

# Local Coverage Determination (LCD): Manual Wheelchair Bases (L33788)

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## Contractor Information

<b>Contractor Name</b>	<b>Contract Type</b>	<b>Contract Number</b>	<b>Jurisdiction</b>	<b>State(s)</b>
<a href="#">CGS Administrators, LLC</a>	DME MAC	17013 -	DME MAC J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota
<a href="#">CGS Administrators, LLC</a>	DME MAC	18003 -	DME MAC J-C	
<a href="#">Noridian Healthcare Solutions, LLC</a>	DME MAC	16013 -	DME MAC J-A	
<a href="#">Noridian Healthcare Solutions, LLC</a>	DME MAC	19003 -	DME MAC J-D	

## LCD Information

### Document Information

LCD ID L33788	Original Effective Date For services performed on or after 10/01/2015
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Original ICD-9 LCD ID <a href="#">L27014</a> <a href="#">L11443</a> <a href="#">L11465</a> <a href="#">L11454</a>	Revision Effective Date For services performed on or after 01/01/2017
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	Revision Ending Date N/A
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LCD Title Manual Wheelchair Bases	Retirement Date N/A
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	Notice Period End Date N/A
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CMS National Coverage Policy CMS Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Section 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.

#### GENERAL COVERAGE CRITERIA

A manual wheelchair for use inside the home (E1037 - E1039, E1161, K0001 – K0009) is covered if:

- Criteria A, B, C, D, and E are met; and
  - Criterion F or G is met.
- 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 resolved by the use of an appropriately fitted cane or walker.
- C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
- D. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.
- E. The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.
- F. The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home 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.
- G. The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

## ADDITIONAL CRITERIA FOR SPECIFIC MANUAL WHEELCHAIRS (E1037, E1038, E1039, E1161, K0002 – K0008)

In addition to the general manual wheelchair criteria above, the specific criteria below must be met for each manual wheelchair. If the specific criteria are not met, the manual wheelchair will be denied as not reasonable and necessary.

A transport chair (E1037, E1038 or E1039) is covered as an alternative to a standard manual wheelchair (K0001) and if basic coverage criteria A-E and G above are met.

A standard hemi-wheelchair (K0002) is covered when the beneficiary requires a lower seat height (17" to 18") because of short stature or to enable the beneficiary to place his/her feet on the ground for propulsion.

A lightweight wheelchair (K0003) is covered when a beneficiary meets both criteria (1) and (2):

Cannot self-propel in a standard wheelchair in the home; and

The beneficiary can and does self-propel in a lightweight wheelchair.

A high strength lightweight wheelchair (K0004) is covered when a beneficiary meets the criteria in (1) or (2):

The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.

The beneficiary requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

A high strength lightweight wheelchair is rarely reasonable and necessary if the expected duration of need is less than three months (e.g., post-operative recovery).

An ultra lightweight manual wheelchair (K0005) is covered for a beneficiary if criteria (1) or (2) is met and (3) and (4) are met:

1. The beneficiary must be a full-time manual wheelchair user.
2. The beneficiary must require individualized fitting and adjustments for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a K0001 through K0004 manual wheelchair.
3. The beneficiary must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP), 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 LCMP may have no financial relationship with the supplier.
4. The wheelchair is provided by a Rehabilitative Technology Supplier (RTS) 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.

A heavy duty wheelchair (K0006) is covered if the beneficiary weighs more than 250 pounds or the beneficiary has severe spasticity.

An extra heavy duty wheelchair (K0007) is covered if the beneficiary weighs more than 300 pounds.

A manual wheelchair with tilt in space (E1161) is covered if the beneficiary meets the general coverage criteria for a manual wheelchair above, and if criteria (1) and (2) are met:

1. The beneficiary must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP), 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 LCMP may have no financial relationship with the supplier.

2. The wheelchair is provided by a Rehabilitative Technology Supplier (RTS) 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.

A custom manual wheelchair base (K0008) is covered if, in addition to the general coverage criteria above, the specific configuration required to address the beneficiary's physical and/or functional deficits cannot be met using one of the standard manual wheelchair bases plus an appropriate combination of wheelchair seating systems, cushions, options or accessories (prefabricated or custom fabricated), such that the individual construction of a unique individual manual wheelchair base is required.

If K0008 is used to describe a prefabricated manual wheelchair base, even one that has been modified in any fashion, the claim will be denied for incorrect coding. Refer to the CODING GUIDELINES section of the related Policy Article for additional information about correct coding of K0008.

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

If the manual wheelchair will be used inside the home and the coverage criteria are not met, it will be denied as not reasonable and necessary.

If the manual wheelchair will only be used outside the home, see NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article for information concerning statutory coverage requirements.

If the manual wheelchair base is not covered, then related accessories will be denied as not reasonable and necessary.

