUSTOM MANUAL WHEELCHAIR/BASE IS DEFINED AS:

- Any manual wheelchair or base that doesn't fit within the specific guidelines for other HCPCS codes; and
- Has been uniquely constructed or substantially modified for a specific client.

STANDARD RECLINING WHEELCHAIR

A STANDARD RECLINING WHEELCHAIR IS DEFINED AS A MANUAL WHEELCHAIR THAT:

- Has the same features as a standard or hemi manual wheelchair, with the following exception:
 - Has the ability to allow the back of the wheelchair to move independently of the seat to provide a change in orientation by opening the seat-to-back support angle greater than 80 degrees.

ADULT SIZED TILT-IN-SPACE WHEELCHAIR

AN ADULT SIZED TILT-IN-SPACE WHEELCHAIR IS DEFINED AS A MANUAL WHEELCHAIR THAT:

- Has the ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal, while maintaining a constant seat to back support angle, to provide a change of orientation and redistribute pressure from one area (such as the buttocks and the thighs) to another area (such as the trunk and the head);
- Has a weight capacity of at least 250 pounds;
- Has a seat width or depth 15 inches or greater.

PEDIATRIC MANUAL WHEELCHAIR

A PEDIATRIC MANUAL WHEELCHAIR IS DEFINED AS A MANUAL WHEELCHAIR THAT:

- Has a seat width or depth 14 inches or less;
- Has the ability to adjust features to appropriately accept specialized seating or positioning;
- Has adjustability to grow the frame size to accommodate growth of the member over the expected lifetime of the wheelchair
- Provides the member with the ability to self-propel or potential to self-propel to accomplish basic and instrumental activities of daily living in the home and/or community.

TILT-IN-SPACE PEDIATRIC MANUAL WHEELCHAIR

A PEDIATRIC SIZED TILT-IN-SPACE WHEELCHAIR IS DEFINED AS A MANUAL WHEELCHAIR THAT:

- Has the ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal, while maintaining a constant seat to back support angle, to provide a change of orientation and redistribute pressure from one area (such as the buttocks and the thighs) to another area (such as the trunk and the head);
- Has a seat width or depth 14 inches or less.

BASIC ADAPTIVE STROLLERS

A BASIC ADAPTIVE STROLLER IS DEFINED AS MOBILITY BASE THAT:

- Is a dependent mobility base with small rear wheels not intended for independent self-propulsion;
- Is available in a wide range of sizes accommodating very young children to grown adults;
- Has limited adjustability of frame size and features;
- Does not accept separate specialized seating or positioning components; seating/positioning features, if available, are integrated into the device. ;
- Has limited adjustability to grow the frame size to accommodate growth of the member over the expected lifetime of the mobility base;
- Generally weighs less and is easier to fold than a pediatric manual wheelchair making it appropriate for transportation and stowage needs.

TRANSPORT CHAIRS/ROLLABOUT CHAIRS: INCLUDING ADULT, PEDIATRIC, AND HEAVY DUTY SIZED

A ROLLAABOUT CHAIR IS DEFINED AS A WHEELCHAIR THAT:

- Has casters of at least five inches in diameter and is specifically designed to meet the needs of a member with an Impairment of Body Structure or Function.

A TRANSPORT CHAIR IS DEFINED AS A WHEELCHAIR THAT:

- Has casters of at least five inches in diameter and is specifically designed to meet the needs of a member with an Impairment of Body Structure or Function.
- A standard Transport Chair has a weight capacity of up to and including 300 pounds.
- A heavy duty Transport Chair has a weight capacity greater than 300 pounds.

DEFINITION OF POWER MOBILITY DEVICE (PMD) TYPES

PMD refers to the following two categories:

POWER OPERATED VEHICLES (POVS):

Power operated vehicles (POVs), commonly known as "scooters", are three or four-wheeled, non-highway motorized, transportation systems for persons with impaired ambulation. These devices are operated by a tiller with a professionally manufactured basic seating system.

POWER WHEELCHAIRS (PWCS):

A PWC is a professionally manufactured device that provides motorized wheeled mobility and body support specifically for individuals with impaired mobility. PWCs are four or six-wheeled motorized vehicles whose steering is operated by an electronic device or joystick to control direction, turning, and alternative electronic functions, such as power seating options.

