

### Basic Coverage Criteria

- ☐ Documentation of the mobility evaluation must be documented in the clinician's usual medical record-keeping format. A separate letter will not meet documentation requirements. Please avoid vague or subjective descriptions such as: weakness, poor endurance, gait instability or abnormal gait, difficulty walking, SOB, pain, and fatigue.
- ☐ An in-person visit specifically addressing the client's mobility needs (Face-to-Face encounter)
- ☐ Client diagnosis(s) responsible for the mobility limitation. A mobility limitation is a condition(s) that significantly impairs his/her ability to participate in one or more mobility-related activities within the home. Including qualifying dx for custom seating and back.
- ☐ Progression of ambulation difficulty over time/throughout the day. Pace of ambulation
- ☐ How far can the client walk without stopping? What assistive device is being used?
- ☐ History of falls. Include frequency of falls and circumstances leading to the falls
- ☐ Why can't the client use a cane or walker?
- ☐ What are the client mobility limitation that significantly impairs their ability to participate in one or more Mobility Related Activities of Daily Living. (MRADLs example: toileting, feeding, dressing, grooming, and bathing in the home)
  - Prevents client from accomplishing an MRADL entirely **OR**
  - Places the client at heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL **OR**
  - Prevents the client from completing the MRADL within a reasonable time frame
- ☐ Why can't the client use an optimally configured manual wheelchair or scooter to meet this client's mobility needs inside the home?
- ☐ Limitations of strength, endurance, range of motion or coordination, presence of pain or deformity. Absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- ☐ Can the client safely use a power wheelchair? Does this client exhibit the physical and mental capability to operate the equipment?
- ☐ The client's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
- ☐ Clients' height and weight are in range of requested power wheelchair base
- ☐ If applicable, the specialty evaluation (performed by LCMP such as an OT/PT), requires the practitioner to concur, sign, and date the evaluation.

(Refer to individual HCPCS below for additional coverage criteria)

### Group 2 Power wheelchair (K0820-K0829)

- ☐ Covered if all the basic coverage criteria for a PWC are met and the wheelchair is appropriate for the client's weight

### Group 2 Single Power Option Power Wheelchair (K0835-K0840)

- ☐ Covered if all the basic coverage criteria for a PWC are met **AND**
- ☐ The client 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) **OR** meets coverage criteria for a power tilt or a power recline seating system and the system is being used on the wheelchair.

## MEDICAL NECESSITY CHECKLIST POWER WHEELCHAIR

- ☐ Must have a specialty evaluation performed by a LCMP such as a PT or OT and documents the medical necessity and its special features.
- ☐ ATP needs to have direct in-person involvement with wheelchair selection.

### Group 2 Multiple Power Option Power Wheelchair (K0841-K0843)

- ☐ Covered if all the basic coverage criteria for a PWC are met **AND**
- ☐ The client meets coverage criteria for a power tilt and recline seating system and the system is being used on the wheelchair **OR** the client uses a ventilator which is mounted on the wheelchair.
- ☐ Must have a specialty evaluation performed by a LCMP such as a PT or OT and documents the medical necessity and its special features.
- ☐ ATP needs to have direct in-person involvement with wheelchair selection.

### Group 3 Power Wheelchair No Power Options (K0848-K0855)

- ☐ Covered if all the basic coverage criteria for a PWC are met **AND**
- ☐ The client's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity. (Example: ALS, spinal cord injuries resulting in quadriplegia, stroke (CVA) with hemiplegia, late-stage Parkinson's, late-stage MS, cerebral palsy, or muscular dystrophy.)
- ☐ Must have a specialty evaluation performed by a LCMP such as a PT or OT and documents the medical necessity and its special features.
- ☐ ATP needs to have direct in-person involvement with wheelchair selection.

### Group 3 Power Wheelchair with Single/Multiple Power Option (K0856-K0864)

- ☐ Covered if all the basic coverage criteria for a PWC are met **AND**
- ☐ The Group 2 Single Power Option or Multiple Power Options are met.
- ☐ The client's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity. (Example: ALS, spinal cord injuries resulting in quadriplegia, stroke (CVA) with hemiplegia, late-stage Parkinson's, late-stage MS, cerebral palsy, or muscular dystrophy.)
- ☐ Must have a specialty evaluation performed by a LCMP such as a PT or OT and documents the medical necessity and its special features.
- ☐ ATP needs to have direct in-person involvement with wheelchair selection.

### Group 5 Pediatric PWC with Single (K0890) or Multiple Power Option (K0891)

- ☐ Covered if all the basic coverage criteria for a PWC are met **AND**
- ☐ The client is expected to grow in height
- ☐ The Group 2 Single Power Option or Multiple Power Options criteria are met.

### Push-Rim Activated Power Assist (E0986)

- ☐ Covered if all the basic coverage criteria for a PWC are met **AND**
- ☐ The client has been self-propelling in a manual wheelchair for at least one year
- ☐ Must have a specialty evaluation performed by a LCMP such as a PT or OT and documents the medical necessity and its special features.
- ☐ ATP needs to have direct in-person involvement with wheelchair selection.
- ☐ Standard Written Order for Base-All elements must be completed by the clinician

## MEDICAL NECESSITY CHECKLIST POWER WHEELCHAIR

Second SWO for options/accessories-Can be prepared by the supplier. Must include all billable options or accessories.

*\*\*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.*