MEDICAL POLICY

Medical Policy Title	**Wheelchairs and Power Operated Vehicles (POVs)**
Policy Number	**1.01.16**
Current Effective Date	August 21, 2025
Next Review Date	August 2026

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. Wheelchairs are considered **medically appropriate** when used by an individual for mobility in the performance of activities of daily living in their residence. (See Policy Guideline VI for additional criteria for non-standard wheelchairs and mobility devices.)

II. Power operated vehicles (POV's) are considered **medically appropriate** when an individual meets coverage criteria for a wheelchair, is unable to self-propel a manual wheelchair, and is cognitively and physically able to operate a POV.

III. Wheelchairs are considered **not medically necessary** in **ANY** of the following circumstances:

- A. When used primarily for comfort or convenience;
- B. When used primarily for transportation outside the home, except for dependent children who require a wheelchair to attend school;
- C. When used for sports or recreational purposes.

IV. Wheelchairs with stair climbing ability (e.g., iBOT) are considered **not medically necessary**.

V. If an upgrade in equipment is requested, the patient's functional status (diagnosis, prognosis and severity of condition) must be reviewed, as part of the justification for medical necessity as described below. (See Policy Guideline VI for additional criteria for non-standard wheelchairs and mobility devices).

VI. Durable Medical Equipment (DME) Repair

- A. Repair of a medically appropriate wheelchair and power operated vehicle or components not under warranty will be considered **medically appropriate** when the following criteria are met:
  1. Physician documentation includes **ALL** the following:
     - a. date of DME initiation;
     - b. manufacturer warranty information, if applicable;
     - c. attestation that the patient has been compliant with the use of the DME and will continue to benefit from the use of the DME;

2. The DME is no longer functioning adequately; and **BOTH** of the following criteria are met:
    a. inadequate function interferes with activities of daily living; **and**
    b. repair is expected to make the equipment fully functional (as defined by manufacturer).

B. Repair of equipment damaged due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

VII. DME Replacement

A. Replacement of a medically appropriate wheelchair and power operated vehicle or components not under warranty will be considered **medically appropriate** when **EITHER** of the following criteria are met:

1. The DME is no longer functioning adequately and has been determined to be non-repairable, or the cost of the repair is in excess of the replacement cost;
2. There is documentation that a change in the patient's condition makes the present unit non-functional and improvement is expected with a replacement unit.

B. The replacement of a properly functioning wheelchair and power operated vehicle, its components or accessories is considered **not medically necessary**. This includes, but is not limited to, replacement desired due to advanced technology or to make the DME more aesthetically pleasing;

C. The replacement of equipment damaged or lost due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

VIII. Accessories or components for wheelchairs and power operated vehicles that are considered not medically necessary or investigational by peer-reviewed literature will also be considered as **not medically necessary or investigational** by the Health Plan.

RELATED POLICIES

Corporate Medical Policy

1.01.00 Durable Medical Equipment- Standard and Non-Standard

1.01.46 Standing Devices

11.01.11 Comfort, Convenience, Custodial, or Cosmetic Services

POLICY GUIDELINE(S)

I. Supporting Documentation Required

Coverage of wheelchairs and accessories/special features requires documentation of **medical necessity** by the individual's practitioner. Documentation must be submitted for review and must include the patient's diagnosis, a narrative description with functional criteria for the wheelchair and any requested non-standard features. At a minimum, such documentation must include:

A. Diagnosis, prognosis and severity of condition;

B. Seating and mobility evaluation by a trained professional familiar with seating, positioning and wheeled mobility options taking into account the current functional abilities and disabilities of the patient as well as potential long-term needs. The Health Plan reserves the right to require an assessment for a requested mobility device to be performed on the patient by an independent rehabilitation specialist, therapist, or equipment specialist;

C. Assessment of the home environment for wheelchair accessibility and the ability to accommodate any special equipment, positioning devices or motorized component (e.g., door frame size) if requested;

D. If a motorized wheelchair is requested an explanation as to why a standard wheelchair is inadequate for the particular activity of daily living; and

E. Relevant medical records.

II. Coverage will be provided for one manual wheelchair, one motorized wheelchair, or one scooter. More than one mobility device is considered a matter of convenience for the member and their family. No coverage for a back-up wheelchair will be provided except that a one-month rental will be covered if the owned wheelchair is being repaired.

