PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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<tr><td colspan="4">Policy/Procedure Number: MCUP3133</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Wheelchair Mobility, Seating and Positional Components</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 11/18/2015</td><td colspan="4">Next Review Date: 08/14/2025
Last Review Date: 08/14/2024</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 08/14/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3013 – Durable Medical Equipment (DME) Authorization
C. MCCP2024 – Whole Child Model for California Children's Services (CCS)

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Claims
D. Member Services

III. DEFINITIONS:

A. **Activities of Daily Living (ADL):** The activity of dressing/bathing, eating, ambulating (walking), toileting and hygiene.
B. **Custom Rehabilitation Equipment:** Any item, piece of equipment or product system, whether modified or customized, that is used to increase, maintain or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of individuals with disabilities. Custom rehabilitation equipment includes, but is not limited to, non-standard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based upon patient height, weight and disability, specialized wheelchair electronics and cushions, custom bath equipment, standards, gait trainers and specialized strollers.
C. **Durable Medical Equipment (DME):** Devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a physician, physician assistant, or advanced practice registered nurse (which includes nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist)in the treatment of a specific medical condition and which have all of the following characteristics:
    1. Can withstand repeated use
    2. Is used to serve a medical purpose
    3. Is not useful to an individual in the absence of an illness, injury, functional impairment or congenital anomaly; and
    4. Is appropriate for use in or out of a patient's home.
D. **Instrumental Activities of Daily Living (IADL):** Activities that allow an individual to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within one's community.

E. **Licensed Practitioners:** Clinical professionals furnishing medical care, or any other type or remedial

care recognized under State law within their scope of practice as defined by State Law.

F. **Medical Necessity:** For the purposes of this policy, a wheelchair is considered medically necessary if the beneficiary's medical condition and mobility limitation are such that without the use of a wheelchair, the beneficiary's ability to perform one or more mobility related Activities of Daily Living or Instrumental Activities of Daily Living, in or out of the home, including access to the community, is impaired and the beneficiary is not ambulatory or functionally ambulatory without static supports such as a cane, crutches or walker.

G. **Power Mobility Device (PMD):** Base codes include both integral frame and modular construction type power wheelchairs (PWCs) and power operated vehicles (POVs).

H. **Power Operated Vehicle (POV):** Chair-like battery power fed mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and four-wheel non-highway construction.

I. **Power Wheelchair (PWC):** Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, electronic steering, and four or more wheel non-highway construction.

J. **Qualified Healthcare Professional (QHP):** Licensed physical, occupational, or speech therapists with competence in analyzing the needs of consumers with disabilities, assisting in the selection of appropriate assistive technology for the consumer's needs, and training in the use of the selected device(s). Specialty certification is required for professionals working in seating, positioning and mobility.

K. **Qualified Rehabilitation Technical Professional (QRTP):** Individuals typically certified as Assistive Technology Professionals who are employed by the vendor providing assistive technology devices to PHC members. They may have an additional certification of a Certified Rehabilitation Specialist. The QRTP is responsible for ensuring the equipment provided meets the technical needs of the patient.

L. **SPC:** Seating and provisional components

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the policy and processes for review of wheelchairs (manual and electric powered) and Power Operated Vehicles (POV) in accordance with the Department of Health Care Services All Plan Letter (APL) 15-018 Criteria For Coverage of Wheelchairs and Applicable Seating and Positioning Component issued July 9, 2015 as well as the California Children's Services (CCS) Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) issued August 8, 2003 and CCS N.L. 09-0514 Powered Mobility Devices (PMD) issued May 29, 2014.