THERE ARE FIVE GROUPS OF PWCS. FEATURES RELATED TO RANGE, SPEED, DURABILITY AND OBSTACLE-CLIMB CAPABILITIES ARE USED TO DIFFERENTIATE THE GROUPS, AS FOLLOWS:

GROUP 1 PWC:

In general, the range, speed, durability, and obstacle climb capabilities of a Group 1 PWC make them appropriate primarily for light-duty use in accommodated environments only. These chairs cannot accommodate seating and positioning items and have limited configurability in seating dimensions. They cannot accommodate an expandable controller, or an Alternate Control System. They may have cross-brace construction and they are typically intended to be portable.

GROUP 2 PWCS:

In general, the range, speed, durability, and obstacle climb capabilities of a Group 2 PWC make them appropriate primarily for daily use in accommodated environments and occasional use in non-accommodated environments. Some Group 2 PWCs can accommodate a seat platform that allows for the addition of specialty seat cushions and back supports. CMS defines a small subsection of Group 2 PWCs as being capable of accommodating power tilt, expandable electronics, and Alternate Control Systems; however the vast majority of Group 2 coded PWCs cannot and do not meet this capability.

GROUP 3 PWCS:

In general, the range, speed, durability, and obstacle climb capabilities of a Group 3 PWC make them appropriate for daily use in accommodated environments and intermittent use in non-

accommodated environments. A Group 3 PWC has more available options in the configurability of the seat dimensions than a Group 1 or 2 PWC, and the dimensions of the seating system can often be modified to meet a client's changing needs. A Group 3 PWC can accommodate a large array of seating and positioning items. A Group 3 PWC can be upgraded to accommodate an expandable controller and an Alternate Control System. These PWCs do not have cross-brace construction and they are not portable.

GROUP 4 PWCS:

In general, the range, speed, durability, and obstacle climb capabilities of a Group 4 PWC make them appropriate primarily for extended use in accommodated and non-accommodated environments. A Group 4 PWC has more available options in the configurability of the seat dimensions than a Group 1 or 2 PWC, and the dimensions of the seat system can be modified to meet a client's changing needs. A Group 4 PWC can accommodate a large array of seating and positioning items. A Group 4 PWC can be upgraded to accommodate an expandable controller and an Alternate Control System. A Group 4 PWC can travel at a minimum speed of 6 mph and has a minimum range of 16 miles per day, making them appropriate for extended use at high speeds in non-accommodated environments where varied, rough, and uneven terrain is regularly encountered. These PWCs do not have cross-brace construction and they are not portable.

GROUP 5 PWCS:

In general, the range, speed, durability, and obstacle climb capabilities of a Group 5 PWC make them appropriate for daily use in accommodated environments and intermittent use in non-accommodated environments. A Group 5 Single Power Seating Option power PWC is appropriate for individuals who need the special developmental features of the chair, such as very low seat to floor height, overall small base size, and/or growth capabilities. A Group 5 Multi-Power Seating Option PWC is appropriate for individuals who require the specialized power seat functions not available on other PWCs. A Group 5 PWC can accommodate a large array of seating and positioning items. A Group 5 PWC can be upgraded to accommodate an expandable controller and an Alternate Control System.

DEFINITION OF POWER SEAT FUNCTION OPTIONS FOR PWCS:

Various power seat function options are available for PWCs described in the previous section. Power seat function options refer to the capability of the PWC to accept power tilt, recline, seat elevation, and/or standing systems. There are three power seat function options, which are defined as follows:

NO POWER SEATING OPTION WHEELCHAIRS

No-power seating option PWCs do not have the capability to accept power tilt, power recline, power seat elevation, or a power standing system. If a PWC can ONLY accept power elevating legrests, it is considered to be a no-power seating option chair.

SINGLE POWER SEATING OPTION WHEELCHAIRS

Single-power seating option PWCs have the capability to accept and operate a power tilt or power recline system, but not a combination of power tilt **and** power recline. It may also be able to accommodate power elevating legrests, a power seat elevator, and/or a power standing system.