#### MISCELLANEOUS

Payment is made for only one wheelchair at a time. Backup chairs are denied as not reasonable and necessary. One month's rental for a standard manual wheelchair (K0001) is covered if a beneficiary-owned wheelchair is being repaired.

#### GENERAL

A Detailed Written Order (DWO) (if applicable) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must also obtain a DWO before submitting a claim for any associated options, accessories, and/or supplies that are separately billed. In this scenario, if the supplier bills for associated options, accessories, and/or supplies without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

A WOPD (if applicable) must be received by the supplier before a DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a completed WOPD, the claim shall be statutorily denied. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

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.

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## [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.

N/A

## 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.

N/A

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 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:**

E1037 TRANSPORT CHAIR, PEDIATRIC SIZE

E1038 TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS

E1039 TRANSPORT CHAIR, ADULT SIZE, HEAVY DUTY, PATIENT WEIGHT CAPACITY GREATER THAN 300 POUNDS

E1161 MANUAL ADULT SIZE WHEELCHAIR, INCLUDES TILT IN SPACE

E1229 WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED

E1231 WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM

E1232 WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM

E1233 WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM

E1234 WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM

E1235 WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM

E1236 WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM

E1237 WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM

E1238 WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM

K0001 STANDARD WHEELCHAIR  
K0002 STANDARD HEMI (LOW SEAT) WHEELCHAIR  
K0003 LIGHTWEIGHT WHEELCHAIR  
K0004 HIGH STRENGTH, LIGHTWEIGHT WHEELCHAIR  
K0005 ULTRALIGHTWEIGHT WHEELCHAIR  
K0006 HEAVY DUTY WHEELCHAIR  
K0007 EXTRA HEAVY DUTY WHEELCHAIR  
K0008 CUSTOM MANUAL WHEELCHAIR/BASE  
K0009 OTHER MANUAL WHEELCHAIR/BASE

ICD-10 Codes that Support Medical Necessity

**Group 1 Paragraph:** Not specified

**Group 1 Codes:** N/A

ICD-10 Codes that DO NOT Support Medical Necessity

**Group 1 Paragraph:** Not specified

**Group 1 Codes:** N/A

ICD-10 Additional Information

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## [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 physician'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:

- Prescription (orders)
- 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.

### **Miscellaneous**

### **Appendices**

### **Utilization Guidelines**

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

Sources of Information and Basis for Decision

Reserved for future use. [Back to Top](#)

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## **Revision History Information**

<b>Revision History Date</b>	<b>Revision History Number</b>	<b>Revision History Explanation</b>	<b>Reason(s) for Change</b>
01/01/2017	R3	Revision Effective Date: 01/01/2017 COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Removed: Standard Documentation Language Added: New reference language and directions to Standard Documentation Requirements Added: General Requirements 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: Reference to Supplier Manual under Miscellaneous Removed: Reference to PIM under Appendices RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements article	<ul style="list-style-type: none"><li>• Provider Education/Guidance</li></ul>
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.	<ul style="list-style-type: none"><li>• Change in Assigned States or Affiliated Contract Numbers</li></ul>
10/01/2015	R1	<b>Revision Effective Date: 10/31/2014</b> COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility DOCUMENTATION REQUIREMENTS:	<ul style="list-style-type: none"><li>• Provider Education/Guidance</li></ul>



<b>Revision History Date</b>	<b>Revision History Number</b>	<b>Revision History Explanation</b>	<b>Reason(s) for Change</b>
		Revised: Standard Documentation Language to add who can enter date of delivery date on the POD Added: Instructions for Refill Documentation Added: Equipment Retained from a Prior Payer Revised: Repair to beneficiary-owned DMEPOS	

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## **Associated Documents**

Attachments N/A

Related Local Coverage Documents Article(s) [A52497 - Manual Wheelchair Bases - Policy Article A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#)

Related National Coverage Documents N/A

Public Version(s) Updated on 04/26/2017 with effective dates 01/01/2017 - N/A [Updated on 06/07/2016 with effective dates 07/01/2016 - 12/31/2016](#) [Updated on 03/20/2015 with effective dates 10/01/2015 - 06/30/2016](#) [Updated on 04/04/2014 with effective dates 10/01/2015 - N/A](#) [Back to Top](#)

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## **Keywords**

N/A Read the [LCD Disclaimer](#) [Back to Top](#)

**END OF LOCAL COVERAGE DETERMINATION**

Per the Code of Federal Regulations, 42 C.F.R § 426. 325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.

