

WHEELCHAIR BENEFIT COVERAGE STANDARD:

Manual Wheelchair Bases, Power Mobility Devices, Wheelchair Seating and Wheelchair Options and Accessories - Draft

Brief Coverage Statement

Durable medical equipment (DME) and disposable medical supplies (supplies) are a Colorado Medicaid benefit that provides clients with medical equipment and/or disposable supplies when there is a medical need for the treatment or therapy of an illness or physical condition and it is safe and suitable for use in a non-institutional setting.

This policy statement is supplemental to 10 CCR 2505-10 § 8.590, Durable Medical Equipment and Disposable Medical Supplies, of the Colorado Medicaid rules.

The Wheelchair Benefit Coverage Standard is inclusive of general coverage guidelines and limitations that shall apply in adjunct to the guidelines and limitations in each of the following subparts:

Manual wheelchair bases (MWBs): MWBs are a DME benefit for clients with neurological, orthopedic, cardiopulmonary or other conditions that affect their ability to sit or ambulate safely and functionally. The appropriate type of wheelchair is determined by assessment and evaluation of body size, medical and/or functional needs and physical condition.

Power mobility devices (PMDs): PMDs include power operated medical vehicles (POVs) and power wheelchairs (PWCs). PMDs are a DME benefit for clients with neurological, orthopedic, cardiopulmonary, or other conditions that affect their ability to sit or ambulate safely and functionally. Powered mobility devices are considered when alternative types of maneuverability controls are needed for ambulation for clients who have limited functional strength, coordination or endurance in their arms and torso. The appropriate type of wheelchair is determined by assessment and evaluation of body size, medical and/or functional needs and physical condition.

Wheelchair Seating: Wheelchair seating includes devices which serve to support a seated or reclined position within a mobility base, to provide postural support, injury prevention, or skin protection. Many clients who use wheelchairs require specific wheelchair seating products to address impairments in body structures or functions such as decreased muscle strength, paralysis, abnormal muscle tone, limited range of motion, orthopedic asymmetries and/or poor sitting balance. Wheelchair seating devices include both primary and secondary support surfaces. Primary support surfaces include the seat cushion and back support and enable the individual to sit in the mobility system. Secondary supports are typically used to provide support or protection

to the extremities (legs, arms, and head), or to help maintain a very specific posture or position of a certain body segment or area, such as the upper torso, buttocks/thighs or extremities.

Secondary support surfaces can be integrated into the primary seat and/or back supports to provide additional positioning functions, or they may be separate items attached to the wheelchair frame or primary supports via special hardware. Separate secondary supports include, but are not limited to, items such as a head support, lateral trunk supports, medial thigh supports, anterior shoulder straps, pelvic belts, and ankle straps.

Wheelchair Options/Accessories (WOAs): WOAs include additional wheelchair components that are not provided as standard on a manual wheelchair base (MWB) or powered mobility device (PMD). WOAs are a DME benefit for clients with neurological, orthopedic, cardiopulmonary or other conditions that affect their ability to sit or ambulate safely and functionally. The appropriate WOAs are determined by assessment and evaluation of the client's medical and/or functional needs and physical condition. WOAs are covered when the client meets coverage criteria for a MWB or PMD **AND** the WOAs are required for the client to complete basic and instrumental activities of daily living (ADLs) in the home, community or any non-institutional setting in which ADLs take place.

Add a new section

Complex Rehabilitation Technology: means medically necessary durable medical equipment and items that are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living of a complex needs patient. Such equipment and items include, but are not limited to, individually configured power wheelchairs and accessories, individually configured manual wheelchairs and accessories, adaptive seating and positioning systems and accessories, and other specialized equipment such as standing frames and gait trainers.

