# LCD for Power Mobility Devices (L27239)

## Contractor Information

### Contractor Name

National Government Services, Inc.

### Contractor Number

17003

### Contractor Type

DME MAC

## LCD Information

### LCD ID Number

L27239

### LCD Title

Power Mobility Devices

### Contractor's Determination Number

PMD

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### CMS National Coverage Policy

CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Sections 280.3

### Primary Geographic Jurisdiction

Illinois
Indiana
Kentucky
Michigan
Minnesota
Ohio
Wisconsin

## Oversight Region

Region V

## DME Region LCD Covers

Jurisdiction B

## Original Determination Effective Date

For services performed on or after 10/01/2006

## Original Determination Ending Date

Not applicable

## Revision Effective Date

For services performed on or after 02/04/2011

## Revision Ending Date

Not applicable

## Indications and Limitations of Coverage and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this local coverage determination, the criteria for "reasonable and necessary", based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following indications and limitations of coverage and/or medical necessity.

Refer to the related Policy Article for information on orders and a face-to-face examination.

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

**BASIC COVERAGE CRITERIA:**

All of the following basic criteria (A–C) must be met for a power mobility device (K0800–K0898) or a push-rim activated power assist device (E0986) to be covered. Additional coverage criteria for specific devices are listed below.

A) The patient 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 patient from accomplishing an MRADL entirely, or
- Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
- Prevents the patient from completing an MRADL within a reasonable time frame.

B) The patient's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.

C) The patient 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-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 patient 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 patient'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 patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.

G) The patient'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 patient weighing 285 – 450 pounds; a Very Heavy Duty POV is covered for a patient weighing 428 – 600 pounds.

H) Use of a POV will significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home.

I) The patient 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.

Refer to the related Policy Article for information concerning coverage of Group 2 POVs (K0806-K0808).

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

**POWER WHEELCHAIRS (K0813–K0891, K0898):**

A power wheelchair is covered if:

a. All of the basic coverage criteria (A–C) are met; and
b. The patient 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 patient has the mental and physical capabilities to safely operate the power wheelchair that is provided; or

K) If the patient is unable to safely operate the power wheelchair, the patient 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 patient'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 patient weighing 285 – 450 pounds; a Very Heavy Duty PWC is covered for a patient weighing 428 – 600 pounds; an Extra Heavy Duty PWC is covered for a patient weighing 570 pounds or more..

M) The patient'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 patient's ability to participate in MRADLs and the patient will use it in the home. For patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.

O) The patient 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.

**SPECIFIC TYPES OF POWER WHEELCHAIRS:**

A Group 1 PWC (K0813–K0816) or a Group 2 (K0820–K0829) is covered if all of the coverage criteria (a)-(e) for a PWC are met and the wheelchair is appropriate for the patient's weight.

II. A Group 2 Single Power Option PWC (K0835–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 patient 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 patient 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 patient 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 physician 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 physician 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 patient.

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–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 patient 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 patient uses a ventilator which is mounted on the wheelchair.
      3. The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician 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 physician 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 patient.

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–K0855) is covered if:

   A. All of the coverage criteria (a)–(e) for a PWC are met; and
   B. The patient's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
   C. The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician 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 physician 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 patient.

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–K0860) or with Multiple Power Options (K0861–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 Criterion IV(A) is met but all of the other coverage criteria are not met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 or Group 3 PWC.

VI. 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.Refer to the related Policy Article for information concerning coverage of Group 4 PWCs (K0868-K0886).

VII. A Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891)

is covered if:

1. All the coverage criteria (a)–(e) for a PWC are met; and
2. The patient is expected to grow in height; and
3. 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 patient has been self-propelling in a manual wheelchair for at least one year; and
C. The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the need for the device in the patient's home. The PT, OT, or physician 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 patient.

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

**MISCELLANEOUS:**

A POV or power wheelchair with Captain's Chair is not appropriate for a patient 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 patients 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 – K0864, K0870, K0871, K0879, K0880, K0886, 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 patient's weight is outside the range listed in criterion G or L above (i.e., for heavy duty – 285 – 400 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).

The delivery of the PMD must be within 120 days following completion of the face-to face examination. (Exception: For PWCs that go through the Advance Determination of Medicare Coverage (ADMC) process 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 patient-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 (K0899) will be denied as not reasonable and necessary.