III. A wheelchair must be appropriate for the individual's disability, size, weight, activity, and for the home environment.

IV. For individuals residing at a residential facility and receiving custodial care services (custodial care status), wheelchairs are **eligible for coverage** when criteria are met.

V. For individuals temporarily residing in a residential facility and receiving skilled services (skilled status), coverage of wheelchairs is considered global to the skilled nursing facility (SNF) reimbursement.

VI. Wheelchair Features and Coverage Criteria

The following is a list of characteristics and additional coverage criteria for various models of wheelchairs.

Model/Description	Coverage Criteria	Non-Coverage Criteria
Standard -Manual Wt: greater than 36 lbs Seat width: 16-18"	1. Patient has impaired mobility in performance of mobility-related activities of daily	1. Used solely for social, recreational or employment

Model/Description	Coverage Criteria	Non-Coverage Criteria
Seat depth: 16” Seat height: equal or greater than 19” or equal or less than 21” Back height: 16-17” Arm style: fixed or detachable	living (MRADL’s) in the home which would be alleviated by the mobility device; **AND** 2. Patient is able to self- propel a wheelchair; **AND** 3. Patient’s mobility limitation cannot be resolved by use of an appropriately fitted assistive device (e.g., cane or walker); **OR** 4. Patient has a medical condition for which weight-bearing or ambulation is contraindicated; **OR** 5. Patient has a disease process or injury that precludes use of the lower extremities.	activities.
Hemi - Manual Wt: greater than 36 lbs Seat width: 16-18” Seat depth: 16” Seat height: 17-18” Back height: 16-17” Arm style: fixed or detachable Enables short in stature patient to place feet on ground for propulsion.	1. Patient meets criteria for a standard manual wheelchair; **AND** 2. Is unable to propel a manual wheelchair with upper extremities; **OR** 3. Has paralysis in one arm or leg and is able to self-propel a manual wheelchair.	1. Used solely for social, recreational or employment activities.
Lightweight - Manual Wt: equal or less than to 36 lbs Seat width: 16-18” Seat depth: 16” Seat height: equal or greater than 17” or equal or less than 21” Back height: 16-17”	1. Patient meets criteria for a standard manual wheelchair; **AND** 2. Is unable to self-propel a standard manual wheelchair.	1. Used solely for social, recreational or employment activities.

Model/Description	Coverage Criteria	Non-Coverage Criteria
Arm style: fixed or detachable		
<u>Ultra lightweight - Manual</u> Wt: less than 34 lbs Seat width: 14 - 18” Seat depth: 14 - 16” Seat height: equal or greater than 17” or equal or less than 21” Back height: 15-19” Arm style: fixed or detachable	1. Patient meets criteria for a standard manual wheelchair; **AND** 2. Is unable to self-propel in standard or lightweight manual wheelchair.	1. Used solely for social, recreational or employment activities. 2. Titanium frame has marginal weight advantage over aluminum frame; considered not medically necessary.
<u>Full or Semi-reclining-Manual</u> Wt: less than 30 lbs. Seat width: 14-18” Seat depth: 14 - 16” Seat height: equal or greater than 17” or equal or less than 21” Back height: varies Arm style: fixed or detachable	1. Patient meets criteria for a standard manual wheelchair except may not be able to self-propel manual wheelchair; **AND** 2. Any of the following are met: a. Is quadriplegic/ tetraplegic; **OR** b. has trunk or lower extremity cast; **OR** c. has braces that require special positioning; **OR** d. has fixed hip angle; **OR** e. has excess extensor tone of the trunk muscles; **OR** f. has prior history of skin breakdown.	1. Used solely for social, recreational or employment activities. 2. Used for prophylaxis of sacral decubiti without a prior history of skin breakdown.
<u>Tilt in space - Manual</u> Lightweight wheelchairs Custom designed frames which allow the position of the wheelchair to change.	1. Patient meets criteria for a standard manual wheelchair except may not be able to self-propel manual wheelchair; **AND** 2. Patient: a. has fixed hip angle; **OR**	1. Patient has bladder-emptying problems or wears a leg bag (bladder may be constricted, leg bag may leak).

