Local Coverage Determination (LCD): Power Mobility Devices (L33789)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

LCD Information

Document Information

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LCD Title
Power Mobility Devices

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N/A

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AMA CPT / ADA CDT / AHA NUBC Copyright Statement

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CMS National Coverage Policy

CMS Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Sections 280.3

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding "reasonable and necessary" criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.

- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

The term "treating practitioner" is defined as both physicians (defined in section 1861(r)(1) of the Social Security Act) and non-physician practitioners (i.e., PA, NP, and CNS; defined in section 1861(aa)(5) of the Social Security Act).

The term power mobility device (PMD) includes power operated vehicles (POVs) and power wheelchairs (PWCs).

Power Mobility Device bases require a Standard Written Order (SWO) prior to delivery. The SWO may also list all associated options and accessories that are billed separately. Refer to this LCD's related Policy Article for more information.

GENERAL COVERAGE CRITERIA:

All of the following basic criteria (A-C) must be met for a power mobility device (K0800, K0801, K0802, K0806, K0807, K0808, K0812, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898) or a push-rim activated power assist device (E0986) to be covered. Additional coverage criteria for specific devices are listed below.

A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
    - Prevents the beneficiary from accomplishing an MRADL entirely, or
    - Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
    - Prevents the beneficiary from completing an MRADL within a reasonable time frame.
B. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
C. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs 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.
    - An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

POWER OPERATED VEHICLES (K0800, K0801, K0802, K0806, K0807, K0808, K0812):

A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria D-I are also met.

D. The beneficiary is able to:
    - Safely transfer to and from a POV, and
    - Operate the tiller steering system, and
    - Maintain postural stability and position while operating the POV in the home.

E. The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.
F. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.
G. The beneficiary's weight is less than or equal to the weight capacity of the POV that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class POV – i.e., a Heavy Duty POV is covered for a beneficiary weighing 285 – 450 pounds; a Very Heavy Duty POV is covered for a beneficiary weighing 428 – 600 pounds.
H. Use of a POV will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it in the home.
I. The beneficiary has not expressed an unwillingness to use a POV in the home.

If a POV will be used inside the home and coverage criteria A-I are not met, it will be denied as not reasonable and necessary.

Group 2 POVs (K0806, K0807, K0808) have added capabilities that are not needed for use in the home. Therefore, if a Group 2 POV is provided it will be denied as not reasonable and necessary.

If a POV will only be used outside the home, see related Policy Article for information concerning noncoverage.

POWER WHEELCHAIRS (K0013, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898):

A power wheelchair is covered if:

a. All of the basic coverage criteria (A-C) are met; and
b. The beneficiary does not meet coverage criterion D, E, or F for a POV; and
c. Either criterion J or K is met; and
d. Criteria L, M, N, and O are met; and
e. Any coverage criteria pertaining to the specific wheelchair type (see below) are met.

J. The beneficiary has the mental and physical capabilities to safely operate the power wheelchair that is provided; or
K. If the beneficiary is unable to safely operate the power wheelchair, the beneficiary has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; and
L. The beneficiary's weight is less than or equal to the weight capacity of the power wheelchair that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class PWC – i.e., a Heavy Duty PWC is covered for a beneficiary weighing 285 – 450 pounds; a Very Heavy Duty PWC is covered for a beneficiary weighing 428 – 600 pounds; an Extra Heavy Duty PWC is covered for a beneficiary weighing 570 pounds or more.
M. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
N. Use of a power wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the

beneficiary will use it in the home. For beneficiaries with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.

O. The beneficiary has not expressed an unwillingness to use a power wheelchair in the home.

If a PWC will be used inside the home and if coverage criteria (a)-(e) are not met, it will be denied as not reasonable and necessary.

If a PWC will only be used outside the home, see related Policy Article for information concerning noncoverage.

ADDITIONAL CRITERIA FOR SPECIFIC TYPES OF POWER WHEELCHAIRS:

I. A Group 1 PWC (K0813, K0814, K0815, K0816) or a Group 2 PWC (K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829) is covered if all of the coverage criteria (a)-(e) for a PWC are met and the wheelchair is appropriate for the beneficiary's weight.