The following Healthcare Common Procedure Code System (HCPCS) billing codes include, but are not limited to are designated as Complex Rehabilitation Technology. New codes may be added as needed. The related:

1. Pure Complex Rehab Technology (CRT) Codes. These HCPCS codes contain only CRT items: E0637, E0638, E0641, E0642, E0986, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1011, E1014, E1037, E1161, E1220, E1228, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, E1239, E2209, E2291, E2292, E2293, E2294, E2295, E2300, E2301, E2310, E2311, E2312, E2313, E2321, E2322, E2323, E2324, E2325, E2326, E2327, E2328, E2329, E2330, E2331, E2351, E2373, E2374, E2376, E2377, E2609, E2610, E2617, E8000, E8001, E8002, K0005, 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, and K0898;
2. Mixed CRT Codes. These HCPCS codes contain a mix of CRT items and standard mobility and accessory items: E0950, E0951, E0952, E0955, E0956, E0957, E0958, E0960, E0967, E0978, E0990, E1015, E1016, E1028, E1029, E1030, E2205, E2208, E2231, E2368, E2369, E2370, E2605, E2606, E2607, E2608, E2613, E2614, E2615, E2616, E2620, E2621, E2624, E2625, K0004, K0009, K0040, K0108, and K0669; and
3. Future CRT codes created to expand on or replace those indicated in paragraphs (1.) and (2.) of this subsection

"Complex Rehabilitation Technology" also includes certain services to ensure appropriate design, configuration, and use of the equipment and items. These services include, but are not limited to, evaluation, configuration, fitting, adjustment, and programming.

Services Addressed in Other Benefit Coverage Standards

- Outpatient Physical Therapy and Occupational Therapy Services.

Eligible Providers

All rendering providers must be enrolled with Colorado Medicaid.

RENDERING PROVIDERS

Rendering provider refers to all accredited DME suppliers and pharmacies that use the DME-supply provider type. Pharmacies must use the Supply provider type for all DME-supply claims.

With the exception of pharmacies, DME suppliers must maintain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) accreditation through an authorized CMS accreditation organization. For more information on DMEPOS accreditation, please visit the CMS Web site here:

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/DMEPOSAccreditation.html>

RENDERING COMPLEX TECHNOLOGY PROVIDERS

Rendering Complex Rehabilitation Technology providers refers to means a company or entity that:

- (I) Is accredited by a recognized accrediting organization as a supplier of complex rehabilitation technology;
- (II) Is enrolled in the medicare program and meets the supplier and quality standards established for durable medical equipment suppliers under the medicare program;
- (III) Employs at least one qualified complex rehabilitation technology professional for each location to:
 - (a) Analyze the needs and capacities of complex needs patients for a complex rehabilitation technology item in consultation with the evaluating clinical team, which typically includes, at a minimum, a physician and a licensed physical therapist or occupational therapist;
 - (b) Assist in selecting appropriate complex rehabilitation technology items for such needs and capacities; and
 - (c) Provide the complex needs patient technology-related training in the proper use and maintenance of the selected complex rehabilitation technology items.
- (IV) Has the qualified complex rehabilitation technology professional physically present for the evaluation and determination of the appropriate individually configured complex rehabilitation technology for the complex needs patient;
- (V) Has the capability to provide service and repair by qualified technicians for all complex rehabilitation technology products it sells; and
- (VI) Provides the complex needs patient written information at the time of sale as to how to access service and repair.

The designation as a Qualified Complex Rehabilitation Technology Supplier shall only be given to a companies or entity that meets the approved standards set forth in this document.

PRESCRIBING PROVIDERS

The State of Colorado limits prescriptive authority to certain board-licensed professions. *Prescribing provider* for this benefit coverage statement refers to any of the following provider types:

- Physicians (MDs and DOs)
- Physician Assistants (PAs)
- Nurse Practitioners (NPs)

Note: Physical therapists (PT) and/or occupational therapists (OT) do not have prescriptive authority in Colorado; however, this does not preclude them from providing services related to

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proper assessment and fitting of wheelchairs and related items described in this coverage statement. Outpatient physical therapy and occupational therapy services are addressed in another benefit coverage standard.

