

## MEDICAL POLICY – 1.01.501

# Wheelchairs (Manual or Motorized)


Effective Date: Mar. 1, 2025  
Last Revised: Feb. 24, 2025  
Replaces: N/A

RELATED MEDICAL POLICIES:

- 1.01.506 Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses
- 1.01.519 Patient Lifts, Seat Lifts and Standing Devices
- 1.01.526 Durable Medical Equipment Repair/Replacement
- 1.01.527 Power Operated Vehicles (Scooters) (Excluding Motorized Wheelchairs)
- 1.01.529 Durable Medical Equipment

Select a hyperlink below to be directed to that section.

[POLICY CRITERIA](#) | [DOCUMENTATION REQUIREMENTS](#) | [CODING](#)  
[RELATED INFORMATION](#) | [EVIDENCE REVIEW](#) | [REFERENCES](#) | [HISTORY](#)

 Clicking this icon returns you to the hyperlinks menu above.

## Introduction

Wheelchairs (or strollers designed for children with cerebral palsy or other mobility disorders) are considered durable medical equipment for people who have a mobility problem that gets in the way of their activities of daily living. Some individuals who are temporarily disabled may need mobility assistance on a short-term basis, while those living with chronic conditions may require mobility assistance on a permanent basis.

**Note:** The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

## Policy Coverage Criteria

Medically necessary manual wheelchairs may be rented up to a period of 10 months up to the purchase price of an equivalent manual wheelchair and in accordance with the member benefit as described in the member contract.

Equipment	Medical Necessity
<p><b>Wheelchairs (or strollers designed for children with cerebral palsy or other mobility disorders)</b></p>	<p><b>Wheelchairs may be considered medically necessary when the following basic criterion is met:</b></p> <ul style="list-style-type: none"> <li>• Individuals have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living (MRADLs) such as feeding, bathing, dressing, grooming, and toileting in customary locations in the home. A mobility deficit is one that: <ul style="list-style-type: none"> <li>○ Prevents the individual from accomplishing a MRADL; <b>OR</b></li> <li>○ Places the individual at a heightened risk of morbidity or mortality secondary to attempts to perform a MRADL; <b>OR</b></li> <li>○ Prevents the individual from completing an MRADL within a reasonable time frame</li> </ul> </li> <li>• The individual’s mobility deficit cannot be sufficiently resolved by the use of an appropriately fitted cane or walker</li> <li>• The individual’s home allows for adequate access between rooms with maneuvering space and surfaces for operation of a wheelchair</li> </ul> <p><b>Note:</b> If an individual is unable to self-propel a manual wheelchair, but there is a caregiver who is available and willing to provide assistance, and can transfer the individual to and from the wheelchair, and transport the individual using the wheelchair, a wheelchair may still be considered medically necessary if all other criteria are met</p>
<p><b>Manual wheelchairs</b></p>	<p><b>Manual wheelchairs may be considered medically necessary when the basic criterion for a wheelchair is met (see above).</b></p> <p><b>A manual wheelchair is considered NOT medically necessary:</b></p> <ul style="list-style-type: none"> <li>• If the individual is able to safely walk with a cane or a walker far enough to allow access to all necessary rooms in their home and allow them to perform their activities of daily living</li> <li>• If the manual wheelchair is only for use outside the home</li> </ul> <p><b>A non-standard manual/powered wheelchair (such as a different size, weight, or special feature) is considered medically necessary when:</b></p>