II. A Group 2 Single Power Option PWC (K0835, K0836, K0837, K0838, K0839, K0840) is covered if all of the coverage criteria (a)-(e) for a PWC are met and if:

   A. Criterion 1 or 2 is met; and

   B. Criteria 3 and 4 are met.

      1. The beneficiary requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).
      2. The beneficiary meets coverage criteria for a power tilt or a power recline seating system (see Wheelchair Options and Accessories policy for coverage criteria) and the system is being used on the wheelchair.
      3. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or practitioner may have no financial relationship with the supplier.
      4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

   If a Group 2 Single Power Option PWC is provided and if criterion II(A) or II(B) is not met (including but not limited to situations in which it is only provided to accommodate a power seat elevation feature, a power standing feature, or power elevating legrests), it will be denied as not reasonable and necessary.

III. A Group 2 Multiple Power Option PWC (K0841, K0842, K0843) is covered if all of the coverage criteria (a)-(e) for a PWC are met and if:

   A. Criterion 1 or 2 is met; and

   B. Criteria 3 and 4 are met.

      1. The beneficiary meets coverage criteria for a power tilt and recline seating system (see Wheelchair Options and Accessories policy) and the system is being used on the wheelchair.
      2. The beneficiary uses a ventilator which is mounted on the wheelchair.
      3. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or practitioner may have no financial relationship with the supplier.
      4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

   If a Group 2 Multiple Power Option PWC is provided and if criterion III(A) or III(B) is not met, it will be denied

as not reasonable and necessary.

IV. A Group 3 PWC with no power options (K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855) is covered if:
   A. All of the coverage criteria (a)-(e) for a PWC are met; and
   B. The beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
   C. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or practitioner may have no financial relationship with the supplier; and
   D. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

   If a Group 3 PWC is provided and if criteria (IV)(A) – (IV)(D) are not met, it will be denied as not reasonable and necessary.

V. A Group 3 PWC with Single Power Option (K0856, K0857, K0858, K0859, K0860) or with Multiple Power Options (K0861, K0862, K0863, K0864) is covered if:
   A. The Group 3 criteria IV(A) and IV(B) are met; and
   B. The Group 2 Single Power Option (criteria II[A] and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.

   If a Group 3 Single Power Option or Multiple Power Options PWC is provided and if criterion V(A) or (V)(B) is not met, it will be denied as not reasonable and necessary.

VI. Group 4 PWCs (K0868,K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886) have added capabilities that are not needed for use in the home. Therefore, if these wheelchairs are provided they will be denied as not reasonable and necessary.

VII. A Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) is covered if:
   A. All the coverage criteria (a)-(e) for a PWC are met; and
   B. The beneficiary is expected to grow in height; and
   C. The Group 2 Single Power Option (criteria II[A] and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.

   If a Group 5 PWC is provided and if criteria (VII)(A) – (VII)(C) are not met, it will be denied as not reasonable and necessary.

VIII. A push-rim activated power assist device (E0986) for a manual wheelchair is covered if all of the following criteria are met:
   A. All of the criteria for a power mobility device listed in the Basic Coverage Criteria section are met; and
   B. The beneficiary has been self-propelling in a manual wheelchair for at least one year; and
   C. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the need for the device in the beneficiary’s home. The PT, OT, or practitioner may have no financial relationship with the supplier; and
   D. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

   If all of the coverage criteria are not met, it will be denied as not reasonable and necessary.

A custom motorized/power wheelchair base (K0013) will be covered if:

1. The beneficiary meets the general coverage criteria for a power wheelchair; and

2. The specific configurational needs of the beneficiary are not able to be met using wheelchair cushions, or options or accessories (prefabricated or custom fabricated), which may be added to another power wheelchair base.

If coverage criterion 1 for K0013 is not met, the claim will be denied as not reasonable and necessary.

If coverage criterion 2 for K0013 is not met, the claim will be denied for incorrect coding (see related Policy Article for additional information).

A custom motorized/power wheelchair base is not reasonable and necessary if the expected duration of need for the chair is less than three months (e.g., post-operative recovery).

If the PWC base is not covered, then related accessories will be denied.