Model/Description	Coverage Criteria	Non-Coverage Criteria
	b. has excess extensor tone of the trunk muscles; **OR** c. has cerebral palsy; **OR** d. has spinal cord injuries.	
Heavy Duty - Manual Wt: varies Seat width: 18” Seat depth: 16 - 17” Seat height: equal or greater than 19” or equal or less than 21” Back height: 16-17” Arm style: fixed or detachable Includes reinforced back and seat upholstery.	1. Patient meets criteria for a standard manual wheelchair; **AND** 2. Patient weighs greater than 250 lbs.	1. Used solely for social, recreational or employment activities.
Extra Heavy Duty - Manual Wt: greater than 36 lbs Seat width: 16-18” Seat depth: 16” Seat height: equal or greater than 19” or equal or less than 21” Back height: 16-17” Arm style: fixed or detachable Includes reinforced back and seat upholstery.	1. Patient meets criteria for a standard manual wheelchair; **AND** 2. Patient weighs greater than 300 lbs.	1. Used solely for social, recreational or employment activities.
Wide Heavy Duty- Manual Wt: varies Seat width: greater than 18” Seat depth: 16 - 17” Seat height: equal or greater than 19” or equal or less than 21” Back height: 16-17” Arm style: fixed or detachable	1. Patient meets criteria for a standard manual wheelchair; **AND** 2. Patient’s hip width is greater than 18 inches.	1. Used solely for social, recreational or employment activities.

Model/Description	Coverage Criteria	Non-Coverage Criteria
Motorized Wheelchairs Used in severe impairment of functional mobility. Without the use of the wheelchair, the patient would be severely limited or unable to perform routine ADL's. Inability to safely propel a manual wheelchair due to severely limited upper extremity function.	1. Patient meets criteria for a standard manual wheelchair; **AND** 2. Is unable to maneuver a manual wheelchair for a distance greater than 25 feet; **AND** 3. Has upper extremity impairment and cannot self-propel a manual wheelchair; **AND** 4. Is able to safely operate a power operated wheelchair; **AND** 5. Is expected to continue to need for the motorized wheelchair greater than six weeks.	1. Use as convenience item. 2. When used primarily for transportation to work, shopping, social or recreational activities, to facilitate employment, or for other activities outside the domicile/home. 3. Patient can self-propel from room to room in the home. 4. Caregiver is available and can propel the patient. 5. K0868-K0886 are considered **NMN** due to features that are not necessary for in home use.
Motorized Wheelchairs – Pediatric Used in severe impairment of functional mobility. Without the use of the wheelchair, the patient would be severely limited or unable to perform routine ADL's. Inability to safely propel a manual wheelchair due to severely limited upper extremity function. Inability of the caregiver to safely propel a manual wheelchair.	1. Patient meets criteria for a standard manual wheelchair; **AND** 2. Is able to safely operate a power operated wheelchair as determined by an appropriate developmental evaluation; **AND** 3. Is expected to continue need for the motorized wheelchair for greater than dix weeks.	1. Patient cannot safely operate the power operated wheelchair due to lack of developed cognitive and motor skills. 2. Caregiver is available and can propel the patient. 3. Patient can self-propel from room to room in the home. 4. When used primarily for transportation to shopping, social or recreational activities, or for other activities outside the domicile/home. 5. Use as convenience item.
Power Operated Vehicle Electrically operated three or four wheeled chair or scooter	1. Patient meets criteria for a standard manual wheelchair; **AND**	1. Use as convenience item; **OR** 2. Patient has inadequate