Eligible Place of Service

As outlined in 10 CCR 2505-10 § 8.590.2.B of the Colorado Medicaid rules, clients enrolled in Colorado Medicaid are eligible to receive equipment and supplies through the DME and Supplies benefit as an outpatient service.

Rendering providers are required to include coding that indicates the place of service when submitting claims. The eligible place of service for DME and supplies is not an indication of the client's physical location at the time services are rendered, but rather an indication of where the client is residing. Clients residing in a hospital or other facility must be provided necessary equipment and supplies by the facility, not through the DME benefit.

Eligible Clients

Wheelchairs and wheelchair-related items are a covered benefit for Colorado Medicaid clients who have a neurological, orthopedic, cardiopulmonary or other condition that affects their ability to sit or ambulate safely and functionally. Wheelchairs and wheelchair-related items are provided upon recommendation after any necessary evaluations, assessments and/or documentation requirements have been completed, and medical necessity has been established as indicated in this benefit coverage standard and its subparts.

Eligible Complex Needs Clients

Complex rehabilitation technology, such as individually configured power wheelchairs and accessories, individually configured manual wheelchairs and accessories, adaptive seating and positioning systems and accessories, and other specialized equipment such as standing frames and gait trainers, are a covered benefit for Colorado Medicaid clients who qualify to be considered as a Complex Needs Patient and must be evaluated by:

- (I) A qualified health care professional, including but not limited to a licensed physical therapist, a licensed occupational therapist, or other licensed health care professional who has no financial relationship with the complex rehabilitation technology supplier and performs specialty evaluations within his or her scope of practice; and
- (II) A qualified complex rehabilitation technology professional;

. "Complex needs patient" means an individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities. "complex needs patient" includes individuals with progressive or degenerative neuromuscular diseases, congenital disorders, or injuries or trauma that resulted in significant physical or functional needs and capacities, including but not limited to individuals with spinal cord injury, traumatic brain injury, cerebral palsy, muscular dystrophy, spina bifida, osteogenesis imperfecta, arthrogyrosis, amyotrophic lateral sclerosis, multiple sclerosis, demyelinating disease, myelopathy, myopathy, progressive muscular atrophy, anterior horn cell disease, post-polio syndrome, cerebellar degeneration, dystonia, huntington's disease, spinocerebellar disease, and certain types of amputation, paralysis, or paresis that result in significant physical or functional needs and capacities.

Covered Services and Limitations

Wheelchairs and wheelchair-related requests are reviewed on a case-by-case basis and approval is based on documentation submitted by the eligible provider. In general, items will be considered for coverage if the client's condition or diagnosis is such that, without the recommended item, he or she would be unable to sit or ambulate safely and functionally. Specific information on covered services and limitations are indicated in each of the four subparts of this benefit coverage standard, which include MWBs, PMDs, Wheelchair Seating and WOAs.

Prior Authorization Requirements

Prior Authorization is required for purchase of all wheelchairs and wheelchair-related items as outlined in the Durable Medical Equipment (DME) & Supplies billing manual and updated in Provider Bulletins. The Prior Authorization Request (PAR) must be accompanied by documentation (see Documentation Requirements) which is used to establish medical necessity as determined by the Department's Utilization Management (UM) contractor. A physician, physician assistant or nurse practitioner who has seen the client in the past year must sign the documentation indicating agreement with the recommendation. PARs must include the manufacturer, make, and model of the equipment. A quoted amount must be submitted with the PAR for all purchases or repairs. 4 | Page

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The prior authorization request is a determination of medical necessity only; claims and billing processes are not considered in this determination. Therefore, PAR approval does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. Prior authorization only assures that the approved service is a medical necessity and is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, detailed provider information, detailed description of medical necessity, all required attachments included, etc.) before payment can be made. Please refer to the Durable Medical Equipment (DME) & Supplies billing manual and the current Fee Schedule for billing information.

Note: Medical necessity is defined in 10 CCR 2505-10, Sections 8.590.1 and 8.590.2.A, of the Colorado Medical Assistance Program rules. Equipment and supplies are considered for approval if they are currently accepted by the medical community and evidence-based medical practices and standards are available. Requested items must be within the scope of these rules and as determined by the UM contractor upon PAR submission.