MULTIPLE POWER SEATING OPTION WHEELCHAIRS

Multiple-power seating option PWCs have the capability to accept and operate a combination power tilt **and** power recline seating system. It may also be able to accommodate power elevating legrests, a power seat elevator, and/or a power standing system.

DEFINITIONS OF WHEELCHAIR SEATING EQUIPMENT

CUSTOM CONTOURED SEAT CUSHION AND CUSTOM CONTOURED BACK SUPPORT

A custom contoured seat cushion or custom contoured back support is a static cushion that is individually made for a specific individual starting with basic materials including: (a) liquid foam or a block of foam and (b) sheets of fabric or liquid coating material. The complete cushion must be fabricated using molded-to-member-model technique, direct molded-to-member technique, CAD-CAM technology, or detailed measurements of the person used to create a carved foam cushion. The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface.

GENERAL USE SEAT CUSHION

A GENERAL USE SEAT CUSHION IS A STATIC, PREFABRICATED CUSHION THAT HAS THE FOLLOWING CHARACTERISTICS:

- It is composed of foam, flexible cellular material, air, fluid or solid gel/elastomer or a combination of these materials; and
- It has the following minimum performance characteristics:
 - Simulation tests demonstrate a loaded contour depth of at least 25 mm with an overload deflection of at least 5 mm, or
 - Human subject tests demonstrate peak interface pressures that are less than 125% of those of a standard reference cushion at each of the three following anatomic locations: right and left ischial tuberosities and sacrum/coccyx; and
- Following fatigue testing simulating 12 months of use, overload testing does not demonstrate bottoming out; and
- It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
- The cushion and cover meet the minimum standards for the California Bulletin 117 for flame resistance; and
- It has a permanent label indicating the model and manufacturer, and

- It has a warranty that provides full replacement if the manufacturing defects are identified or the surface does not remain intact due to normal wear within 12 months.

GENERAL USE BACK SUPPORT

A GENERAL USE BACK SUPPORT IS A STATIC, PREFABRICATED CUSHION WHICH HAS THE FOLLOWING CHARACTERISTICS:

- It is composed of foam, flexible cellular material, or solid gel/elastomer; and
- It is planar or contoured; and
- It has a removable vapor permeable or water proof cover or it has a waterproof surface; and
- The cushion and cover meet the minimum standards for the California Bulletin 117 for flame resistance; and
- It has a permanent label indicating the model and manufacturer; and
- It has a warranty that provides full replacement if the manufacturing defects are identified or the surface does not remain intact due to normal wear within 12 months.

SKIN PROTECTION SEAT CUSHION

A SKIN PROTECTION SEAT CUSHION IS A STATIC, PREFABRICATED CUSHION THAT HAS THE FOLLOWING CHARACTERISTICS:

- The cushion must be:
 - Composed of 2 or more of the following materials: foam, flexible cellular material, air, fluid or solid gel/elastomer; or
 - A multi-compartment air cushion; or
 - A cushion composed of two or more types of foam with different stiffness of foam; and
- It has the following minimum performance characteristics:
 - Simulation tests demonstrate a loaded contour depth of at least 40 mm with an overload deflection of at least 5 mm; or
 - Human subject tests demonstrate peak interface pressures that are less than 90% of those of a standard reference cushion at each of the three following anatomic locations: right ischial tuberosities, left ischial tuberosities and sacrum/coccyx; and
- Following fatigue testing simulating 18 months of use, overload testing does not demonstrate bottoming out; and
- It has a removable vapor permeable or water proof cover or it has a waterproof surface; and
- The cushion and cover meet the minimum standards for the California Bulletin 117 for flame resistance; and
- It has a permanent label indicating the model and manufacturer; and
- It has a warranty that provides full replacement if the manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

POSITIONING SEAT CUSHION

A POSITIONING SEAT CUSHION IS A STATIC, PRE-FABRICATED CUSHION THAT HAS THE FOLLOWING CHARACTERISTICS:

- It is composed of foam, flexible cellular material, air, fluid or solid gel/elastomer, or any combination of these materials; and
- It has two or more of the following structural features:
 - A pre-ischial bar or ridge which is placed anterior to the ischial tuberosities and prevents forward migration of the pelvis,
 - Two lateral pelvic supports which are placed posterior to the trochanters and provide lateral stability to the pelvis,
 - A medical thigh support which is placed anterior to the trochanters and provides medial stability to the lower extremities,
 - Two lateral thigh supports which are placed anterior to the trochanters and provide lateral stability to the lower extremities.