Model/Description	Coverage Criteria	Non-Coverage Criteria
designed to transport a patient that is unable to ambulate but has adequate trunk stability to be able to ride safely in the vehicle.	2. Is unable to maneuver a manual wheelchair for a distance greater than 25 feet; **AND** 3. Is able to safely transfer in and out of POV and have adequate trunk stability to ride safely in the vehicle; **AND** 4. Has a condition that is non-progressive; POV may be provided in lieu of motorized wheelchair if the POV meets the needs of the patient and is a more cost-efficient alternative; **AND** 5. Disability is expected to continue for greater than six months.	trunk stability to ride safely; **OR** 3. Patient is disoriented or cannot be left unattended; **OR** 4. Patient is unable to operate controls; **OR** 5. Use as back-up item; **OR** 6. Purchased without a prescription. 7. K0806-K0808 are considered **NMN** due to features that are not necessary for in home use.
Rollabout/Transport Chairs May also be called a mobile geriatric chair (geri-chair). Front and back wheels the same size.	1. Patient meets criteria for a standard manual wheelchair except may not be able to self-propel manual wheelchair; **AND** 2. Is used as primary means of transport in the home.	1. Used solely for social, recreational or employment activities.
Pediatric Stroller	1. Child is non-ambulatory; **AND** 2. Stroller is used to transport child to and from school; **AND** 3. Child requires more support than is available in a standard pediatric wheelchair; **OR** 4. Child is too small to safely use a standard pediatric wheelchair; **OR** 5. Commercially available stroller is inadequate to meet the child's needs.	Not Applicable

VII. The following is a list of special features, accessories, and customizations with coverage criteria. This list is not all- inclusive.

Feature / Description	Coverage Criteria	Non-Coverage Criteria
Adjustable Arm-height option	1. Patient spends at least two hours per day in a wheelchair; **AND** 2. Patient needs arm height that is different from standard non-adjustable arms.	Not Applicable
Anti-roll Back or Anti-tip Device Prevents tipping or wheelchair ability to independently raise front wheels when accessing inclines.	Patient propels either a manual wheelchair or power operated wheelchair up ramps/inclines.	Not Applicable
Arm Support / Trough Stabilizes the arm.	Patient has quadriplegia/ tetraplegia, or hemiplegia, or uncontrolled arm movements.	Not Applicable
Attendant Drive Control Allows the caregiver to drive the wheelchair instead of the patient.	Not Applicable	Convenience item
Battery Charger Single mode included with power wheelchair base.	Not Applicable	Dual mode battery charger is a convenience item.
Caster Tires Pneumatic or semi-pneumatic -provides shock absorption from outdoor and rough surfaces. Solid core - used on smooth surfaces and indoors (flat-free).	Not Applicable	Castor tires with lights are considered a convenience item.

Chin Control/Support	Patient has weak neck muscles.	Not Applicable
Clothing/ Side Guards Protects clothing from dirt, mud or water thrown up by the wheels.	Not Applicable	Convenience item (used for outside the home).
Custom Manual/Power Wheelchair Base Frame has been customized to a specific patient.	Patient requires a wheelchair base that is not an available option in an already manufactured base.	Not Applicable
Elevating Leg Rests – Manual or Power Allows the leg to be raised and lowered independently of the recline and/or tilt of the seating system. Power leg elevation for use with a Power Wheelchair. Articulating (telescoping) power elevating leg rests lengthen while also extending the knee.	1. Musculoskeletal condition or presence of cast or brace that prevents 9- degree flexion of the knee; **OR** 2. Significant edema of the lower extremities; **OR** 3. Has a reclining back on a wheelchair.	Not Applicable
Controller- Integral or Modular - Power Controller function allows the patient to operate the power wheelchair. It is used in conjunction with a proportional interface in which the direction and amount of movement by the patient controls the direction and speed of the wheelchair. One example of a proportional interface is a standard joystick. A non-proportional interface	Inability to operate a manual or power wheelchair. *Integral controller for patients who will have little or no change in functional status and need no special control features in their wheelchair. *Modular controller for patients who need enhanced functions such as sip and puff, head array, power seating systems.	Additional modules for the Q-logic Control System (e.g., environmental controls) is a convenience item.