MISCELLANEOUS:

A POV or power wheelchair with Captain's Chair is not appropriate for a beneficiary who needs a separate wheelchair seat and/or back cushion. If a skin protection and/or positioning seat or back cushion that meets coverage criteria (see Wheelchair Seating LCD) is provided with a POV or a power wheelchair with Captain's Chair, the POV or PWC will be denied as not reasonable and necessary. (Refer to Wheelchair Seating LCD and Policy Article for information concerning coverage of general use, skin protection, or positioning cushions when they are provided with a POV or power wheelchair with Captain's Chair.)

For beneficiaries who do not have special skin protection or positioning needs, a power wheelchair with Captain’s Chair provides appropriate support. Therefore, if a general use cushion is provided with a power wheelchair with a sling/solid seat/back instead of Captain’s Chair, the wheelchair and the cushion(s) will be covered only if either criterion 1 or criterion 2 is met:

1. The cushion is provided with a covered power wheelchair base that is not available in a Captain’s Chair model – i.e., codes K0839, K0840, K0843, K0860, K0861, K0862, K0863, K0864, K0890, K0891; or
2. A skin protection and/or positioning seat or back cushion that meets coverage criteria is provided.

If one of these criteria is not met, both the power wheelchair with a sling/solid seat and the general use cushion will be denied as not reasonable and necessary.

If a heavy duty, very heavy duty, or extra heavy duty PWC or POV is provided and if the beneficiary’s weight is outside the range listed in criterion G or L above (i.e., for heavy duty – 285 – 450 pounds, for very heavy duty – 428 – 600 pounds, for extra heavy duty – 570 pounds or more), it will be denied as not reasonable and necessary.

Refer to the related Policy Article for information concerning coverage of Group 2 PWCs with seat elevators (K0830, K0831).

For PWCs that go through Advance Determination of Medicare Coverage (ADMC) or Prior Authorization (PA) and receive an affirmative determination, the delivery must be within 6 months following the determination.

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.

Payment is made for only one wheelchair at a time. Backup chairs are denied as not reasonable and necessary.

One month's rental of a PWC or POV (K0462) is covered if a beneficiary-owned wheelchair is being repaired. Payment is based on the type of replacement device that is provided but will not exceed the rental allowance for the power mobility device that is being repaired.

A power mobility device will be denied as not reasonable and necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

A POV or PWC which has not been reviewed by the Pricing, Data Analysis, and Coding (PDAC) contractor or which has been reviewed by the PDAC and found not to meet the definition of a specific POV/PWC will be denied as not reasonable and necessary and should be coded as K0899.

GENERAL

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

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

HCPCS MODIFIERS:

EY – No physician or other licensed health care provider order for this item or service

GA - Waiver of liability statement issued as required by payer policy, individual case

GY – Item or service statutorily excluded or doesn't meet the definition of any Medicare benefit category

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

KX – Requirements specified in the medical policy have been met

HCPCS CODES:

Group 1 Codes:

CODE	DESCRIPTION
E0983	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, JOYSTICK CONTROL
E0984	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL
E0986	MANUAL WHEELCHAIR ACCESSORY, PUSH-RIM ACTIVATED POWER ASSIST SYSTEM
K0013	CUSTOM MOTORIZED/POWER WHEELCHAIR BASE
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND

CODE	DESCRIPTION
	BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT 601 POUNDS OR MORE
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS

CODE	DESCRIPTION
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 301 TO 450 POUNDS
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS

CODE	DESCRIPTION
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125

CODE	DESCRIPTION
	POUNDS
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED
K0899	POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA

General Information

Associated Information

DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the treating practitioner's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

GENERAL DOCUMENTATION REQUIREMENTS

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- SWO
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

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

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

As a condition of payment pursuant to 42 CFR 410.38, Power Mobility Devices (PMDs) require a standard written order prior to delivery (WOPD) for the base item. If the supplier does not receive the order/prescription for the base item prior to delivery, the claim will be denied as not reasonable and necessary.

The WOPD for the base item may only be written after the completion of the face-to-face encounter requirements. Pursuant to the Social Security Act, Title XVIII, §1834(a)(1)(E)(iv), the treating practitioner who completes the face-to-face requirements must be the same practitioner who writes the order/prescription for the PMD (base item).

A supplier may provide a template to the treating practitioner for their use in creating the WOPD for the base item. Such a template may list the elements of a WOPD, but the supplier must not fill in or complete any of these elements.