The feature must be at least 25 mm in height in the pre-loaded state, from the lowest point of contact, to the targeted body part, to the highest point of contact; and

- It has the following minimum performance characteristics:
 - Simulation tests demonstrate a loaded contour depth of at least 25 mm with an overload deflection of at least 5 mm; or
 - Human subject tests demonstrate peak interface pressures that are less than 125% of those of a standard reference cushion at each of the three following anatomic locations: right ischial tuberosities, left ischial tuberosities and sacrum/coccyx; and
- Following fatigue testing simulating 18 months of use, overload testing does not demonstrate bottoming out; and
- It has a removable vapor permeable or water proof cover or it has a waterproof surface; and
- The cushion and cover meet the minimum standards for the California Bulletin 117 for flame resistance; and
- It has a permanent label indicating the model and manufacturer; and
- It has a warranty that provides full replacement if the 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.

POSITIONING BACK SUPPORT

A POSITIONING BACK SUPPORT IS A STATIC, PRE-FABRICATED CUSHION WHICH PROVIDES ALL OF THE FOLLOWING FEATURES:

- Full back support, which starts in the sacral spine or pelvis and reaches the spine of the scapula; and
- Both posterior and lateral support; and
- One inch or more of posterior contour, either through pre-contouring or load-contouring; and
- Three inches or more of lateral support, either through pre-contouring or load contouring
- The cushion is:
 - Composed of two or more of the following materials: foam, flexible cellular material, air, fluid or solid gel/elastomer, or
 - A multi-compartment air cushion; or
 - A cushion composed of two or more types of foam with different stiffness of foam; and
- It has a removable vapor permeable or water proof cover or it has a waterproof surface; and
- The cushion and cover meet the minimum standards for the California Bulletin 117 for flame resistance; and
- It has a permanent label indicating the model and manufacturer; and
- It has a warranty that provides full replacement if the manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months

SKIN PROTECTION AND POSITIONING CUSHION

A SKIN PROTECTION AND POSITIONING CUSHION IS A STATIC, PRE-FABRICATED CUSHION WHICH PROVIDES ALL OF THE FOLLOWING FEATURES:

- The cushion must be:
 - Composed of two or more of the following materials: foam, flexible cellular material, air, fluid or solid gel/elastomer, or
 - A multi-compartment air cushion; or
 - A cushion composed of two or more types of foam with different stiffness of foam; and
- It has two or more of the following structural features:
 - A pre-ischial bar or ridge which is placed anterior to the ischial tuberosities and prevents forward migration of the pelvis,
 - Two lateral pelvic supports which are placed posterior to the trochanters and provide lateral stability to the pelvis,
 - A medial thigh support which is placed anterior to the trochanters and provides medial stability to the lower extremities,

- Two lateral thigh supports which are placed anterior to the trochanters and provide lateral stability to the lower extremities.
- The feature must be at least 25 mm in height in the pre-loaded state, from the lowest point of contact, to the targeted body part, to the highest point of contact; and
- It has materials and components which may be added or removed to help address orthopedic deformities or postural asymmetries; and
- It has the following minimum performance characteristics:
 - Simulation tests demonstrate a loaded contour depth of at least 40 mm with an overload deflection of at least 5 mm; or
 - Human subject tests demonstrate peak interface pressures that are less than 90% of those of a standard reference cushion at each of the three following anatomic locations: right ischial tuberosities, left ischial tuberosities and sacrum/coccyx; and
- Following fatigue testing simulating 18 months of use, overload testing does not demonstrate bottoming out; and
- It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
- The cushion and cover meet the minimum standards for the California Bulletin 117 for flame resistance; and
- It has a permanent label indicating the model and manufacturer; and
- It has a warranty that provides full replacement if the manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

Change Log

Revision Date	Section/Action	Made by
12/1/2022	Policy clarified to allow secondary PMDs in certain situations.	HCPF