# Local Coverage Article: Manual Wheelchair Bases - Policy Article (A52497)

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## Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
<a href="#">CGS Administrators, LLC</a>	DME MAC	17013 -	DME MAC J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota
<a href="#">CGS Administrators, LLC</a>	DME MAC	18003 -	DME MAC J-C	
<a href="#">Noridian Healthcare Solutions, LLC</a>	DME MAC	16013 -	DME MAC J-A	
<a href="#">Noridian Healthcare Solutions, LLC</a>	DME MAC	19003 -	DME MAC J-D	

## Article Information

### General Information

**Article ID**

A52497

**Original Article Effective Date**

10/01/2015

Original ICD-9 Article ID

[A47082](#)[A25580](#)[A25311](#)[A25378](#)**Revision Effective Date**

01/01/2017

**Revision Ending Date**

N/A

**Article Title**

Manual Wheelchair Bases - Policy Article

**Retirement Date**

N/A

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### Article Guidance

**Article Text:****NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES**

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. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

Manual wheelchairs are covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

If the manual wheelchair is only for use outside the home, it will be denied as noncovered, no benefit, as the DME benefit requires use within the home for coverage eligibility.

Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair. Reimbursement also includes support services such as emergency services, delivery, set-up, education, and on-going assistance with use of the wheelchair.

A custom manual wheelchair base (K0008) must be uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of the beneficiary's treating physician. The beneficiary's needs cannot be accommodated by any other existing manual wheelchair and accessories, including customized seating arrangements. See 42 CFR Section 414.224, and Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 20, Section 30.3 for more information on customized DME.

### **REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g)**

42 CFR 410.38(g) requires a face-to-face evaluation and a specific written order prior to delivery for specified HCPCS codes. CMS provides a list of the specified codes, which is periodically updated, located [here](#).

Claims for the specified items subject to 42 CFR 410.38(g) that do not meet the requirements specified in the LCD-related Standard Documentation Requirements Article will be denied as statutorily noncovered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

### **POLICY SPECIFIC DOCUMENTATION REQUIREMENTS**

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

Information showing that the coverage criteria in the Coverage Indications, Limitations, and/or Medical Necessity section of the related LCD have been met must be present in the beneficiary's medical record. Information about whether the beneficiary's home can accommodate the wheelchair (Criterion C), also called the home assessment, must be fully documented in the medical record or elsewhere by the supplier. For manual wheelchairs, the home assessment may be done directly by visiting the beneficiary's home or indirectly based upon information provided by the beneficiary or their designee. When the home assessment is based upon indirectly obtained information, the supplier must, at the time of delivery, verify that the item delivered meets the requirements specified in criterion C. Issues such as the physical layout of the home, surfaces to be traversed, and obstacles must be addressed by and documented in the home assessment. Information from the beneficiary's medical record and the supplier's records must be available upon request.

Manual wheelchairs described by codes E1161, E1231-E1234, K0005, K0008 and K0009 are eligible for Advance Determination of Medicare Coverage (ADMC). Refer to the ADCM chapter in the Supplier Manual for details concerning the ADCM process.

If documentation of the medical necessity for a K0005 wheelchair is requested, it must include a description of

the beneficiary's routine activities. This may include the types of activities the beneficiary frequently encounters and whether the beneficiary is fully independent in the use of the wheelchair. Describe the features of the K0005 base which are needed compared to the K0004 base.

If documentation of the medical necessity for a K0008 wheelchair is requested, contractors must be able to determine that the item delivered is a customized item. Documentation must include a description of the beneficiary's unique physical and functional characteristics that require a customized manual wheelchair base. This must include a detailed description of the manufacturing of the wheelchair base, including types of materials used in custom fabricating or substantially modifying it, and the construction process and labor skills required to modify it. The record must document that the needs of the beneficiary cannot be met using another manual wheelchair base that incorporates seating modifications or other options or accessories (prefabricated and/or custom). The documentation must demonstrate that the K0008 is so different from another wheelchair base that the two items cannot be grouped together for pricing purposes.

If documentation of the medical necessity for a transport chair (E1037, E1038 and E1039) is requested, it must include a description of why the beneficiary is unable to make use of a standard manual wheelchair (K0001-K0005) on their own, and provide specific information that the beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

## **MODIFIERS**

KX, GA, GY, AND GZ MODIFIERS:

Suppliers must add a KX modifier to the code for the manual wheelchair base only if all of the coverage criteria in the Coverage Indications, Limitations, and/or Medical Necessity section of the related LCD have been met and evidence of such is retained in the supplier's files and available to the DME MAC upon request. If the coverage criteria are not met, the KX modifier must not be used.

If all of the coverage criteria in the Coverage Indications, Limitations, and/or Medical Necessity section of the related LCD have not been 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 the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

If the wheelchair is only to be used for mobility outside the home, the GY modifier must be added to the code.