An SWO is required prior to claim submission for all options, accessories, and/or supplies that are separately billed in addition to the base. This SWO obtained prior to claim submission, may be prepared by someone other than a treating practitioner. If someone other than a treating practitioner prepares the SWO for separately billed options, accessories, and/or supplies, a treating practitioner must review and sign the order.

The treating practitioner who reviews and signs the SWO for separately billable options, accessories, and/or supplies does not need to be the same treating practitioner who completed the WOPD for the PMD base and conducted the face-to-face encounter. In this situation, the treating practitioner who orders the options, accessories, and/or supplies must:

- Verify that a qualifying face-to-face encounter occurred within 6-months prior to the date of the WOPD for the base item; and,
- Have documentation of the qualifying face-to-face encounter that was conducted for the base item;
- Review and sign their order.

Refer to the Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for additional information.

FACE-TO-FACE ENCOUNTER:

The face-to-face encounter must be conducted within six (6) months prior to the order date on the WOPD for the PMD (base item).

The report of the face-to-face encounter (see Policy Article) should provide information relating to the following questions.

For POVs and PWCs	What is this beneficiary’s mobility limitation and how does it interfere with the performance of a
For POVs and PWCs	Why can’t a cane or walker meet this beneficiary’s mobility needs in the home?
For POVs and PWCs	Why can’t a manual wheelchair meet this beneficiary’s mobility needs in the home?
For POVs	Does this beneficiary have the physical and mental abilities to transfer into a POV and to operat
For PWCs	Why can’t a POV (scooter) meet this beneficiary’s mobility needs in the home?
For PWCs	Does this beneficiary have the physical and mental abilities to operate a power wheelchair safel

The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

- History of the present condition(s) and past medical history that is relevant to mobility needs
    - Symptoms that limit ambulation
    - Diagnoses that are responsible for these symptoms
    - Medications or other treatment for these symptoms
    - Progression of ambulation difficulty over time
    - Other diagnoses that may relate to ambulatory problems
    - How far the beneficiary can walk without stopping
    - Pace of ambulation
    - What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
    - What has changed to now require use of a power mobility device
    - Ability to stand up from a seated position without assistance
    - Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to mobility needs
    - Weight and height
    - Cardiopulmonary examination
    - Musculoskeletal examination
        - Arm and leg strength and range of motion
    - Neurological examination
        - Gait
        - Balance and coordination

The evaluation should be tailored to the individual beneficiary's conditions. The history should paint a picture of the beneficiary's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the beneficiary's ambulatory difficulty or impact on the beneficiary's ambulatory ability.

The written report of this encounter must be available upon request.

Practitioners shall document the encounter in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility encounter.

Many suppliers have created forms which have not been approved by CMS which they send to practitioners and ask them to complete. Even if the treating practitioner completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate practitioners on the type of information that is needed to document a beneficiary's mobility needs.

Practitioners shall also provide reports of pertinent laboratory tests, x-rays, and/or other diagnostic tests (e.g., pulmonary function tests, cardiac stress test, electromyogram, etc.) performed in the course of management of the beneficiary. Upon request, suppliers shall provide notes from prior visits to give a historical perspective of the progression of disease over time and to corroborate the information in the face-to-face encounter.

If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the face-to-face encounter (see Policy Article), there must be a signed and dated attestation by the supplier or LCMP that the LCMP has no financial relationship with the supplier. (Note: Evaluations performed by an LCMP who has a financial relationship with the supplier may be submitted to provide additional clinical information, but will not be considered as part of the face-to-face encounter by the treating practitioner.)

Although beneficiaries who qualify for coverage of a power mobility device may use that device outside the home, because Medicare's coverage of a wheelchair or POV is determined solely by the beneficiary's mobility needs within the home, the encounter must clearly distinguish the beneficiary's abilities and needs within the home from any additional needs for use outside the home.

SPECIALTY EVALUATION:

The specialty evaluation that is required for beneficiary's who receive a Group 2 Single Power Option or Multiple Power Options PWC, any Group 3 PWC, or a push-rim activated power assist device is in addition to the requirement for the face-to-face encounter. The specialty evaluation provides detailed information explaining why each specific option or accessory – i.e., power seating system, alternate drive control interface, or push-rim activated power assist – is needed to address the beneficiary's mobility limitation. There must be a written report of this evaluation available on request.

