



Manual Wheelchair Power Accessories Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Manual Wheelchair Power Accessories		
MNG #: 122	<input checked="" type="checkbox"/> CCA Senior Care Options (HMO D-SNP) (MA) <input checked="" type="checkbox"/> CCA One Care (Medicare-Medicaid) (MA) <input checked="" type="checkbox"/> CCA Medicare Preferred (PPO) (MA & RI) <input checked="" type="checkbox"/> CCA Medicare Value (PPO) (MA & RI) <input checked="" type="checkbox"/> CCA Medicare Maximum (HMO D-SNP) (RI) <input checked="" type="checkbox"/> CCA Medicare Excel (HMO POS) (MI) <input checked="" type="checkbox"/> CCA Medicare Maximum (HMO D-SNP) (MI) <input checked="" type="checkbox"/> CCA Medicare Excel (HMO) (CA)	Prior Authorization Needed? <input checked="" type="checkbox"/> Yes (always required) <input type="checkbox"/> Yes (only in certain situations. See this MNG for details) <input type="checkbox"/> No
Benefit Type: <input checked="" type="checkbox"/> Medicare (E0983, E0984 are not a Medicare Benefit) <input checked="" type="checkbox"/> Medicaid	Approval Date: 3/14/2024	Effective Date: 9/30/2024
Last Revised Date:	Next Annual Review Date: 3/14/2025	Retire Date:

OVERVIEW: Manual wheelchair power accessories are components that are added to a manual wheelchair. Accessories can be from the same manufacturer as the manual wheelchair or from a different manufacturer. The accessories meet specific needs of an individual that the base model manual wheelchair is not able to meet. These accessories can be added either when the wheelchair is prescribed or when a change in member’s condition warrants the addition of the accessory. These accessories facilitate the individual’s ability to propel the manual wheelchair.

A push-rim activated power assist (e.g. SmartDrive) is an option for a manual wheelchair in which sensors in specially designed wheels determine the force that is exerted by the individual upon the wheel. Additional propulsive and/or braking force is then provided by motors in each wheel. Other accessories to a manual wheelchair include a joystick-controlled power mobility device and a tiller-controlled power mobility device that convert a manual wheelchair to a motorized wheelchair.

A manual wheelchair with power accessories may offer similar functionality to a power wheelchair, however, there may be benefits that a power wheelchair offers over a power assist device. An evaluation by a licensed/certified medical professional is beneficial to help determine what might best suit an individual’s needs.



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MA Medicare Preferred, MA Medicare Value, RI Medicare Preferred, RI Medicare Value, RI Medicare Maximum, MI Medicare Excel, MI, MI Medicare Maximum, CA Medicare Excel

DEFINITIONS: MA Medicare Preferred, MA Medicare Value, RI Medicare Preferred, RI Medicare Value, RI Medicare Maximum, MI Medicare Excel, MI, MI Medicare Maximum, CA Medicare Excel

Durable Medical Equipment (DME): Equipment which;

- Can withstand repeated use; i.e., could normally be rented and used by successive patients
- Is primarily and customarily used to serve a medical purpose
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in a member's home.

DECISION GUIDELINES: MA Medicare Preferred, MA Medicare Value, RI Medicare Preferred, RI Medicare Value, RI Medicare Maximum, MI Medicare Excel, MI, MI Medicare Maximum, CA Medicare Excel

Clinical Coverage Criteria:

For **MA Medicare Preferred, MA Medicare Value, RI Medicare Preferred, RI Medicare Value, RI Medicare Maximum, MI Medicare Excel, MI, MI Medicare Maximum, CA Medicare Excel** members, the following coverage guidance is used: **Power Mobility Devices Local Coverage Determination (LCD) L33789 and related Power Mobility Devices-Policy Article A52498.**

LIMITATIONS/EXCLUSIONS: MA Medicare Preferred, MA Medicare Value, RI Medicare Preferred, RI Medicare Value, RI Medicare Maximum, MI Medicare Excel, MI, MI Medicare Maximum, CA Medicare Excel

1. An add-on to convert a manual wheelchair to a joystick-controlled power mobility device (E0983) or to a tiller-controlled power mobility device (E0984) will be denied as not reasonable and necessary.
2. Payment is made for only one wheelchair at a time. Backup chairs are denied as not reasonable and necessary.
3. If any power wheelchair (PWC) is only for use outside the home, it will be denied as noncovered.
4. If the manual wheelchair is only for use outside the home, it will be denied as noncovered, no benefit, as the DME benefit requires use within the home for coverage eligibility.
5. Upgrades that are beneficial primarily in allowing the member to perform leisure or recreational activities are noncovered.

Senior Care Options and One Care

DEFINITIONS: Senior Care Options and One Care

Accessories: Products that are used primarily and customarily to modify or enhance the usefulness or functional capability of an item of durable medical equipment and that are generally not useful in the absence of the item of durable medical equipment.