consists of a number of switches. An example of a non-proportional interface is a sip and puff control. Integral controller has single housing unit with joystick; may be standard. (e.g., Remote Plus electronic system). Modular controller has separate components for different functions. Able to mix and match components to accommodate function enhancers. (e.g., Q-logic Control System).		
<u>Fully Reclining/ Folding Back- Manual</u>	1. Patient is quadriplegic/tetraplegic; **OR** 2. Has trunk or lower extremity cast/braces that require specially positioning; OR 3. Has fixed hip angle; **OR** 4. Has excess extensor tone of the trunk muscle; **OR** 5. Has prior history of skin breakdown; **OR** 6. Utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; **OR** 7. Is unable to carry out a functional weight shift due to spinal cord disease, neurological disease, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease.	1. Convenience item if purpose is for transport only. 2. Used for prophylaxis of sacral decubiti.

Head Rest (Not included in power tilt and recline or power recline seating system.)	1. Patient meets criteria for manual tilt-in-space; **OR** 2. Manual semi- or fully reclining back; **OR** 3. Power tilt and or recline seating system.	Considered **NMN** on a Power Wheelchair with a Captain's seat.
Miscellaneous Accessories Amputee adapter, heel loops, IV rod, narrowing device, oxygen carrier, ventilator tray, speech generative device table, suspension fork, wide stance arm bracket, leg straps, footrests, back straps, additional pads for hips, arms, or legs.	May be considered medically necessary based on individual consideration when adequate documentation is provided.	Not Applicable
Miscellaneous Accessories (Non-Covered) Trays, back packs, crutch or cane holder, shock absorbers, impact guards, lighting systems any option or accessory that is primarily for the purpose of allowing the member to perform leisure, recreation or sports activities, electrical or mechanical features that enhance basic equipment and that usually serve a convenience function.	Not Applicable	Convenience items
Upholstery - Reinforced Back or Seat Not standard with power wheelchair base.	Patient weighs more than 200 lbs.	1. Should be included with heavy duty or extra heavy-duty wheelchair base. 2. If used in conjunction with other manual wheelchair bases.
Push/ Hand Rims/ Handles		

Addition to wheel to aid in self-propelling a manual wheelchair rather than pushing on tire rim. Poorly designed hand rims can cause pain in hands and wrists associated with Carpal Tunnel Syndrome (e.g., Natural Fit hand rims provide ergonomic grip and greater control when braking).	Pain in hands from pushing standard hand rims or tires.	Not designed for patients with poor hand function.
Power add-ons/ Push Activated System Provides an additional power boost to wheels upon the users input force on the push rims. This added boost often provides the necessary force to get the users up hills or to allow them to continue on in a manual chair when shoulder pain, strength or fatigue might otherwise force them to go to a powered wheelchair.	Based on individual consideration when adequate documentation provided.	Not Applicable
Safety Belt/ Shoulder Harness, Structured Harness Allows for proper positioning.	1. Weak upper body muscles; **OR** 2. Patient has upper body instability or muscle spasticity.	Not Applicable
Seat Cushion or Back Cushion General Use: Prefabricated cushion made of foam, flexible cellular material, air fluid or solid gel. Skin Protection: Composed of foam, flexible cellular material, air, fluid or solid gel or a multi-compartment air cushion or	1. Patient spends at least two (2) hours per day in a wheelchair; **AND** 2. History of or current pressure ulcer on area of contact with seating surface; **OR** 3. Absent or impaired sensation in area of contact with seating surface; **OR** 4. Unable to carry out a	1. Patient does not have a wheelchair. 2. Use with transport chair (comfort item). 3. Patient cannot reposition self at least every two hours (seat cushion will not prevent development of pressure ulcers).