VI. POLICY / PROCEDURE:

A. An authorization request for rental or purchase of a manual or powered mobility device (wheelchair, POV) requires a written request/prescription from a licensed professional and will be reviewed as follows:

1. Upon receipt of the Treatment Authorization Request (TAR) for custom rehabilitation equipment (as per III.B.) and/or powered mobility devices (as per III.G.), Partnership HealthPlan of California (PHC) will arrange for an assessment by an independent Qualified Healthcare Professional (QHP) who is not employed by or paid by a mobility device vendor. The purpose of the assessment is to evaluate the appropriateness of the request, document medical necessity for the mobility device, and identify the type of equipment best suited to meet the member's specific needs. The assessment must be performed in the setting where the member will use the mobility device. The independent QHP's

written summary of findings and recommendations is required to be submitted to PHC before a determination decision can be made for the mobility device authorization request. PHC does not offer incentives or compensation to independent consultants or health plan staff to deny medically appropriate services requested by members or providers.

2. A prescription for a wheelchair will not be denied on the grounds that it is for use only outside the home.
3. A TAR is required for all wheelchair requests when PHC is the secondary payer to Medicare.
4. The following sequential questions offer clinical guidance for the ordering of an appropriate device to meet the medical need of treating and restoring the beneficiary's ability to perform one or more mobility related ADLs or IADLs. These guiding principles will be used by PHC in making a benefit coverage determination.
    a. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs? A mobility limitation is one that:
        1) Prevents the beneficiary from accomplishing the ADLs or IADLs entirely, or,
        2) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in ADLs or IADLs, or
        3) Prevents the beneficiary from completing the ADLs or IADLs within a reasonable time frame
    b. Are there other conditions that limit the beneficiary's ability to participate in ADLs or IADLs?
        1) Some examples are impairment of cognition or judgment and/or vision.
        2) For these beneficiaries, the provision of a wheelchair and seating and provisional components (SPC) might not enable them to participate in ADLs or IADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with wheelchair and SPC.
    c. If these other limitations exist, can they be ameliorated or compensated such that the additional provision of wheelchair and SPC will be reasonably expected to improve the beneficiary's ability to perform or obtain assistance to participate in ADLs or IADLs?
        1) If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair and SPC coverage if it results in the beneficiary continuing to have a limitation.
        2) It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of wheelchair and SPC.
    d. Does the beneficiary demonstrate the capability and the willingness to consistently operate the wheelchair and SPC safely and independently?
        1) Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
        2) A history of unsafe behavior may be considered.
        3) Additional information may be requested from the member's treating medical providers.
    e. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane, crutches or walker?
        1) The cane, crutches or walker should be appropriately fitted to the beneficiary for this evaluation.
        2) Assess the beneficiary's ability to safely use a cane, crutches or walker.
    f. Does the beneficiary's typical environment support the use of wheelchair and SPC?
        1) Determine whether the beneficiary's environment will support the use of medically

necessary types of wheel chair and SPC.
2) Keep in mind such factors as physical layout, surfaces, and obstacles, which may render wheelchair and SPC unusable.

g. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair to participate in ADLs or IADLs during a typical day? The manual wheelchair should be optimally configured (SPC), wheelbase, device weight, and other appropriate accessories) for this determination.
1) Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
2) A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light-weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
3) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
4) Assess the beneficiary's ability and willingness to safely and effectively use a manual wheelchair.

h. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
1) A covered POV is a 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation without additional SPC. Three-wheeled devices are not covered.
2) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a POV.
3) Assess the beneficiary's ability to safely use a POV/scooter.

i. Are the additional features provided by a power wheelchair or powered SPC needed to allow the beneficiary to participate in one or more ADLs or IADLs?
1) The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
2) The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
3) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
4) Assess the beneficiary's ability to safely and independently use a power wheelchair and powered SPC.

4. When a manual or powered mobility device authorization is approved, it is the vendor's responsibility to have a Qualified Rehabilitation Technical Professional (QRTP) ensure the equipment provided meets the technical needs of the member. Any customized additions or added features that are not specifically covered under the approved authorization will require submission of another request (for a "custom wheelchair or device") to authorize these additions. Failure on the part of the vendor to do so before building and delivering the customized device could result in denial of requests for payment for the additional features.