Documentation Requirements

There are two levels of documentation requirements associated with prior authorization requests for wheelchairs and wheelchair-related items:

- 1) Basic documentation: This level of documentation does not require a specialty evaluation. Basic documentation requirements apply to all wheelchairs and wheelchair-related items that require a PAR as indicated in each of the subparts of this benefit coverage standard.
- 2) Specialty evaluation documentation: Some wheelchairs and wheelchair-related items require specialty evaluation documentation, which provides further details in order to establish medical necessity. Items that require a specialty evaluation must include both the basic and specialty evaluation documentation. Items requiring specialty evaluation are indicated in each of the subparts of this benefit coverage standard.

Basic Documentation Requirements (no specialty evaluation required):

All items that require a PAR must be accompanied by a Letter of Medical Necessity which includes, at a minimum, the following information:

- Beneficiary's name, date of birth, residence address, height and weight, and all relevant medical diagnoses.
- A summary of the client's current medical condition, prognosis, previous and current treatments that are pertinent to the requested item.
- Length of anticipated need for the requested item.
- A brief description of the client's impairment in functional mobility that establishes that they have a *mobility limitation* (see Definitions) and the item is needed for a medical purpose.
- If the recommended item is not the least costly option available to meet the client's

medical need, documentation must contain a brief description of the impairments in body functions or structures that rule out use of the less costly item to justify the need for the recommended item.

- A description of how the client will operate the MWB, PMD (e.g. self-propel, tiller, joystick, etc.) and/or WOAs. Include a statement summarizing the client's mental and physical abilities/limitations providing evidence of client's ability to operate the recommended equipment appropriately for the duration of recommended use and in the environments in which it will routinely be used.
- If applicable, a brief description of the client's seating and positioning needs, and how these will be adequately met by the recommended MWB, PMD and/or WOAs.
- If applicable, a brief description of where the equipment is to be used, including the accessibility of client's residence or non-institutional setting. Include if the equipment will be transported in a vehicle and how, as well as the capability of the client or caregiver to properly operate the equipment in these environments.
- A brief description of any anticipated changes in the client's physical size, medical or functional status which may require modifications to the equipment, and how the equipment will accommodate the client's needs over time. The recommended equipment should be capable of modification to meet the needs for anticipated improvement or deterioration of functional mobility when possible.
- Any additional documentation required for the other components of the wheelchair that are indicated in the *Covered Services and Limitations* section of each subpart of this benefit coverage standard.
- Detailed description of all manually priced items that will be provided including manufacturer's retail pricing or invoice information with itemized pricing, including the description of the specific base, any attached seating system components, and any attached accessories.

NOTE: All basic documentation paperwork requires the signature of the ordering physician, indicating that he or she agrees with the recommendation, and has evaluated the client within the past 12 months of signing and dating the required paperwork.

Specialty Evaluation Documentation Requirements:

Items that require a Specialty Evaluation (see Definitions) are indicated in each of the subparts of this benefit coverage standard. A specialty evaluation must be performed by a licensed/certified medical professional (such as a PT, OT, or physician) who has specific training and experience in Complex Rehab Technology (see Definitions) wheelchair evaluations. The documentation must demonstrate the medical necessity for each item that requires a specialty evaluation and include the following information **in addition to the 6 | Page**

Basic Documentation Requirements previously listed:

- Date(s) of specialty evaluation; name and signature of licensed/certified medical professional completing the evaluation and assessment. A statement attesting that the person performing the assessment has no financial relationship with the DME provider should be included.
- A brief description of the specialty evaluation process that was completed, which includes a summary of the pertinent assessment findings/outcomes in the following assessment areas that apply:
 - Functional mobility, including transfers
 - Sitting balance/postural alignment.
 - Existence and severity of postural asymmetries
 - Sensory function, if impaired
 - Neuromusculoskeletal function (movement, muscle tone, coordination)
 - Mat exam (joint range of motion, deformities, orthopedic impairment), addressing the existence and severity of orthopedic deformities.
 - Equipment trials/simulations
- A description of the client's current mobility and/or seating equipment, how long the client has been using the current equipment and why it no longer meets the client needs.
- Information on any recent changes in the client's physical or functional status, and any expected or potential surgeries that will improve or further limit mobility.
- Information regarding the client's seating and positioning needs and the specific seating equipment and accessories required to meet those needs.
- A summary of the type of mobility equipment that will best meet the client's medical and functional needs, and an explanation of the basic and/or instrumental ADLs that will be possible with this equipment that would not be possible with a lower level or lower cost item.
- If applicable, documentation that supports why a tilt seat function is necessary to meet the client's medical and/or functional needs.
- If a client has a progressive disability, the documentation must indicate how the item will accommodate the client's needs over time. If a client is expected to grow, the wheelchair must have a growth potential.

NOTE: All specialty evaluation paperwork requires the signature of the ordering physician, indicating that he or she agrees with the recommendation and has evaluated the client within the past 12 months of signing and dating the required paperwork.

PRICING POLICES FOR COMPLEX REHABILITATION TECHNOLOGY

Pricing policies for Complex Rehabilitation Technology shall include the following guidelines:

- 1) Ensuring that the reimbursement amounts for complex rehabilitation technology and supporting clinical complex rehabilitation technology services are adequate to provide qualified individuals with access to the items, taking into account the unique needs of complex needs patients and the complexity and customization of complex rehabilitation technology;
- 2) Exempting complex rehabilitation technology from inclusion in competitive bidding programs or similar processes; and

(III) Preserving the option to purchase in a lump sum all complex rehabilitation technology as the method of payment;

Non-Covered Services and General Limitations

Items for coverage are reviewed on a case-by-case basis using documentation that is submitted. Approval decisions are based on the equipment that is the least costly alternative to meet the client's medical and functional needs. Approval will not be granted for equipment that is solely

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intended to allow the client to engage in leisure, recreational or social activities if this equipment is more costly than wheelchair seating which meets the client's medical and basic functional needs. The Colorado Medical Assistance Program pays for some secondary/back-up equipment when there is a medical necessity and the services are not duplicative and being used for the same purpose as items already utilized by the client. Please see the ***Primary, Secondary and Back-Up Mobility Devices*** section on page ## for details.

Any item that has not received a written coding verification from the Pricing, Data Analysis, and Coding (PDAC) contractor may be denied as not reasonable and necessary and will be reviewed on a case-by-case basis.

Replacement

Colorado Medicaid covers replacement of medically necessary items only when there is a change in the client's condition which warrants a new device or when reasonable wear and tear renders the item nonfunctioning and not repairable, and there is coverage for the specific item available under the plan.

Clients 21 and older are *eligible* for wheelchair replacement every five years. However, early replacement will be considered with documentation that demonstrates a medical or functional need, and why repairs or modifications to the current wheelchair are not sufficient.

- Prior authorization documentation should include detailed information on evidence of need due to a change in the type or severity of the client's impairments in body structures or functions, or significant change in body size or weight.
- Equipment requested should accommodate current needs as well as anticipated future needs OR have the ability to be modified to accommodate changes in the event that changes in the client's condition are foreseeable.
- Projected repairs should not exceed the cost of new equipment.

Clients under the age of 21 are *eligible* for wheelchair replacement every three years. However, early replacement will be considered with documentation that demonstrates a medical or functional need, and why repairs or modifications to the current wheelchair are not sufficient.

- Prior authorization documentation should include detailed information on evidence of need due to a change in the type or severity of the client's impairments in body structures or functions, or significant changes in body size/dimensions.
- Equipment requested should accommodate current needs as well as anticipated future needs OR have the ability to be modified to accommodate changes in the event that changes in the client's condition are foreseeable.
- Projected repairs should not exceed the cost of new equipment.