composed of two or more types of foam with different stiffness. Positioning: Composed of foam, flexible cellular material, air, fluid and supporting structural features.	functional weight shift due to spinal cord disease, neurological disease, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; **OR** 5. Significant postural asymmetries due to spinal cord injury/disease, demyelinating disease, neurological diseases, Alzheimer's disease, Parkinson's disease, hemiplegia due to stroke, traumatic brain injury.	
Seat or Back Cushion - Custom Fabricated Has removable waterproof cover or surface.	1. Meets criteria for skin protection seat or positioning seat cushion; **AND** 2. Explanation from health care profession why this type of cushion is necessary.	Not Applicable
Seat Cushion - Powered Battery operated, prefabricated cushion powered by an air pump to cause the cushion to inflate and deflate.	Not Applicable	Considered **investigational** as its effectiveness has not been established.
Seat and Back Cushions - Replacement	1. Would be considered when out of warranty; **OR** 2. Irreparably damaged (other than wear and tear); **OR** 3. Item is lost or stolen; **OR** 4. A change in member's medical condition that requires a different type of seating or positioning item.	Not Applicable
Seating System Ensures optimal posture and	Based on individual	Not Applicable

positioning. Consists of: • Seat, • Back, and • Supports. <u>Four different types:</u> 1. Sling – minimal support; 2. Planar – flat surface without contours – firm support. For patients with no pelvis/spinal deformities. 3. Contoured – postural support and pressure relief (e.g., Synergy, TruComfort, Jay Fit for pediatric patients). 4. Custom Contoured- conforms to shape of pelvis and spine. Provides maximum support and pressure distribution.	consideration when adequate documentation provided.	
<u>Seat Elevation- Power</u> Raises and lowers the patient in their seated position by the use of an electro-mechanical lift system, without changing the seated angles or the seat's angle relative to the ground, in order to provide varying amounts of added vertical access. A seat elevator may elevate vertically from a standard seat height or may lower the user closer to the floor.	Not Applicable	Convenience item
<u>Stander Attachment- Power</u> Patient requires assistance to	Not Applicable	No evidence that power stander improves lower body

assume standing position and has some residual muscular strength in legs, such that standing will improve lower body strength.		strength for patients who are completely paralyzed in the legs and hips.
Tilt and/or Recline Seating Systems - Manual/Power Designed to reduce the weight placed on a person's coccyx (tailbone) and buttocks. Disperses weight evenly over the buttocks and legs. Tilting backwards shifts weight off the buttocks and legs while maintaining a normal sitting posture.	1. Patient is quadriplegic/tetraplegic; **OR** 2. Has trunk or lower extremity cast/braces that require specially positioning; **OR** 3. Has fixed hip angle; **OR** 4. Has excess extensor tone of the trunk muscle; **OR** 5. Has prior history of skin breakdown; **OR** 6. Significant edema of lower extremities; **OR** 7. Utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; **OR** 8. Is unable to carry out a functional weight shift due to spinal cord disease, neurological disease, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease.	Used for prophylaxis of sacral decubiti.
Swing Away, Retractable or Removable Leg Rests/ Hardware	If needed for patient to perform a slide transfer to a chair or bed.	1. If primary use is to allow patient to move closer to desks or other surfaces. 2. Should be considered part of the wheelchair base.
Transport Tie Down Keeps chair stabilized when traveling. Usually, an addition to the transport vehicle rather	Covered for pediatric patients if wheelchair is used to transport to and from school.	Convenience item for adults.