## Coding Information

### Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

### Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to

report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

## CPT/HCPCS Codes

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:**

| HCPCS | 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 ACTIVATED POWER ASSIST, EACH |
| 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 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 |

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| 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 |
| 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 |

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| 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 |
| 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 |

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

### ICD-9 Codes that Support Medical Necessity

Not specified

| CODE | DESCRIPTION |
|---|---|
| XX000 | Not Applicable |

### Diagnoses that Support Medical Necessity

Not specified

### ICD-9 Codes that DO NOT Support Medical Necessity

Not specified

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

### Diagnoses that DO NOT Support Medical Necessity

Not specified

## General Information

### Documentation Requirements

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records,

home health agency records, records from other health care professionals and test reports. This documentation must be available upon request.

**ORDERS:**

The order that the supplier must receive within 45 days after completion of the face-to-face examination (see Policy Article) must contain all of the following elements:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general—e.g., "power operated vehicle," "power wheelchair," or "power mobility device"—or may be more specific.
3. Date of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician's signature
7. Date of physician signature

A date stamp or equivalent must be used to document receipt date.

If a written order containing all of these required elements is not received by the supplier within 45 days after completion of the face-to-face examination an EY modifier must be added to the HCPCS codes for the power mobility device and all accessories. The order must be available on request.

Once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician's order, the supplier must prepare a written document (termed a detailed product description) that lists the wheelchair base and all options and accessories that will be separately billed. For the wheelchair base and each option/accessory, the supplier must enter all of the following:

- HCPCS code
- Narrative description of the item
- Manufacturer name and model name/number
- Supplier's charge
- Medicare fee schedule allowance

If there is no fee schedule allowance, the supplier must enter "not applicable." The physician must sign and date this detailed product description and the supplier must receive it prior to delivery of the PWC or POV. A date stamp or equivalent must be used to document receipt date. The detailed product description must be available on request.

**FACE-TO-FACE EXAMINATION:**

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

| TYPE | DESCRIPTION |
|---|---|
| For POVs and PWCs | What is this patient's mobility limitation and how does it interfere with the performance of activities of daily living? |
| For POVs and PWCs | Why can't a cane or walker meet this patient's mobility needs in the home? |
| For POVs and PWCs | Why can't a manual wheelchair meet this patient's mobility needs in the home? |
| For POVs | Does this patient have the physical and mental abilities to transfer into a POV and to operate it safely in the home? |
| For PWCs | Why can't a POV (scooter) meet this patient's mobility needs in the home? |
| For PWCs | Does this patient have the physical and mental abilities to operate a power wheelchair safely in the home? |

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 patient 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 patient's conditions. The history should paint a picture of the patient'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 patient's ambulatory difficulty or impact on the patient's ambulatory ability.

A date stamp or equivalent must be used to document the date that the supplier receives the report of the face-to-face examination The written report of this examination must be available upon request.

Physicians shall document the examination 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 examination.

Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician 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 physicians on the type of information that is needed to document a patient's mobility needs.

Physicians 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 patient. 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 examination.

If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the face-to-face examination (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 examination by the physician.)

Although patients 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 patient's mobility needs within the home, the examination must clearly distinguish the patient'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 patients who receive a Group 2 Single Power Option or Multiple Power Options PWC, any Group 3 or Group 4 PWC, or a push-rim activated power assist device is in addition to the requirement for the face-to-face examination. 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 patient'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 patient's home to verify that the patient 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.

**KX, GA, GY, AND GZ MODIFIERS:**

If the requirements related to a face-to-face examination (see related Policy Article) have not been met, the GY modifier must be added to the codes for the power mobility device and all accessories.

If the power mobility device or push-rim activated power assist device that is provided is only needed for mobility outside the home, the GY modifier must be added to the codes for the item and all accessories.

A KX modifier may be added to the code for a power mobility device and all accessories only if one of the following conditions is met:

1. If all of the coverage criteria specified in this LCD have been met for the product that is provided; or
2. If there is an affirmative Advance Determination of Medicare Coverage (ADMC) for the product that is provided,: or
3. If a Group 4 PWC is provided and if all of the coverage criteria for a comparable Group 3 PWC have been met.

If the requirements for use of the KX modifier or GY modifier are not met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter GA on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or GZ if they have not obtained a valid ABN.

