

## **DOCUMENTATION CHECKLIST FOR POWER MOBILITY DEVICES**

### **Policy References:**

- [Local Coverage Determination \(L33789\)](#)
- [Policy Article \(A52498\)](#)

**Documentation References:** [Standard Documentation Requirements Policy Article \(A55426\)](#)

The supplier must be able to provide all of these items on request:

[Face-to-Face and Written Order Prior to Delivery \(WOPD\) \(CMS Required Face-to-Face Encounter and Written Order Prior to Delivery List\)](#)

If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the F2F, there must be physician concurrence or disagreement with the LCMP examination

[Prior Authorization \(CMS Required Prior Authorization List\)](#)

[Beneficiary Authorization](#)

[Proof of Delivery \(POD\)](#)

[Continued Need](#)

[Continued Use](#)

Financial Attestation Statement

Home Assessment

Medical records from treating practitioner as noted below

### **General Coverage Criteria**

Criteria A - C must be 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 and safely resolved by the use of an appropriately fitted cane or walker.

C. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.

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

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

D. The beneficiary is able to:

Safely transfer to and from a POV, **and**

Operate the tiller steering system, **and**

Maintain postural stability and position while operating the POV in the home.

E. The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.

F. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.

G. The beneficiary's weight is less than or equal to the weight capacity of the POV that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class POV – i.e., a Heavy Duty POV is covered for a beneficiary weighing 285 – 450 pounds; a Very Heavy Duty POV is covered for a beneficiary weighing 428 – 600 pounds.

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

I. The beneficiary has not expressed an unwillingness to use a POV in the home.

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

A power wheelchair is covered if:

a. All of the basic coverage criteria (A-C) are met; **and**

- b. The beneficiary does not meet coverage criterion D, E, or F for a POV; **and**
- c. Either criterion J or K is met; **and**
- d. Criteria L, M, N, and O are met; **and**
- e. Any coverage criteria pertaining to the specific wheelchair type are met.
  - J. The beneficiary has the mental and physical capabilities to safely operate the power wheelchair that is provided; **or**
  - K. If the beneficiary is unable to safely operate the power wheelchair, the beneficiary has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; **and**
  - L. The beneficiary's weight is less than or equal to the weight capacity of the power wheelchair that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class PWC – i.e., a Heavy Duty PWC is covered for a beneficiary weighing 285 – 450 pounds; a Very Heavy Duty PWC is covered for a beneficiary weighing 428 – 600 pounds; an Extra Heavy Duty PWC is covered for a beneficiary weighing 570 pounds or more.
  - M. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
  - N. Use of a power wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it in the home. For beneficiaries with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.
  - O. The beneficiary has not expressed an unwillingness to use a power wheelchair in the home.

#### **ADDITIONAL CRITERIA FOR SPECIFIC TYPES OF POWER WHEELCHAIRS:**

- I. A **Group 1 PWC (K0813, K0814, K0815, K0816)** or **Group 2 PWC (K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829)** is covered if all of the coverage criteria (a)-(e) for a PWC are met and the wheelchair is appropriate for the beneficiary's weight.
- II. **Group 2 Single Power Option PWC (K0835, K0836, K0837, K0838, K0839, K0840)** is covered if all of the coverage criteria (a)-(e) for a PWC are met and if:
  - A. Criterion 1 **or** 2 is met; **and**
  - B. Criteria 3 **and** 4 are met.

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

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

A. Criterion 1 **or** 2 is met; **and**

B. Criteria 3 **and** 4 are met.

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

IV. A **Group 3 PWC with no power options (K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855)** is covered if:

A. All of the coverage criteria (a)-(e) for a PWC are met; **and**

B. The beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; **and**

C. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or practitioner may have no financial relationship with the supplier; **and**

D. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

V. A **Group 3 PWC with Single Power Option (K0856, K0857, K0858, K0859, K0860)** or with **Multiple Power Options (K0861, K0862, K0863, K0864)** is covered if:

A. The Group 3 criteria IV(A) and IV(B) are met; **and**

B. The Group 2 Single Power Option (criteria II[A] and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.

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

VII. A **Group 5 (Pediatric) PWC with Single Power Option (K0890)** or **with Multiple Power Options (K0891)** is covered if:

A. All the coverage criteria (a)-(e) for a PWC are met; **and**

B. The beneficiary is expected to grow in height; **and**

C. The Group 2 Single Power Option (criteria II[A] and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.

VIII. A **push-rim activated power assist device (E0986)** for a manual wheelchair is covered if all of the following criteria are met:

A. All of the criteria for a power mobility device listed in the Basic Coverage Criteria section are met; **and**

B. The beneficiary has been self-propelling in a manual wheelchair for at least one year; **and**

C. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the need for the device in the beneficiary's home. The PT, OT, or practitioner may have no financial relationship with the supplier; **and**

D. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

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

1. The beneficiary meets the general coverage criteria for a power wheelchair; **and**
2. The specific configurational needs of the beneficiary are not able to be met using wheelchair cushions, or options or accessories (prefabricated or custom fabricated), which may be added to another power wheelchair base.