than to the wheelchair.		
Wheelchair Tires Specially designed tires which may be more lightweight, narrower, have custom rims or be "flat-free". May be used for sports or recreational activities. Pneumatic: air filled: lightweight provides cushioned ride. Semi-pneumatic: possible problematic maintenance. Flat-free: standard tires filled with polyfoam.	Not Applicable	1. Used for sports or recreational purpose; or 2. Snow tires (convenience item).

DESCRIPTION

A wheelchair is a manually operated or power-driven device designed for use by an individual with a mobility disability for the purpose of locomotion. Traditional wheelchairs have a seat that is positioned between two large wheels with two smaller wheels at the front. Manual wheelchairs can be self-propelled or pushed by another individual.

Power Operated Vehicles (POVs), commonly known as mobility scooters and power wheelchairs, are electric mobility devices designed to assist individuals with mobility challenges. Powered wheelchairs are battery operated and can be controlled through electronic switches.

See Policy Guideline VI for further descriptions of specific DME.

SUPPORTIVE LITERATURE

This policy is based upon Health Plan contract benefits and is intended to clarify those benefits.

PROFESSIONAL GUIDELINE(S)

Not Applicable

REGULATORY STATUS

Various wheelchairs and Power Operated Vehicles have been cleared for marketing by the FDA for specified indications. FDA device approval status can be determined using the following link: https://www.accessdata.fda.gov/scripts/cdrh/devicesatfda/index.cfm [Accessed 2025 Jul 10]

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
Not Applicable	

HCPCS Codes

Code	Description
Wheelchairs	
E1031	Rollabout wheelchair, any and all types with casters 5in or greater
E1038	Transport chair, adult size, patient weight capacity less than 300 pounds
E1050 E1060 E1070	Fully reclining wheelchairs
E1083 E1084 E1085 E1086	Standard hemi (low seat) wheelchair
E1087 E1088 E1089 E1090	High strength, lightweight wheelchair
E1092 E1093 E1280-E1295 K0006	Heavy duty wheelchair

Code	Description
E1100 E1110	Semi-reclining wheelchairs
E1130-E1160	Standard wheelchair
E1161	Manual adult size wheelchair, includes tilt in space
E1170-E1200	Amputee wheelchairs
K0011	Standard–weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
E1220-E1228	Other manual wheelchair/base or accessories
E1229	Wheelchair, pediatric size, not otherwise specified
E1230	Power operated vehicle (three- or four-wheel non-highway), specify brand name and model number
E1231-1234	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with or without seating system
E1235-1238	Wheelchair, pediatric size, rigid or folding, adjustable, with or without seating system
E1239	Power wheelchair, pediatric size, not otherwise specified
E1240-E1270 K0003	Lightweight wheelchair
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0004	High strength, lightweight wheelchair
K0005	Ultralightweight wheelchair
K0007	Extra heavy-duty wheelchair
K0008	Custom Manual Wheelchair Base
K0009	Other manual wheelchair/base
K0010	Standard-weight frame motorized/power wheelchair
K0012	Lightweight portable motorized/power wheelchair
K0013	Custom Motorized/Power Wheelchair Base

Code	Description
K0014	Other motorized/power wheelchair base
K0800-K0898	Power operated vehicles/wheelchairs
Options / Accessories	
E0953 E0954	Lateral thigh support; footbox; including hardware
E0955 E0966	Headrest, headrest extension
E0971	Manual wheelchair accessory, antitipping device, each
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each
E1022	Wheelchair transportation securement system, any type includes all components and accessories
E1023	Wheelchair transit securement system, includes all components and accessories
E1028	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other
E1032	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware used with joystick or other drive control interface
E1033	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for headrest, cushioned, any type
E1034	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for lateral trunk or hip support, any type
E1014 E1225-E1226 E2291 E2293 E2398 E2611-E2617 E2619-E2621 K0669	Back of chair