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

**MISCELLANEOUS:**

The following power wheelchairs are eligible for Advance Determination of Medicare Coverage (ADMC):

1. A Group 2, 3, 4 or 5 Single Power Option or Multiple Power Options wheelchair (K0835–K0843, K0856–K0864, K0877–K0891)—whether or not a power seating system will be provided at the time of initial issue.
2. A Group 3 or 4 No Power Option wheelchair (K0848–K0855, K0868–K0871) that will be provided with an alternative drive control interface at the time of initial issue.

Refer to the ADMC section in the Supplier Manual for details concerning the ADMC process.

Refer to the Supplier Manual for more information on documentation requirements

## Appendices

## Utilization Guidelines

Refer to Indications and Limitations of Coverage and/or Medical Necessity.

## Sources of Information and Basis for Decision

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

## Advisory Committee Meeting Notes

Written comments received at the Open Meeting are included in the Response to Comments document with all other written comments received during the comment period.

## Start Date of Comment Period

09/14/2005

## End Date of Comment Period

10/31/2005

## Start Date of Notice Period

08/15/2006

## Revision History Number

## Revision History Explanation

**Revision Effective Date: 02/04/2011**
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Coverage criteria relating to patient weight for POVs and PWCs
Deleted: Least costly alternative language for multiple codes.
Moved: Denial information on Group 2 POVs, Group 2 PWCs with Seat Elevators, and Group 4 PWCs to the Policy Article
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

**Revision Effective Date: 10/01/2009 (January 2010 Revision)**
DOCUMENTATION REQUIREMENTS:
Revised: Wording of one element of the detailed product description.

**Revision Effective Date: 10/01/2009**
HCPCS MODIFIERS:
Added: GA and GZ modifiers
Revised: KX modifer
DOCUMENTATION REQUIREMENTS:
Revised: Requirements for detailed product description
Added: Instructions for use of the GA and GZ modifiers

**Revision Effective Date: 01/01/2009**
INDICATIONS AND LIMITATIONS OF COVERAGE:
Changed: Terminology from Assistive Technology Supplier/Practitioner to Assistive Technology Professional

Changed: References from SADMERC to PDAC
HCPCS CODES:
Revised: K0899
DOCUMENTATION REQUIREMENTS:
Revised: Guidance concerning the content of the face-to-face examination

**Revision Effective Date: 04/01/2008**
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Requirement for ATP-certified individual to perform specialty evaluation.
Clarified: Requirement for ATS or ATP-certified individual to be involved with the evaluation of patients for rehab PWCs.

3/1/2008 – In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC National Government Services (17003) LCD L27239 from DME PSC TriCenturion (77011) LCD L21271.

**Revision Effective Date: 07/01/2007**
DOCUMENTATION REQUIREMENTS:
Removed: DMERC reference

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

**Revision Effective Date: 11/15/2006 (November publication)**
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised criterion for Single Power Option PWCs to remove the reference to the number of actuators.
Revised criterion for Multiple Power Option PWCs to indicate that coverage is determined by the need for a combination power tilt and recline power seating system regardless of the number of actuators .
Removed the inability to stand and pivot to transfer as a coverage criterion for Group 3 PWCs and added congenital orthopedic deformities to the list of covered conditions.
HCPCS CODES:
Corrected narrative description for K0825
DOCUMENTATION REQUIREMENTS:
Revised chairs that are available for ADMC.

**Revision Effective Date: 11/15/2006 (September publication)**
Implementation of the LCD has been changed from 10/1/2006
INDICATIONS AND LIMITATIONS OF COVERAGE:
Eliminated downcoding of Group 2 to Group 1 PWCs.
Indicated that if a Group 3 or Group 4 PWC were downcoded to a lower level PWC, it would be a Group 2 PWC.
Deleted several statements in the Least Costly Alternative section.
Eliminated downcoding of portable to nonportable wheelchairs.

Indicated that a Group 2 PWC with seat elevator would be downcoded to a Group 2 PWC without seat elevator.
DOCUMENTATION REQUIREMENTS:
Revised instructions for detailed product description.
Revised instructions for use of KX modifier.

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

## Reason for Change

## Last Reviewed On Date

## Related Documents

### Article(s)

Power Mobility Devices - Policy Article - Effective February 2011 (A47122)

### LCD Attachments

There are no attachments for this LCD

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Last Modified: 12/30/2010