HOME ASSESSMENT:

Prior to or at the time of delivery of a POV or PWC, the supplier or practitioner must perform an on-site evaluation of the beneficiary's home to verify that the beneficiary can adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces. There must be a written report of this evaluation available on request.

Miscellaneous

Appendices

Utilization Guidelines

Refer to Coverage Indications, Limitations, and/or Medical Necessity

Sources of Information

CMS Decision Memorandum on Mobility Assistive Equipment.
Information received from multiple sources during the comment period.

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
01/01/2020	R7	Revision Effective Date: 01/01/2020 COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY: Added: Definition of "treating practitioner"	• Provider Education/Guidance • Other

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS MISCELLANEOUS: Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS Revised: Reference to weight range capacity for heavy duty PWCs and POVs from "400" to "450" CODING INFORMATION: Removed: Field titled "Bill Type" Removed: Field titled "Revenue Codes" Removed: Field titled "ICD-10 Codes that Support Medical Necessity" Removed: Field titled "ICD-10 Codes that DO NOT Support Medical Necessity" Removed: Field titled "Additional ICD-10 Information" POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Revised: Section information to include SWO for options/accessories, WOPD for PMD base item, and face-to-face encounter related information Added: Statement indicating that if the supplier does not receive SWO (for the PMD base) prior to delivery, the claim will deny as not reasonable and necessary *03/12/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713, HCPCS code changes, and non-substantive corrections (listing individual HCPCS codes instead of a HCPCS code-span).*	
01/01/2020	R6	Revision Effective Date: 01/01/2020 COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY: Removed: 7-element order requirement Added: SWO requirement MISCELLANEOUS: Removed: Information indicating delivery of PMD must be completed within 120 days following completion of the face-to-face examination GENERAL: Removed: Order information from section GENERAL DOCUMENTATION REQUIREMENTS: Revised: "Prescriptions (orders)" to "SWO" POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Removed: 7-element order requirements Removed: Detailed Product Description (DPD) information	• Provider Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		Revised: References of face-to-face "examination" to face-to-face "encounter" Removed: Requirement of date stamp or equivalent Revised: Header "FACE-TO-FACE EXAMINATION" to "FACE-TO-FACE ENCOUNTER" Revised: References of "practitioner" to "treating practitioner"	
01/01/2019	R5	Revision Effective Date: 01/01/2019 PRESCRIPTION (ORDER) REQUIREMENTS: Revised: PIM reference for 7-Element Orders from 5.9.2 to 5.2.4 Updated: 7-Element Order elements to be consistent with the PIM	• Provider Education/Guidance
01/01/2017	R4	Revision Effective Date: 01/01/2017 COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Updated: Reference for Detailed Product Description Removed: Standard Documentation Language Added: New reference language and directions to Standard Documentation Requirements Added: General Requirements Revised: Delivery requirements for PA eligible bases DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: General Documentation Requirements Added: New reference language and directions to Standard Documentation Requirements POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: Direction to Standard Documentation Requirements Removed: Information under Miscellaneous Removed: PIM reference under Appendices RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements article	• Provider Education/Guidance
07/01/2016	R3	Revision Effective Date 07/01/2016 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Removed: Group 4 power wheelchair HCPCS Codes from the Miscellaneous section	• Provider Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		DOCUMENTATION REQUIREMENTS: Revised: Standard documentation language for orders, added New order requirements, and Correct coding instructions; revised Proof of delivery instructions – Effective 04/28/16	
07/01/2016	R2	Effective July 1, 2016 oversight for DME MAC LCDs is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the LCDs.	• Change in Assigned States or Affiliated Contract Numbers
10/01/2015	R1	**Revision Effective Date: 01/01/2015** COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility HCPCS CODES: Revised: HCPCS Narrative for E0986 DOCUMENTATION REQUIREMENTS: Revised: Standard Documentation Language to add who can enter date of delivery date on the POD Added: Instructions for equipment retained from a prior payer and repair/replacement verbiage	• Provider Education/Guidance • Revisions Due To CPT/HCPCS Code Changes

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)
A52498 - Power Mobility Devices - Policy Article
A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

Related National Coverage Documents

N/A

Public Version(s)

Updated on 03/07/2020 with effective dates 01/01/2020 - N/A
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