Code	Description
E0973 E0994 K0015 K0017-K0020	Arm of chair
E0968 E0978 E0981 E0992 E1007 E2230 (NMN) E2231 E2292 E2294 E2295 E2601-E2610 K0669	Seat
E2298 (NMN)	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type
E0951 E0952 E0970 E0990 E0995 E1010 K0047 K0050-K0053 K0195	Footrest/Leg rest
E1011 K0056	Seat Width, Depth, Height
E2205	Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured), any type, replacement only, each

Code	Description
E0967	Manual wheelchair accessory, hand rim with projections, any type, replacement only, each
K0065-K0070	Rear Wheels
K0071-K0077	Front Caster
E0961 E0974 E2206	Wheel Lock
E2360-E2367	Batteries/Chargers for Motorized/Power Wheelchairs
E0950	Wheelchair accessory, tray, each
E0950 E0958 E0959 E2368-E2370 K0098	Motorized/Power Wheelchair Parts
E2373-E2377	Power wheelchair accessory control interface/controller
E2381-E2396	Power wheelchair wheel/caster/tire
E0986	Manual wheelchair accessory, push-rim activated power assist system
K0733	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)
E0956 E0957 E0969 E1035 K0105 K0108	Miscellaneous Accessories
E0950 E0958 E0959 E2368-E2370 K0098	Motorized/Power Wheelchair Parts

ICD10 Codes

Code	Description
Multiple Codes	

REFERENCES

Rentschler AJ, et al. Evaluation of selected electric-powered wheelchairs using the ANSI/RESNA standards. Arch Phys Med Rehabil. 2004 Apr;85(4):611-9.

Rehabilitation Engineering and Assistive Technology Society of North America [Internet]. Position papers, white papers, and provision guides. RESNA Position on the application of tilt, recline, and elevating leg rests for wheelchairs. Update 2023. [accessed 2025 Jun 2] Available from: https://www.resna.org/Resources/Position-Papers-and-Service-Provision-Guidelines

United States Dept. of Education. National Institute on Disability and Rehabilitation Research. Grant #H133E990001, Washington. DC.

Worobey LA, et al. RESNA position on the application of ultralight manual wheelchairs. Assist Technol. 2023 Aug 2:1-18.

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

NCD - Mobility Assistive Equipment (MAE) (280.3) [accessed 2025 Jul 29]

LCD - Manual Wheelchair Bases (L33788) [accessed 2025 Jul 29]

Article - Manual Wheelchair Bases - Policy Article (A52497) [accessed 2025 Jul 29]

LCD - Wheelchair Seating (L33312) [accessed 2025 Jul 29]

Article - Wheelchair Seating - Policy Article (A52505) [accessed 2025 Jul 29]

NCD - Seat Elevation Equipment (Power Operated) on Power Wheelchairs (280.16) [accessed 2025 Jul 29]

LCD - Wheelchair Options/Accessories (L33792) [accessed 2025 Jul 29]

LCD - Power Mobility Devices (L33789) [accessed 2025 Jul 29]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a

specific service, medical policy criteria apply to the benefit.

- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
10/18/01, 11/29/01, 02/27/03, 03/25/04, 04/28/05, 04/27/06, 04/26/07, 06/26/08, 02/26/09, 06/24/10, 06/24/11, 06/28/12, 08/22/13, 08/28/14, 06/25/15, 06/22/16, 06/22/17, 06/28/18, 06/27/19, 06/25/20, 06/24/21, 06/16/22, 07/20/23, 08/22/24, 08/21/25	
Date	**Summary of Changes**
08/21/25	• Annual review; Canned repair/replacement policy statements added
01/01/25	• Summary of changes tracking implemented.
10/18/01	• Original effective date