Equipment	Medical Necessity
	<ul style="list-style-type: none"> <li>The specific configurational needs of the individual are unable to be met using standard wheelchair options or accessories</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>The individual had a specialty evaluation performed by a licensed/certified medical professional (e.g., PT/OT, or physician) who has specific training in rehabilitation wheelchair evaluations, and the evaluation documents the medical necessity for the wheelchair and its special features</li> </ul>
<p><b>Electric, power, or motorized wheelchairs</b></p>	<p><b>Power wheelchairs may be considered medically necessary if the basic criterion for a wheelchair is met (see <a href="#">Wheelchairs</a> above) and the individual is unable to operate a manual wheelchair.</b></p> <p><b>Documentation must include:</b></p> <ul style="list-style-type: none"> <li>The medical necessity for the power wheelchair</li> <li>The individual lacks the upper body arm strength to push (propel) the wheels of a manual wheelchair or the individual's medical condition does not allow the individual to push the wheels of a manual wheelchair</li> <li>The individual is able to safely operate the controls of a power wheelchair*</li> </ul> <p><b>*Note:</b> If an individual is unable to operate a power wheelchair, and there is a caregiver available who is willing and able to provide assistance, but is unable to adequately propel a manual wheelchair, a power wheelchair may be considered medically necessary if all other criteria are met.</p> <p><b>Note:</b> Power operated vehicles (POVs)/scooters are addressed in a separate policy (see <a href="#">Related Policies</a>).</p>
<p><b>Push-rim activated power assist device (E0986)</b></p>	<p><b>A push-rim activated power assist device for a manual wheelchair may be considered medically necessary when the criteria for a wheelchair (noted above) are met and ALL of the following criteria are met:</b></p> <ul style="list-style-type: none"> <li>The individual has been self-propelling in a manual wheelchair for at least one year but no longer has sufficient upper extremity function to self-propel a manual wheelchair in the home to perform MRADLs.</li> </ul>



Equipment	Medical Necessity
	<ul style="list-style-type: none"> <li>The individual has had a specialty evaluation performed by a licensed/certified rehabilitation medical professional (e.g., a PT/OT, or physician) who has specific training and experience in rehabilitation wheelchair evaluations</li> <li>The wheelchair is provided by a supplier that specializes in wheelchairs with a specialist who has direct, in-person involvement in the wheelchair selection for the individual</li> <li>The evaluation documents the need for the device in the individual's home</li> </ul>
<b>Batteries for powered (electric) wheelchairs</b>	<b>A single deep cycle lead acid battery OR a gel cell battery generally provides adequate power for a power wheelchair. Up to two (2) batteries are allowed at one time.</b>
<b>Coverage for more than one wheelchair/stroller</b>	Payment is made for no more than one wheelchair or stroller at a time. Depending upon the limits and conditions of the member's benefit plan, services for a wheelchair or stroller that is used as a backup to the primary device may not be covered (see <a href="#">Scope</a> ).

Equipment	Not Covered
<b>Durable medical equipment</b>	<p><b>Durable medical equipment, including wheelchairs, is NOT covered when:</b></p> <ul style="list-style-type: none"> <li>It is considered experimental or investigational or used for experimental or investigational therapy or interventions</li> <li>It is associated with athletic, scholastic, educational/vocational training of the individual</li> <li>It is available over the counter or off-the-shelf without a prescription</li> </ul> <p><b>Note:</b> For additional information refer to <a href="#">Related Information</a> and <a href="#">Benefit Application</a>.</p>
<b>Convenience items</b>	<p><b>The following items are considered extra cost convenience items and are not covered:</b></p> <ul style="list-style-type: none"> <li>Dual mode battery charger (E2367) (A standard battery charger is included with a power wheelchair and the dual mode charger is considered a convenience item)</li> <li>Heavy duty shock absorber, manual wheelchair (E1017)</li> <li>Heavy duty shock absorber, power wheelchair (E1018)</li> </ul>



