Dear Physician,

For Medicare to provide reimbursement for a manual wheelchair (MWC) base, the medical necessity documentation requirements of certain coverage criteria must be met. The following information is intended to provide you with summary guidance on Medicare's coverage and documentation requirements for MWC bases.

Medical Necessity Documentation

CMS requires that the MWC be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Information to support the medical necessity for an MWC will come from your, and other qualified healthcare practitioners', documentation. A summary of the coverage criteria for MWC bases is provided below.

Please note: The medical record documentation for the MWC should paint a picture of your patient's functional abilities and limitations in their home on a typical day. It should contain as much objective data as possible. The examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability. Vague terms such as "difficulty walking" are insufficient since they do not objectively address the mobility limitation or provide a clear picture of the patient's mobility deficits when participating in mobility-related activities of daily living (MRADLs). The beneficiary's medical records include the treating practitioner'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 to the supplier upon request.

If the MWC will be used inside the home and the below coverage criteria are not met, the MWC will be denied as not reasonable and necessary. If the MWC is only for use outside the home, it will be denied as non-covered/no benefit, as the Durable Medical Equipment (DME) benefit requires use within the home for coverage eligibility. If the MWC base is not covered, then all related accessories will be denied as not reasonable and necessary.

General Coverage Criteria

An MWC, described by HCPCS code K0001, for use inside the home is covered if the following general coverage criteria A-E and either G **or** F are met:

A. The beneficiary has a mobility limitation that significantly impairs their 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 attempting 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; and,

C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the MWC that is provided; and,

D. Use of an MWC will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home; and,

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E. The beneficiary has not expressed an unwillingness to use the MWC that is provided in the home; and,

F. The beneficiary has sufficient upper extremity function, and other physical and mental capabilities needed, to safely self-propel the MWC that is provided in the home during a typical day. (Limitations of strength, endurance, range of motion, coordination, the presence of pain, deformity, or the absence of one or both upper extremities, are relevant to the assessment of upper extremity function); or,

G. The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Note: A transport chair (HCPCS codes E0137, E0138 and E1039) is covered as an alternative to a standard manual wheelchair (K0001) if the above general coverage criteria A-E and G are met. If documentation of the medical necessity for a transport chair is requested, it must include a description of why the beneficiary is unable to make use of a manual wheelchair (HCPCS codes K0001, K0002, K0003, K0004 and 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.

Specific Coverage Criteria

In addition to the above General Coverage Criteria (A-E and G **or** F), a MWC base described by HCPCS codes E1161, K0002, K0003, K0004, K0005, K0006, K0007 and K0008, is covered if the below specific coverage criteria are also met:

- E1161 (Manual, adult size wheelchair, includes tilt in space):
    1. The beneficiary must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP), such as a physical therapist (PT) or occupational therapist (OT) or physician/treating practitioner who has specific training and experience in rehabilitation wheelchair evaluations, and who documents the medical necessity for the wheelchair and its special features. The LCMP may have no financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, the PT, OT, or practitioner working in the inpatient or outpatient hospital setting may perform the specialty evaluation.); and,
    2. The E1161 is provided by a Rehabilitative Technology Supplier (RTS) that employs a Rehabilitation Engineering & Assistive Technology Society of North America (RESNA) certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.
- K0002 (Standard hemi (low seat) wheelchair):
    1. 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.
- K0003 (Lightweight wheelchair):
    1. The beneficiary cannot self-propel in a standard wheelchair in the home; and,
    2. The beneficiary can and does self-propel in a lightweight wheelchair.
- K0004 (High strength, lightweight wheelchair):
    1. The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair; or,
    2. 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.
        - Note: 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).
- K0005 (Ultralight wheelchair):

1. Documentation that the beneficiary must be a full-time MWC user is to include whether the beneficiary is fully independent in the use of the MWC, and a description of the beneficiary's routine and frequently encountered activities; or,
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, that cannot be accommodated by a K0001 through K0004 MWC; and,
3. The beneficiary must have a specialty evaluation that was performed by an LCMP, such as a PT or OT or a physician/treating practitioner who has specific training and experience in rehabilitation wheelchair evaluations, and who documents the medical necessity for the wheelchair and its special features. The LCMP may have no financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, the PT, OT, or practitioner working in the inpatient or outpatient hospital setting may perform the specialty evaluation.); and,
4. The wheelchair is provided by an RTS who employs a RESNA certified ATP who specializes in wheelchairs, and who has direct, in-person involvement in the wheelchair selection for the patient.

- K0006 (Heavy duty wheelchair):
  1. The beneficiary weighs more than 250 pounds; or,
  2. The beneficiary has severe spasticity.
- K0007 (Extra heavy duty wheelchair):
  1. The beneficiary weighs more than 300 pounds.
- K0008 (Custom manual wheelchair/base):
  1. Include the configuration of the uniquely constructed or substantially modified MWC/base for a specific beneficiary according to the description and order(s) for the beneficiary's treating practitioner to support that the custom MWC/base is required to specifically address the beneficiary's physical and/or functional deficits that cannot be met using one of the other MWCs and accessories, including customized seating arrangements; and,
  2. An appropriate combination of wheelchair seating systems, cushions, options or accessories (prefabricated or custom fabricated), such that the individual construction of a unique individual MWC/base is required.
     - Note: A custom MWC base is not reasonable and necessary if the expected duration of need is less than three months (e.g., post-operative recovery).

This summary is not intended to take the place of the written law, regulations, national coverage determinations (NCDs) or local coverage determinations (LCDs). Coverage, coding and documentation requirements may be found in the MWC Bases LCD (https://www.cms.gov/Medicare-Coverage-database/view/lcd.aspx?LCDId=33788) and LCD-related Policy Article (https://www.cms.gov/Medicare-Coverage-Database/view/article.aspx?articleId=52497), located in the Medicare Coverage Database at http://www.cms.gov/medicare-coverage-database.

Your participation and cooperation with the supplier in this process will allow your patient to receive the most appropriate type of mobility equipment. We appreciate all your efforts in providing quality services to your Medicare patients.

Sincerely,

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