B. Medical Necessity
1. Manual wheelchairs are medically necessary when:
a. Criteria 1), 2), 3), 4) and 5) below are met; and
b. Criterion 6) or 7) is met, and
c. Criteria is met for specific devices listed below.
1) The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs, and
2) The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an

appropriately fitted cane, crutches or walker, and

3) The manual wheelchair supplied to the beneficiary for use in or out of the home and community settings provides adequate access to these settings (e.g., between rooms, in and out of the home, transportation, over surfaces and a secure storage space), and
4) Use of a manual wheelchair will improve the beneficiary's ability to participate in ADLs or IADLs.
5) The beneficiary has expressed a willingness to use the manual wheelchair that is provided, and
6) The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair 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.
7) A standard wheelchair may be medically necessary
   a) When the beneficiary is able to self-propel the wheelchair, or
   b) Propel with assistance
8) A standard hemi-wheelchair may be medically necessary
   a) For disarticulation of one or both lower extremities, or
   b) Requires a lower seat height because of short stature, or
   c) To enable the beneficiary to place his/her feet on the ground for propulsion
9) A lightweight wheelchair may be medically necessary
   a) When a beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel, or
   b) For a beneficiary with marginal propulsion skills.
10) A high strength lightweight wheelchair may be medically necessary when
   a) The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent ADLs or IADLs that cannot be performed in a standard or lightweight wheelchair, or
   b) The beneficiary requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair
11) An ultra-lightweight multi-adjustable wheelchair may be medically necessary when
   a) The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent ADLs or IADLs that cannot be performed in a standard, lightweight or high strength lightweight wheelchairs, and
   b) The beneficiary's medical condition and the position of the push rim in relation to the beneficiary's arms and hands is integral to the ability to self-propel the wheelchair effectively, and
   c) The beneficiary has demonstrated the cognitive and physical ability to independently and functionally self-propel the wheelchair, or
   d) The beneficiary's medical condition requires multi-adjustable features or dimensions that are not available in a less costly wheelchair (e.g., pediatric size and growth options)
12) A heavy duty wheelchair is medically necessary when
   a) The beneficiary weighs more than 250 pounds, as documented in clinical notes within the past 12 months, or
   b) The beneficiary has severe spasticity, or
   c) Body measurements cannot be accommodated by standard sized wheelchairs.
13) An extra heavy duty wheelchair is medically necessary when

a) The beneficiary weighs more than 300 pounds, as documented in clinical notes within the past 12 months, or
b) Body measurements cannot be accommodated by a heavy duty wheelchair

14) Manual tilt-in-space wheelchairs are medically necessary when
a) The beneficiary is dependent for transfers, and
b) The beneficiary has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.

15) Pediatric sized folding adjustable wheelchairs with seating systems are covered as primary or back-up wheeled mobility when
a) The beneficiary meets the criteria for wheeled mobility, and
b) The wheelchair is an appropriate size for the beneficiary, and
c) The beneficiary meets the criteria for recline and positioning options, and
d) The wheelchair provides growth capability in width and length

2. Powered Mobility Devices are medically necessary when:
a. Criteria 1), 2), and 3) below are met, and
b. Criteria is met for specific devices listed below.
1) The beneficiary has a mobility limitation that impairs his or her ability to participate in one or more ADL or IADLs, and
2) The beneficiary's mobility limitation cannot be safely resolved by the use of an appropriately fitted cane, crutches or walker, and
3) The beneficiary does not have upper extremity function to self-propel an optimally-configured manual wheelchair to perform ADLs or IADLs 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 non-powered accessories.

A four wheeled Power Operated Vehicle (POV) is covered if all of the basic coverage criteria 1) - 3) have been met and if criteria 4) - 9) are also met.

4) The beneficiary is able to:
a) Safely transfer to and from a POV, and
b) Operate the tiller steering system, and
c) Maintain postural stability and position in standard POV seating while operating the POV without the use of any additional positioning aids
5) The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in or out of the home, and
6) The beneficiary's home provides adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the POV that is provided, and
7) The beneficiary's weight, as documented in clinical notes within the past 12 months, is less than or equal to the weight capacity of the POV that is provided, and
8) Use of a POV will significantly improve the beneficiary's ability to participate in ADLs or IADLs, and
9) The beneficiary has expressed willingness to use a POV

A Power Wheelchair (PWC) is covered if all of the basic coverage criteria 1) – 3) have been met and

a) The beneficiary does not meet coverage criterion 4), 5), or 6) above for a POV; and
b) Criteria 10) – 13) below are met; and
c) Any coverage criteria pertaining to the specific wheelchair grouping (see below) are met.