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Durable Medical Equipment (DME): Equipment which;

- Is used primarily and customarily to serve a medical purpose;
- Is generally not useful in the absence of disability, illness or injury;
- Can withstand repeated use over an extended period; and
- Is appropriate for use in any setting in which normal life activities take place, other than a hospital, nursing facility, ICF/IID, or any setting in which payment is or could be made under Medicaid inpatient services that includes room and board, except as allowed pursuant to 130 CMR 409.415 and 409.419(C).

Home: A member's home may be a dwelling owned or rented by the member, a relative's or other person's home in which the member resides, a rest home, assisted living, or another type of group residence or community setting in which normal life activities take place. A home does not include an institutional setting including but not limited to a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or any setting in which payment is or could be made under Medicaid inpatient services that includes room and board, except for items that are allowable pursuant to 130 CMR 409.415.

DECISION GUIDELINES Senior Care Options and One Care

Clinical Coverage Criteria: Senior Care Options and One Care

For **Senior Care Options and One Care**, the following coverage guidance is used for manual wheelchair accessory, push-rim activated power-assist system (E0986):

Power Mobility Devices Local Coverage Determination (LCD) L33789 and related Power Mobility Devices-Policy Article A52498.

The Plan may cover wheelchair accessory to convert a manual wheelchair to a motorized wheelchair (E0983, E0984) for **SCO and One Care** member when all the following criteria are met:

1. Member is requesting accessory in addition to initial request for manual wheelchair and meets the eligibility requirements for manual wheelchair (MWC) [Refer to Manual Wheelchair Base Local Coverage Determination L33788]; or
Member currently has a manual wheelchair in good working order; and
2. Manual wheelchair does not consistently meet member's functional/mobility needs due to one or more of the following:
 - a. Insufficient upper extremity strength and/or range of motion of member; or
 - b. Insufficient cardiovascular function of member; or
 - c. Risk for repetitive motion injury to member's upper extremity(ies); or
 - d. The need for occasional powered assistance in the home or community (e.g. long distances, uneven terrain, incline); or
 - e. Addition of accessory will allow member's wheelchair to be transferred in a standard vehicle rather than requiring a wheelchair accessible vehicle; and



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3. Member demonstrates adequate upper extremity function to safely operate joystick or tiller control accessory; and
4. Member has had an evaluation by a LCMP (licensed/certified medical professional) to determine the need for the equipment.

LIMITATIONS/EXCLUSIONS: Senior Care Options and One Care

The Plan will not cover requested accessory that converts manual wheelchair to power wheelchair when:

- Accessory cannot reasonably be expected to make a meaningful contribution to the treatment of a member's illness, disability, or injury
- Accessory serves the same purpose as DME already in use by the member
- Member's need could be met by a less costly alternative DME and/or accessory

CODING:

When applicable, a list(s) of codes requiring prior authorization is provided. This list is for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment.

CPT/HCPCS CODE	CODE DESCRIPTION
E0983	Manual wheelchair power accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control
E0984	Manual wheelchair power accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control
E0986	Manual wheelchair accessory, push-rim activated power-assist system

Documentation Requirements:

1. Standard Written Order (SWO)
2. Letter of Medical Necessity (LMN)
 - Document provided by a licensed/certified medical professional (LCMP), such as a physical therapist, occupational therapist or physician.

Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual® criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.



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Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider’s agreement with the Plan (including complying with Plan’s Provider Manual specifications).

This Medical Necessity Guideline is not a rigid rule. As with all CCA’s criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member’s unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member’s unique clinical circumstances will generally be required.

RELATED REFERENCES:

1. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD) L33789 Power Mobility Devices. Accessed February 23, 2024. <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33789>
2. Centers for Medicare & Medicaid Services. Policy Article A52498. Accessed February 23, 2024. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52498&ver=57>
3. Center for Medicare & Medicaid Services. National Coverage Determination (NCD) 280.3 for Mobility Assistive Equipment. Accessed February 23, 2024. <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=219&ncdver=2&bc=0>
4. Commonwealth of Massachusetts Executive Office of Health and Human Services of Medicaid. Transmittal Letter DME-37. Accessed February 23, 2024. <https://www.mass.gov/doc/dme-37-changes-to-program-regulations-2/download>
5. Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment: Subchapter 6; Service Codes last accessed February 23, 2024. <https://www.mass.gov/doc/durable-medical-equipment-dme-subchapter-6-2/download>
6. Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment, 130 CMR 409.420 Accessed February 23, 2024. <https://www.mass.gov/doc/durable-medical-equipment-regulations/download>

REVISION LOG:

REVISION DATE	DESCRIPTION



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