Equipment	Not Covered
	<ul style="list-style-type: none"> <li>• Non-sealed battery (E2360, E2362, E2364, E2372) <b>Note:</b> A standard sealed battery is included with a power wheelchair and recommended for replacement. A non-sealed battery is considered an extra cost convenience item.</li> <li>• Power standing system wheelchair accessory (E2301)</li> <li>• Power wheelchair insert for pneumatic drive wheel tire (E2383)</li> <li>• Shock absorber, manual wheelchair (E1015)</li> <li>• Shock absorber, power wheelchair (E1016)</li> <li>• Stair-climbing wheelchairs, computerized or gyroscopic mobility systems (e.g., iBOT Mobility System)</li> <li>• Transport tie downs</li> </ul>
<b>Home/environmental modifications</b>	<p><b>Modifications to the structure of the home or a vehicle to accommodate a wheelchair are not covered. Examples include:</b></p> <ul style="list-style-type: none"> <li>• Elevators</li> <li>• Lowered bath or kitchen counters and sinks</li> <li>• Stairway lifts</li> <li>• Van modifications</li> <li>• Vehicle lifts</li> <li>• Wheelchair accessible shower</li> <li>• Wheelchair ramps</li> <li>• Widening of doorways</li> </ul>

<b>Medical justification must be provided for wheelchair options and accessories</b>	
Equipment	Medical Necessity
<b>Accessories and options</b>	<p><b>Wheelchair accessories/options may be considered medically necessary if they assist the individual to perform at least ONE of the following activities:</b></p> <ul style="list-style-type: none"> <li>• Maintain current physical functions in the home</li> <li>• Perform essential activities of daily living</li> </ul> <p><b>Wheelchair accessories/options are considered NOT medically necessary when they are used primarily for the performance and participation in leisure or recreational activities</b></p>
<b>Custom fabricated wheelchair seat cushion</b>	<p><b>A custom fabricated seat and/or back cushion is considered medically necessary when there is a comprehensive written evaluation by a licensed professional which clearly explains</b></p>



Medical justification must be provided for wheelchair options and accessories	
Equipment	Medical Necessity
and/or back cushion (E2609, E2617)	why a prefabricated seating system is not sufficient to meet the individual's positioning needs
Electronic interface (E2351)	An electronic interface is considered medically necessary to allow a medically necessary speech-generating device to be operated by the power wheelchair control interface
Gear-reduction drive wheel for manual wheelchair (E2227)	<p>A gear-reduction drive wheel for use with a manual wheelchair is considered medically necessary when <b>ALL</b> the following criteria are met:</p> <ul style="list-style-type: none"> <li>The individual has been self-propelling in a manual wheelchair for at least one year</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>The need for the device in the individual's home is documented</li> </ul>
Lever-activated wheel drive (E0988)	A lever-activated wheel drive is considered medically necessary when documentation supports that propelling a manual wheelchair is stressing and/or straining the individual's shoulder muscles
Mechanically linked or power leg elevation systems (E1009, E1010, E1012)	<p>Mechanically linked or power leg elevation systems added to a power seating system may be considered medically necessary when one or more of the following conditions/needs exist:</p> <ul style="list-style-type: none"> <li>The individual has a musculoskeletal condition or a cast or brace that prevents 90-degree flexion at the knee</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>The individual meets the criteria for a power recline seating system</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>There is severe swelling (edema) in the lower extremities that requires elevation of the legs</li> </ul>
Manual standing system for a manual wheelchair (E2230)	A manual standing system for a manual wheelchair is considered not medically necessary
Non-standard seat (E2341, E2342, E2343)	<p>A non-standard seat width, depth, or height may be considered medically necessary when <b>BOTH</b> of the following criteria are met:</p> <ul style="list-style-type: none"> <li>The ordered item is at least two inches greater than or less than a standard option</li> </ul>



