Medica Central Utilization Management Policy

Policy Name: **WHEELCHAIRS, SCOOTERS AND ACCESSORIES MP9782 (III-DEV.25)**

Effective Date: **July 1, 2024**

This policy was developed with input from specialists in nephrology, transplants, and oncology, and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

PURPOSE

To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, The Health Plan uses MCG™ Care Guidelines, 28th edition, 2024:

- *ACG: A-0352 (AC), Scooters*
- *ACG: A-0353 (AC), Wheelchairs, Powered*
- *ACG: A-0354 (AC), Wheelchairs, Manual.*

BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for purchase of manual wheelchairs, powered wheelchairs, and scooters, including replacements, for outpatient use primarily in the home setting. Please see the prior authorization list for product specific prior authorization requirements.

- Note: Replacement of a mobility device will only be considered due to normal wear and use or when a written medical professional's statement documents a change in the member's medical condition warranting a different type of mobility device.

2. Prior authorization **is required** for accessories, repairs and modifications that are a billed charge of $1000.00 or more per item.
   - Note: Repair of a mobility device or accessory will only be considered due to normal wear and use.
3. Purchase of a powered mobility device is not reasonable and necessary if the medical condition is reversible and the length of need is less than 3 months.
4. Must be ordered by the licensed, treating medical professional. An order is not needed for repairs.
5. A wheelchair evaluation performed by a licensed/certified medical professional (LCMP), such as a physical therapist or occupational therapist, or physician may have no financial relationship with the supplier.
6. The Health Plan reserves the right to determine whether an item will be rented or purchased.
7. The Health Plan reserves the right to determine if the device will be repaired or replaced dependent on which is the most cost-effective.
8. Standard wheelchairs (routine and non-customized) used in a post-hospital facility, e.g., skilled nursing facility, long-term acute care hospital, hospital swing bed, are included in the facility per diem and are not eligible for separate reimbursement.
   - Note: A standard model is a wheelchair that meets the minimum specifications for the member's needs.
9. Customized wheelchairs used in a post-hospital facility, noted above, will be reviewed for medical necessity and may be approved for purchase outside a facility's per diem. The wheelchair must be used exclusively by the member.
10. The following services are generally excluded from coverage. Refer to member's plan document for details.
    a. Wheelchairs, scooters and accessories not on The Health Plan eligible list.
    b. Items without an order from the licensed, treating medical professional.
    c. Replacement or repair of any covered item that is damaged and/or destroyed by member carelessness, misuse, abuse, loss or theft. Note: Items that are stolen would only be considered for coverage with appropriate documentation (i.e., police report).
    d. Duplicate of similar device, including repair, replacement, or revision of duplicate items.
    e. Items which are primarily used for comfort and convenience, such as modifications to device (e.g., wheelchair-mounted assistive robotic arm [JACO]/dynamic support device), remodeling or modifications to a home or vehicle.
    f. Communication aids or devices.
    g. Professional fees, delivery charges, taxes, and other associated costs directly related to dispensing or customizing the device. These are considered part of the total eligible expense and not reimbursable in addition to the device expense.
    h. If the mobility device is covered by The Health Plan, but the model selected is not considered a standard model, the member will be responsible for the cost difference. This limitation is intended to exclude coverage for deluxe devices or accessories not necessary to meet the member's minimal specification to treat an injury or sickness.
11. A back up manual wheelchair for individuals with a powered device is generally considered a duplicate device and/or convenience item and is excluded from coverage.
    a. Rental of medically necessary equipment while the individual's owned equipment is being repaired is covered according to the terms of the individual's plan document.
    b. If the device is being rented, the provider should provide a replacement during the repair without cost for additional rental. The Health Plan will cover the repair cost per the provider agreement.
12. Coverage may vary according to the terms of the member's plan document.
13. If the Medical Necessity Criteria and Benefit Considerations are met, The Health Plan will authorize benefits within the limits in the member's plan document.

14. If it appears that the Medical Necessity Criteria and Benefit Considerations are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are reminded of the appeals process in their Provider Administrative Manual.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at: https://www.cms.gov/medicare-coverage-database/new-search/search.aspx

DOCUMENT HISTORY

Original Effective Date	Created: 06/20/2024; Effective 07/01/024
Began use of MCG™ Care Guidelines	
MCG Care Guidelines Edition Updates *(The Health Plan Effective Date)*	24th Edition 05/01/2024
Administrative Updates	06/20/2024