10) The beneficiary has the mental and physical capabilities to safely and independently operate the power wheelchair that is provided, and
11) The beneficiary's typical environment (in or out of the home) provides adequate access between rooms, maneuvering space, over surfaces and a secure storage space for the operation of the power wheelchair that is provided, and
12) The beneficiary has expressed willingness to use a power wheelchair.

Power Wheelchairs are segmented into the following groupings:

13) A Group 1 PWC (K0813-K0816) or a Group 2 (K0820-K0829) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and the wheelchair is appropriate for the beneficiary's weight.
14) Group 2 Single Power Option PWC (K0835 – K0840) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if Criterion a) or b) below is met;
    a) 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), or
    b) The beneficiary meets coverage criteria for a power tilt or a power recline seating system and the system is being used on the wheelchair
15) A Group 2 Multiple Power Option PWC (K0841-K0843) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if Criterion a) or b) below is met;
    a) The beneficiary meets coverage criteria for a power tilt and recline seating system and the system is being used on the wheelchair, or
    b) The beneficiary uses a ventilator which is mounted on the wheelchair.
16) A Group 3 PWC with no power options (K0848-K0855) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if the beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
17) A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
    a) The Group 3 criteria [17)] are met, and
    b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
18) A Group 4 PWC with no power options (K0868-K0871) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
    a) The Group 3 criteria [17)] are met, and
    b) The minimum range, top end speed, obstacle climb or dynamic stability incline that is medically necessary for the beneficiary engaging in frequent ADLs or IADLs cannot be performed in a Group 3 PWC.
19) A Group 4 PWC with Single Power Option (K0877-K0880) or with Multiple Power Options (K0884-K0886) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:

a) The Group 4 criteria [19)] are met, and
b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.

20) A Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) is covered if the coverage criteria [1) – 3), 10) - 13)] for a PWC are met; and
   a) The beneficiary is expected to grow in height, and
   b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
21) A push-rim activated power assist device (E0986) for a manual wheelchair is covered if the coverage criteria [1) – 3), 10) - 13)] for a PWC are met, and:
   a) The beneficiary has been self-propelling in a manual wheelchair for at least one year, and
   b) The beneficiary has a non-progressive disease, and
   c) The beneficiary has successfully completed a two-month trial period (reimbursable with prior approval as a rental).
22) SPC may be included with new wheelchair or billed separately under the following conditions:
   a) Refer to the SPC Coverage Criteria for information concerning coverage of general use, skin protection, positioning, powered and custom made components.
   b) A POV or PWC with Captain's Chair seating is not appropriate for a beneficiary who needs a separate SPC
   c) If a beneficiary needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it is appropriate to provide a Captain's Chair seat (if the code exists) rather than a sling/solid seat/back and a separate general use seat and/or back cushion.
   d) A general use seat and/or back cushion provided with a PWC with a sling/solid seat/back will be considered equivalent to a power wheelchair with Captain's Chair and will be coded and priced accordingly, if that code exists.
23) If a beneficiary's weight, as documented in clinical notes within the past 12 months, combined with the weight of seating and positioning accessories can be accommodated by wheelchair with a lower weight capacity than the wheelchair that is requested or provided, approval or payment will be based on the appropriate HCPCS code that meets the medical need.
24) A power mobility device (PMD) will be denied as not medically 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).

3. Backup manual wheelchairs are medically necessary when
   a. The beneficiary meets the criteria for a powered mobility device, and
   b. The beneficiary meets the criteria for the rented or purchased back-up manual wheelchair, and
   c. The beneficiary is unable to complete ADLs or IADLs without a backup manual wheelchair, and
   d. The backup wheelchair accommodates the SPC on the primary wheelchair.

