PROVIDER POLICIES & PROCEDURES

WHEELCHAIRS AND RELATED ACCESSORIES

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for wheelchairs and related accessories. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

A wheelchair is considered durable medical equipment for individuals who have a mobility issue that prevents them from performing mobility-related activities of daily living (MRADLs). This includes individuals who need mobility assistance on a short-term basis and individuals with chronic conditions that require mobility assistance on a permanent basis. Wheelchairs can be manual, electrically powered, or motorized. Wheelchairs may also require accessories to allow an individual to maintain current physical functions and perform essential MRADLs while using the wheelchair.

Note: Effective July 1, 2024, wheelchair repairs do not require prior authorization.

HUSKY Health primarily uses Change Healthcare's InterQual® Criteria when reviewing prior authorization requests for most wheelchairs and related accessories. HUSKY Health will use this policy to review requests for wheelchairs and related accessories for which InterQual® Criteria are not available.

CLINICAL GUIDELINE

Coverage guidelines for wheelchairs and related accessories are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines only. Coverage determinations are based on an assessment of the individual and his or her unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Standard, Heavy Duty, and Lightweight Manual Wheelchairs

A standard, heavy duty, or lightweight manual wheelchair may be considered medically necessary when:

A. The individual has a mobility limitation that impairs their ability to participate in one or more MRADLs, such as feeding, dressing, toileting, grooming, and bathing in the customary locations in their customary and anticipated environment;
B. The individual's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted walker or cane;
C. The individual's living environment can accommodate a manual wheelchair;
D. The individual (or caregiver) is willing to use the manual wheelchair in their customary and anticipated

environment; and

E. The type of manual wheelchair ordered is based on the individual's physical or functional assessment and body size:
    1. Standard: meets above criteria for standard wheelchair.
    2. Lightweight: meets above criteria for standard wheelchair and the individual cannot consistently self-propel in a standard wheelchair.
    3. High strength lightweight: meets above criteria for standard wheelchair and the individual participates in daily activities that cannot be completed in a standard or lightweight wheelchair.
    4. Heavy duty: meets above criteria for standard wheelchair and the individual's body size cannot be accommodated by a standard wheelchair.
    5. Fully reclining meets above criteria for standard wheelchair and the individual needs the ability to recline to allow for frequent stretching/position changes to off-set pressure and improve comfort.
    6. Hemi: meets above criteria for standard wheelchair and the individual requires a lower seat height due to short stature or the need to place their feet on the ground for propulsion.
    7. Amputee: meets the above criteria for standard wheelchair and the individual requires a wheelchair with increased stability to offset the imbalance created due to a missing limb.

Wheelchair Frames/Bases

A motorized, power wheelchair frame or base (HCPCS codes K0010-K0012) may be considered medically necessary for individuals when the following criteria are met:

A. The individual has a mobility limitation that impairs their ability to participate in one or more MRADLs, such as feeding, dressing, toileting, grooming, and bathing in the customary locations in their customary and anticipated environment;
B. The individual's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted walker or cane;
C. The individual does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform daily MRADLs;
D. The individual and/or caregiver can safely operate the controls of a powered or motorized wheelchair;
E. The individual's weight is less than or equal to the weight capacity of the selected power wheelchair;
F. The individual's customary and anticipated environment provides adequate access between rooms with maneuvering space and surfaces for the operation of powered or motorized wheelchair;
G. The individual is willing to use the powered or motorized wheelchair in their customary and anticipated environment; and
H. The use of a powered or motorized wheelchair will improve the individual's ability to participate in MRADLs and the powered or motorized wheelchair will be used on a regular basis in their customary and anticipated environment.

Miscellaneous Wheelchair Options and Accessories

A shoulder elbow mobile arm support as an accessory to a wheelchair (HCPCS codes E2626 -E2630) may be considered medically necessary when the individual has severe shoulder girdle weakness or upper extremity weakness related to a neurological, muscular, or orthopedic condition.

A nonstandard seat frame as an accessory to a power wheelchair (HCPCS codes E2340 – E2343) may be considered medically necessary when the individual's physical size justifies the need for a nonstandard seat.

Wheelchair Component or Accessory, Not Otherwise Specified (HCPCS code K0108)

A booster base pediatric seating system as a component of a stroller may be considered medically necessary when:

A. The option or accessory is needed for the individual to maintain current physical functions and/or perform activities of daily living;
B. The option or accessory is primarily and customarily being used to serve a medical purpose and would not be useful in the absence of injury or illness; and
C. There is documentation of one or more barriers that impact the caregiver's ability to carry a stroller into and out of the home e.g., multiple stairs.

A blind spot detection system or back-up camera as an attachment to a power wheelchair may be considered medically necessary when:

The individual has limited range of motion/weakness of the neck or other condition that impairs their ability to safely operate the power wheelchair without use of these items.

Other miscellaneous wheelchair options or accessories may be considered medically necessary when:

A. The option or accessory is needed for the individual to maintain current physical functions and/or perform activities of daily living;
B. The option or accessory is primarily and customarily being used to serve a medical purpose and would not be useful in the absence of injury or illness; and
C. There is documentation in the *Wheeled Mobility Letter of Medical Necessity* supporting both A and B.

Not Medically Necessary

The following items (typically requested under HCPCS code K0108) do not meet the definition of DME (as they are not primarily medical in nature and would be considered useful to someone in the absence of injury or illness) and are therefore generally not covered:

- USB chargers
- Hand warmers
- Cup holders
- Under storage baskets (may be covered if needed to hold medically necessary items)
- Bag hooks (may be covered if needed to hold medically necessary items)

Backup Wheelchairs

A backup manual wheelchair or stroller may be considered medically necessary when:

A. The individual is using a power wheelchair and requires a manual wheelchair or stroller to access medical care in the community or other activity outside of the home, even if not needed for other activities of daily living; **or**
B. The individual is using a power wheelchair and the wheelchair is not functioning; **or**
C. The individual has dual residency between caregivers and the power wheelchair does not fit in the second residence.