Medical justification must be provided for wheelchair options and accessories	
Equipment	Medical Necessity
	<p><b>AND</b></p> <ul style="list-style-type: none"> <li>The individual's physical size justifies the need for a non-standard seat</li> </ul>
Power add-on-conversion of manual wheelchair to motorized wheelchair (E0983, E0984)	<b>An add-on accessory to convert a manual wheelchair to a joystick controlled or tiller controlled motorized wheelchair is considered not medically necessary</b>
Power wheelchair attendant control (E2331)	<b>A power wheelchair drive attendant control is considered medically necessary in place of an individual-operated drive control system if the individual is unable to operate a manual or power wheelchair and has a caregiver who is unable to operate a manual wheelchair but is able to operate a power wheelchair</b>
Powered seat cushion (E2610)	<b>A battery-powered wheelchair seat cushion with sequential inflation and deflation of air cells, such as an alternating pressure cushion, is considered not medically necessary</b>
Reclining, tilt, or combination power seating system or fully or semi-reclining seat back (E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1014, E1050, E1060, E1070, E1100, E1110, E1161, E1231, E1232, E1233, E1234)	<p><b>A fully reclining or semi-reclining back option or tilt-in-space, or power seating systems for tilt only, recline only, or combination tilt and recline options may be considered medically necessary if the individual spends at least two hours a day in the wheelchair and at least ONE of the following conditions/needs exist:</b></p> <ul style="list-style-type: none"> <li>Quadriplegia</li> <li>Fixed hip angle</li> <li>Trunk or lower extremity casts/braces that require the reclining back feature for positioning</li> <li>Manage increased tone or spasticity</li> <li>Resting in a recumbent position is required two or more times a day and transfer between the wheelchair and bed is very difficult</li> <li>Individual is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift</li> <li>Intermittent catheterization for bladder management is utilized and the individual is unable to independently transfer from the wheelchair to a bed</li> </ul>



**Medical justification must be provided for wheelchair options and accessories**

Equipment	Medical Necessity
<p><b>Skin protection seat cushion (E2292, E2622, E2623)</b></p>	<p><b>A skin protection seat cushion may be considered medically necessary when BOTH of the following criteria are met:</b></p> <ul style="list-style-type: none"> <li>• The individual has a manual wheelchair or a power wheelchair with a sling or solid seat/back and the individual meets the criteria for wheelchairs (noted <a href="#">above</a>)</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• The individual has <b>ONE</b> of the following:           <ul style="list-style-type: none"> <li>○ Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; <b>or</b></li> <li>○ Absent or impaired sensation in the area of contact with the seating surface; <b>or</b></li> <li>○ Inability to carry out a functional weight shift due to one of the following diagnoses:               <ul style="list-style-type: none"> <li>▪ Alzheimer’s disease</li> <li>▪ Athetoid cerebral palsy</li> <li>▪ Childhood cerebral degeneration</li> <li>▪ Hemiplegia</li> <li>▪ Huntington’s chorea</li> <li>▪ Idiopathic torsion dystonia</li> <li>▪ Muscular dystrophy</li> <li>▪ Quadriplegia</li> <li>▪ Spina bifida</li> </ul> </li> </ul> </li> </ul>
<p><b>Specialty positioning components (E2295, E2398, E2620, E2621)</b></p>	<p><b>A specialty positioning component may be considered medically necessary when both of the following criteria are met:</b></p> <ul style="list-style-type: none"> <li>• The individual has a manual wheelchair or a power wheelchair with a sling or solid seat/back and the individual meets the criteria for wheelchairs (noted <a href="#">above</a>)</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• The individual has significant postural asymmetries due to <b>ONE</b> of the following diagnoses:           <ul style="list-style-type: none"> <li>○ Above knee leg amputation</li> <li>○ Alzheimer’s disease</li> <li>○ Anterior horn cell diseases including amyotrophic lateral sclerosis (ALS)</li> </ul> </li> </ul>





## Medical justification must be provided for wheelchair options and accessories

Equipment	Medical Necessity
	<ul style="list-style-type: none"><li>○ Athetoid cerebral palsy</li><li>○ Cerebral palsy</li><li>○ Childhood cerebral degeneration</li><li>○ Hemiplegia due to stroke</li><li>○ Idiopathic torsion dystonia</li><li>○ Monoplegia of the lower limb</li><li>○ Multiple sclerosis</li><li>○ Muscular dystrophy</li><li>○ Osteogenesis imperfecta</li><li>○ Other demyelinating disease</li><li>○ Paraplegia</li><li>○ Parkinson's disease</li><li>○ Post-polio paralysis</li><li>○ Quadriplegia</li><li>○ Spina bifida</li><li>○ Spinocerebellar disease</li><li>○ Transverse myelitis</li><li>○ Traumatic brain injury resulting in quadriplegia</li><li>○ Traumatic brain injury</li></ul>