NOTE: Exceptions to the replacement guidelines defined above will be made on a case by case basis for unforeseen changes in medical and/or physical condition.

Additional circumstances which may justify a replacement include:

- The equipment is stolen. Replacement of stolen equipment requires a police report that conforms to criteria outlined in the Colorado Revised Statutes. The request for replacement must also include a statement that the theft was not covered by auto or homeowner's insurance.
- The equipment is damaged or destroyed in a motor vehicle accident. An official police report must be submitted with the replacement request. The request for replacement must also include a statement that the damage was not covered by auto or homeowner's insurance.
- The equipment has been damaged beyond repair in some manner, and is not the result of client misuse. The request for replacement must include an itemized price breakdown showing the cost to repair the wheelchair. The equipment must not be thrown away prior to the Department's decision on replacement.

NOTE: All policies and prior approval requirements that apply to the purchase of the original wheelchair also apply to replacements.

Primary, Secondary, and Back-Up Mobility Devices

The PMD or MWB that a client uses the majority of the time in accommodated and/or non-accommodated environments to meet their daily medical and/or functional needs is referred to as their *primary mobility device*. Purchase of a primary mobility device is approved upon recommendation after medical necessity for the device has been evaluated, assessed and well-documented by an appropriate provider.

A *secondary mobility device* is a PMD, MWB, stroller or walking aid that the client uses routinely a minority of time in situations in which he or she is unable to use their primary mobility device to meet their medical and/or functional need. While the client's secondary mobility device is not used as frequently as their primary mobility device, the client requires it on a routine basis in accommodated and/or non-accommodated environments in order to perform basic and instrumental ADLs which cannot be performed using the primary mobility device. Decisions regarding purchase of a secondary mobility device are made on a case by case basis upon recommendation after medical necessity for the device has been evaluated, assessed and well-documented by an appropriate provider.

Duplicate services are not provided. If a client uses a PMD as the primary mobility device, Medicaid will not pay for another PMD to be used as the secondary mobility device. Likewise, if a client uses a MWB as the primary mobility device, Medicaid will not pay for another MWB to be used as the secondary mobility device. If the client uses a stroller as the primary mobility device, Medicaid will not pay for another stroller to be used as the secondary mobility device. A stroller can serve as a secondary mobility device to either a PMD or a MWB. 9 | P a g e

A ***back-up mobility device*** is a client-owned PMD or MWB that is used infrequently as a back-up to the primary mobility device or secondary mobility device when either device requires repair or maintenance. Medicaid does not pay for the purchase of a back-up mobility device.

Medicaid may either pay for repair/modifications to an existing client-owned back-up device, OR the rental of a back-up device for clients who require only a primary mobility device. However, medical and/or functional need for a back-up mobility device must be established and be the least costly alternative. Repairs, rental, or modifications to a back-up mobility device are provided upon recommendation after medical necessity has been evaluated, assessed and well-documented by an appropriate provider (See the Repair and Rental sections for more details).

Wheelchair Seating and WOAs for Primary, Secondary and Back-Up Mobility Devices

If a client owns a primary mobility device and a secondary mobility device (see Definitions), Colorado Medicaid may approve the purchase of a wheelchair seating system and/or WOAs for each device if the provider demonstrates medical necessity for the items to enable the client to perform basic and instrumental ADLs at home and/or in the community. Duplicate services will not be approved (i.e. purchase of two wheelchair seating systems for the same MWB or PMD).

In some limited situations, Medicaid may pay for repair, modifications, or replacement of wheelchair seating and/or WOAs used in an existing client-owned back up mobility device (see Definitions), if the medical and/or functional need for the back-up mobility device is established. Repairs, modifications, or replacement of the wheelchair seating and/or WOAs on a back-up mobility device are provided upon recommendation after medical necessity has been evaluated, assessed and well-documented by an appropriate provider, and there are no other less costly options to meet the client's medical and/or basic functional needs. (See the Repair and Rental sections for more details).

ADD OUR DEFINITIONS TO THE APPENDIX A: DEFINITIONS