A custom backup manual wheelchair or stroller may be considered medically necessary if the criteria above for a backup manual wheelchair or stroller have been met and the wheelchair or stroller requires customization to maintain the individual in an appropriate position.

Not Covered

The following are typically considered not medically necessary. Requests for these items will be reviewed on a case-by-case basis:

- Wheelchair options and accessories used primarily for the performance and participation in leisure or recreational activities
- Stair climbing wheelchair systems
- Computerized mobility systems (e.g., iBOT™ Mobility System)

The following items are not covered as they do not meet the DSS definition of durable medical equipment:

- Home modifications to accommodate a wheelchair, i.e., widening of doors; wheelchair ramps; lowered bath or kitchen counters and sinks; wheelchair accessible showers
- Vehicle purchase and/or vehicle modifications to accommodate a wheelchair, i.e., vehicle lifts, vehicle door modifications

EPSDT Special Provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization of wheelchairs and related accessories is required. Requests for coverage will be reviewed in accordance with procedures in place for reviewing requests for durable medical equipment. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for wheelchairs and related accessories:

- Fully completed authorization request via web portal
- Prescription from a licensed physician, APRN, or PA enrolled in the Connecticut Medical Assistance Program (CMAP)
- Clinical documentation from the ordering physician/APRN/PA supporting medical necessity*
- For members residing in a skilled nursing facility (SNF) only:
  - Documentation of an evaluation performed by an orthopedic or physiatrist within three (3) months of the prior authorization request
  - Signed W628 dated within three (3) months of the prior authorization request
- Completed *Wheeled Mobility Letter of Medical Necessity Form**
- Completed *Accessibility Survey*
- Detailed product description including manufacturer, model/part number, product description, HCPCS code, unit(s), quantity, and the Manufacturer's Suggested Retail Pricing (MSRP)

* Evaluations/forms/medical record documentation must be completed within the last six (6) months for individuals living in the community or within the last ninety (90) days for individuals living in a skilled nursing facility.

EFFECTIVE DATE
This Policy is effective for prior authorization requests for wheelchairs and related accessories for individuals covered under the HUSKY Health Program beginning November 01, 2024.

LIMITATIONS
N/A

CODES

Codes Reviewed Using Policy

Code/Code Range	Description
E1050-E1070	Fully-reclining wheelchairs
E1083-E1086	Hemi-wheelchairs
E1087-E1090	High-strength lightweight wheelchairs
E1130	Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests
E1170-E1190	Amputee wheelchairs
E1195	Heavy-duty wheelchair, fixed full-length arms, swing-away detachable elevating leg rests
E1200	Amputee wheelchair, fixed full-length arms, swing-away detachable footrest
E1220*	Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification
E1260	Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
E2340-E2343	Power wheelchair accessory, nonstandard seat frame
E2626-E2630	Wheelchair accessory, mobile arm support
K0010	Standard weight frame, motorized/power wheelchair
K0011	Standard weight frame, motorized/power wheelchair with programmable control
K0012	Lightweight, portable motorized/power wheelchair
K0108	Wheelchair component or accessory, not otherwise specified

*****E1220 may be used to submit a prior authorization request for a custom wheelchair; however, authorization will be given for the wheelchair base and all necessary components. Reference DSS Provider Bulletin 2016-28: Billing for Customized Wheelchairs.

Codes/Code Ranges Reviewed Using InterQual Criteria

E0950 - E0958	E0961	E0973 - E0978	E0983-E0990	E0995	E1002 - E1014

E1017 - E1018	E1028 - E1030	E1035 - E1039	E1161	E1225 - E1226	E1232 - E1238
E2201 - E2204	E2227 - E2231	E2291 - E2322	E2325 - E2331	E2351	E2366
E2373	E2375 - E2378	E2397 - E2398	E2603 - E2609	E2613 - E2617	E2620 - E2625
K0001 - K0008	K0013	K0040	K0042	K0669	K0080 - K0816
K0820 - K0898					

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B)recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

- Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD) for Manual Wheelchair Bases (L33788). January 1, 2020. Accessed July 9, 2024. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33788

- Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD) for Power Mobility Devices (L33789). May 16, 2023. Accessed July 9, 2024. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33789
- Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD) for Wheelchair Options/Accessories (L33792). April 1, 2024. Accessed July 9, 2024. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33792
- Centers for Medicare and Medicaid Services. National Coverage Determination (NCD) for Independence iBOT 4000 Mobility System (280.15). July 26, 2006. Accessed July 9, 2024. Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=317
- DSS Pricing Policy for Medical Equipment, Device, and Supplies (MEDS) Items. Available at: https://www.huskyhealthct.org/provider/policies_procedures.html
- DSS Provider Bulletin 2017-36: Corrected and Updated Policy Regarding Wheeled Mobility Device Policy, Forms and Related Documents, dated June 2017.
- DSS Provider Bulletin 2024-42: (1) Removal of Prior Authorization from Wheelchair Repair Procedure Codes, (2) Manual Pricing Process for Select Wheelchair Repair Codes, dated June 2024.
- Regulations of Connecticut State Agencies. Section 17-134d-46(h), IDT Assessment Requirements

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	September 2024	Approved at the September 11, 2024 Medical Reviewer meeting. Approved at the CHNCT Clinical Quality Subcommittee on September 16, 2024. Approved by DSS on September 27, 2024.