C. Wheelchairs are NOT covered when:
1. Not medically necessary
2. Not used by the beneficiary
3. Used as a convenience item
4. Used to replace private or public transportation such as an automobile, bus or taxi

5. Not generally used primarily for health care and are not regularly and primarily used by persons who do not have a specific medical need for them
6. Used in a facility that is expected to provide such items to the beneficiary
7. Used in a skilled nursing facility, unless the beneficiary demonstrates the need for a custom wheelchair under Title 22 of the Code of Regulation section 51321(h)
8. Not prescribed by a licensed practitioner, or, in the case of a custom wheelchair, by a licensed practitioner after evaluation by a QHP.

D. Seating and Positioning Component Coverage Criteria

SPC are covered when criteria 1. 2. and 3., at least one of 4. – 9., and 10. – 19. (if applicable) are met:

1. The beneficiary has met the criteria for wheelchair, and
2. The SPC meets the quality standards and coding definitions specified in the APL 15-018. The Medicaid program reserves the right to review any and all coding assignments by vendors and the Medicare Pricing, Data Analysis and Coding (MPDAC) web site based on submitted and published product specifications and other relevant information.
3. The primary and back-up wheelchair bases accommodate the SPC.
4. A general use seat cushion and a general use back cushion are covered when 1., 2. and 3. are met.
5. A skin protection seat cushion or decubitus wheelchair pad is covered when 1., 2. and 3. are met and that beneficiary has one of the following:
   a. A current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or
   b. Absent or impaired sensation in the area of contact with the seating surface due to but not limited to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; or
   c. Inability to carry out a functional weight shift due to one of, but not limited to, the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn, cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; or
   d. Confined to their wheelchair for more than four (4) continuous hours on a daily basis
   e. A well-documented history (as well as current status) of malnutrition.
6. A positioning seat cushion or positioning back cushion, is covered when 1., 2. and 3. are met and the beneficiary has one of the following:
   a. Significant postural asymmetries that are due to but not limited to one of the diagnoses listed in criterion "5." above; or
   b. One of the following diagnoses: monoplegia of the lower limb or hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonias, spinocerebellar disease.
7. A positioning accessory is covered when criteria 1., 2., 3. and 6. are met and specifically:
   a. A headrest or headrest extension (sling support for the head) is covered when the recipient has a covered manual tilt-in space, manual semi or fully reclining back, or power tilt and/or recline power seating system or needs additional head support. The code for a headrest includes any type of cushioned headrest, fixed, removable or non-removable hardware.
   b. An upper extremity support system (UESS) is covered when the medical need for positioning in a wheelchair cannot be met with less costly alternatives such as any combination of a safety belt, pelvic strap, harness, prompts, armrest modifications, recline, tilt in space or other existing or

potential seating or wheelchair features. UESS dimensions should not exceed the positioning length of the forearms (e.g., 12-15"). UESS and related accessories are not covered when used solely for activities of daily living.

c. UESS padding and positioning blocks are covered in addition to a UESS when there is a medical need for stabilization of the UESS due to strong spasticity or exaggerated muscle activity.

d. Foot-Ankle Padded Positioning Straps (e.g., "ankle huggers") are covered when there is a medical need for stabilization of the foot and ankle due to strong spasticity or exaggerated muscle activity, and positioning in the wheelchair cannot be met with less costly alternatives, such as any combination of heel loop/holders and or toe/loop/holders, with or without ankle straps.