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

## **CODING GUIDELINES**

Adult manual wheelchairs (K0001-K0009, E1161) are those which have a seat width and a seat depth of 15" or greater. For codes K0001-K0009, the wheels must be large enough and positioned such that the wheelchair could be propelled by the user. In addition, specific codes are defined by the following characteristics:

Standard wheelchair (K0001)  
Weight: Greater than 36 lbs.  
Seat Height: 19 inches or greater  
Weight capacity: 250 pounds or less

Standard hemi (low seat) wheelchair (K0002)  
Weight: Greater than 36 lbs  
Seat Height: Less than 19 inches  
Weight capacity: 250 pounds or less

Lightweight wheelchair (K0003)  
Weight: 34-36 lbs  
Weight capacity: 250 pounds or less

High strength, lightweight wheelchair (K0004)  
Weight: Less than 34 lbs  
Lifetime Warranty on side frames and crossbraces

Ultralightweight wheelchair (K0005)  
Weight: Less than 30 lbs  
Adjustable rear axle position

Lifetime Warranty on side frames and crossbraces

Heavy duty wheelchair (K0006)  
Weight capacity: Greater than 250 pounds

Extra heavy duty wheelchair (K0007)  
Weight capacity: Greater than 300 pounds

Custom manual wheelchair/base (K0008)

In addition to meeting the statutory criteria above in the "Non-Medical Necessity Coverage and Payment Rules", custom manual wheelchairs must also have a lifetime warranty on side frames and crossbraces.

Adult tilt-in-space wheelchair (E1161)  
Ability to tilt the frame of the wheelchair greater than or equal to 20 degrees from horizontal while maintaining the same back to seat angle. Lifetime Warranty: On side frames and crossbraces

Wheelchairs with less than 20 degrees of tilt must not to be coded based upon the tilt feature. The appropriate base product must be coded as K0001 – K0007. The product must not be coded as E1161 or K0108.

"Weight" represents the weight of the wheelchair itself in pounds without the front rigging as in the case of the K0001, K0002, K0003, K0004, and K0005. "Weight capacity" represents the carrying capacity or the amount of weight (beneficiary plus all accessories) that the wheelchair can carry for safe operation as in the case of the K0001, K0002, K0003, K0006 and K0007.

The following features are included in the allowance for all adult manual wheelchairs:

Seat Width: 15" - 19"  
Seat Depth: 15" - 19"  
Arm Style: Fixed, swingaway, or detachable; fixed height  
Footrests: Fixed, swingaway, or detachable

Codes K0003-K0008 and E1161 include any seat height.

Refer to the medical policy on Wheelchair Options and Accessories for information on other features included in the allowance for the wheelchair base.

A manual wheelchair with a seat width and/or depth of 14" or less is considered a pediatric size wheelchair and is billed with codes E1231-E1238 or E1229.

Codes E1050-E1060, E1070-E1160, E1170-E1200, E1220-E1224, E1240-E1295 should only be used to bill for maintenance and service for an item for which the initial claim was paid by the local carrier prior to transition to the DME MAC.

Manual wheelchairs with additional options and accessories, other than tilt, are billed by selecting the correct code for the wheelchair base and then using appropriate codes for wheelchair options and accessories. (Refer to the Wheelchair Options and Accessories policy.)

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items. [Back to Top](#)

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## **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 article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

## 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 article, 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 article should be assumed to apply equally to all Revenue Codes.

N/A

**CPT/HCPCS Codes** N/A

**ICD-10 Codes that are Covered** N/A

**ICD-10 Codes that are Not Covered** N/A

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## Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
01/01/2017	R3	Revision Effective Date: 01/01/2017 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES Added: 42 CFR 410.38(g) POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: Home assessment requirements, ADMC eligible bases, medical necessity documentation requirements for K0005, K0008, E1037, E1038, E1039, and Modifier instructions RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article Effective July 1, 2016 oversight for DME MAC Articles 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 Articles.
07/01/2016	R2	<b>Revision Effective Date: 10/31/2014</b> NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES Removed: "When required by state law" from ACA new prescription requirements Revised: Face-to-Face Requirements for treating practitioner
10/01/2015	R1	

[Back to Top](#) **Related Local Coverage Document(s)** Article(s) [A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#) LCD(s) [L33788 - Manual Wheelchair Bases](#)

**Related National Coverage Document(s)** N/A

**Statutory Requirements URL(s)** N/A

**Rules and Regulations URL(s)** N/A

**CMS Manual Explanations URL(s)** N/A

**Other URL(s)** N/A

**Public Version(s)** Updated on 04/26/2017 with effective dates 01/01/2017 - N/A [Updated on 06/07/2016 with effective dates 07/01/2016 - N/A](#) [Updated on 03/20/2015 with effective dates 10/01/2015 - N/A](#) [Updated on 04/04/2014 with effective dates 10/01/2015 - N/A](#) [Back to Top](#)

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## Keywords

N/A Read the [Article Disclaimer](#) [Back to Top](#)