8. A combination skin protection and positioning seat cushion is covered when 1., 2., 3., 5. and 6. are met, i.e., the criteria for both a skin protection seat cushion and a positioning seat cushion are met.
9. A custom fabricated seat cushion is covered if the criteria for 8. are met and there is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a vendor or manufacturer), which clearly explains why a standard seating system is not sufficient to meet the beneficiary's seating and positioning needs. (If a custom fabricated seat and back are integrated into a one-piece cushion, code using the custom seat plus the custom back codes.)
10. If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual recipient, the cushion must be billed as a customized cushion, not custom fabricated.
11. The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, which is an integral part of the cushion.
12. Payment for all wheelchair seats, backs and accessory codes includes fixed, removable and/or quick-release mounting hardware if hardware is applicable to the item.
13. The swing away, multi-positioning or removable mounting hardware upgrade code may only be billed in addition to the codes for a headrest, lateral trunk, hip supports, medial thigh supports, calf supports, abductors/pommels, and foot supports when medically justified. It must not be billed in addition to the codes for shoulder harness/straps or chest straps, wheelchair seat cushions or back cushions, or with PWCs with swing away, fixed or retractable joysticks.
14. A manual tilt in space option is covered when:
    a. Criteria 1. – 3. above are met, and
    b. The beneficiary is dependent for transfers, and
    c. The beneficiary has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.
15. A power tilt in space option for a PWC is covered when:
    a. Criteria 1. – 3. and 14. above are met, and
    b. The beneficiary has the mental and physical capabilities to safely and independently operate the power tilt in space that is provided.
16. A manual recline option is covered when:
    a. Criteria 1. – 3. above are met, and
    b. The beneficiary has a plan of care that requires a recline position to complete ADLs or IADLs, and
    c. The beneficiary has positioning needs that cannot be met by upright or fixed angle chair, or
    d. The beneficiary's postural control requires a recline feature.

17. A power recline option for a PWC is covered when:
    a. Criteria 1. – 3. and 16. above are met, and
    b. The beneficiary has a plan of care that requires a recline position to complete ADLs or IADLs, and
    c. The beneficiary has the mental and physical capabilities to safely and independently operate the power recline feature that is provided.
18. A combination manual tilt in space and recline option is covered when criteria 14. and 16. are met and if provided alone will not meet the seating and positioning needs.
19. A combination power tilt in space and recline option is covered when criteria 15. and 17. are met and if provided alone will not meet the seating and positioning needs.

E. Portable Ramps
1. For PHC's policy on portable ramps, please see policy MCUP3013 DME Authorization section VI.G.9.

F. Loaner Rental During Repair
1. Back-up or loaner rental power wheelchairs are not a Medi-Cal covered benefit.
    a. On a case by cases basis, up to a one-month rental of a wheelchair may be considered medically necessary (with maximum of one-month renewal with justification) if a member-owned wheelchair requires an extended repair. Payment for the rental is based on the type of replacement device that is provided. Requests for loaner powered mobility device rentals will require documentation of medical necessity to be reviewed by the Chief Medical Officer or Physician Designee.

VII. REFERENCES:

A. Title 22, CCR Sections 52260, 51321
B. Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines (*dura wheel guide*) and Bill for Wheelchairs and Wheelchair Accessories (*dura bil wheel*)
C. Department of Health Care Services (DHCS) All-Plan Letter (APL) 15-018 Criteria For Coverage of Wheelchairs and Applicable Seating and Positioning Components (07/09/2015)
D. CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) (08/08/2003)
E. CCS Numbered Letter (N.L.) 09-0514 Powered Mobility Devices (PMD) (05/29/2014)
F. Senate Bill No.717 Complex Needs Patient Act, California Legislature 2021-2022 Regular Session, Amended in Senate May 20, 2021. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB717

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 08/17/16; 08/16/17; *09/12/18; 11/13/19; 11/11/20; 11/10/21; 05/11/22; 06/14/23; 08/14/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

Policy/Procedure Number: MCUP3133		Lead Department: Health Services
Policy/Procedure Title: Wheelchair Mobility, Seating and Positional Components		☒ **External Policy** ☐ **Internal Policy**
Original Date: 11/18/2015	**Next Review Date: 08/14/2025** **Last Review Date: 08/14/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO:

MCUP3083 - Wheelchair and Power Operated Vehicle Authorization was archived 11/18/2015
Original Date: 04/16/2008
Revision Dates: 07/15/09; 05/18/11

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.