## Documentation Requirements

**The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:**

There must be an evaluation of the individual's physical and medical condition. The documentation should include information on the individual's diagnosis, abilities, and limitations as they relate to the equipment needed (e.g., degree of independence/dependence, frequency, and nature of the activities the individual performs inside and outside the home), the duration of the condition, the expected prognosis, and past experience using similar equipment. The documentation must describe in detail:

1. Why the individual's mobility limitation cannot be resolved by using an appropriately fitted cane or walker
2. Accessibility in the individual's home environment for moving between rooms, turning space, and floor surfaces that support unobstructed use of the provided wheelchair



## Documentation Requirements

3. How the use of a manual wheelchair will significantly improve the individual's ability to participate in mobility related activities of daily living and how the individual will use it on a regular basis in the home
4. The individual's willingness to use the provided wheelchair in the home
5. Verification that the individual has sufficient upper arm strength and other physical and mental abilities needed to safely use the provided wheelchair in the home during a typical day
6. Any limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both arms as relevant to the assessment of arm function.  
If the individual is not able to self-propel the wheelchair, is there a caregiver who is available, willing, and able to provide assistance with the wheelchair use

## Coding

Code	Description
<b>HCPCS</b>	
E0983	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control
E0984	Power add-on to convert manual wheelchair to motorized wheelchair, tiller control
E0986	Manual wheelchair accessory, push-rim activated power assist, each
E0988	Manual wheelchair accessory, lever-activated, wheel drive, pair
E1002	Wheelchair accessory, power seating system, tilt only
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction
E1005	Wheelchair accessory, power seating system, recline only, with power shear reduction
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction



Code	Description
E1009	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each
E1010	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair
E1011	Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each
E1014	Reclining back, addition to pediatric size wheelchair
E1050	Fully-reclining wheelchair; fixed full-length, swing-away, detachable footrests
E1060	Fully-reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests
E1070	Fully-reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable foot rests
E1083	Hemi-wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests
E1084	Hemi-wheelchair; detachable arms, desk or full-length arms, swing-away, detachable, elevating leg rests
E1085	Hemi-wheelchair; fixed full-length arms, swing-away, detachable footrests
E1086	Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable, footrests
E1087	High-strength lightweight wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests
E1088	High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests
E1089	High-strength lightweight wheelchair; fixed-length arms, swing-away, detachable footrests
E1090	High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests
E1100	Semi-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests
E1110	Semi-reclining wheelchair, detachable arms, desk or full-length elevating leg rest
E1160	Wheelchair, fixed full-length arms, swing-away, detachable, elevating leg rests
E1161	Manual adult size wheelchair, includes tilt in space



Code	Description
E1170	Amputee wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests
E1171	Amputee wheelchair; fixed full-length arms, without footrests or leg rests
E1172	Amputee wheelchair; detachable arms, desks or full-length, without footrests or leg rests
E1180	Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests
E1190	Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests
E1195	Heavy duty wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests
E1200	Amputee wheelchair; fixed full-length arms, swing-away, detachable footrests
E1220	Wheelchair; specially sized or constructed, (indicated brand name, model number, if any) and justification
E1221	Wheelchair with fixed arm, footrests
E1223	Wheelchair with detachable arms, footrests
E1224	Wheelchair with detachable arms, elevating leg rests
E1229	Wheelchair, pediatric size, not otherwise specified
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system
E1232	Wheelchair; Pediatric size, tilt-in-space, folding, adjustable, with seating system
E1233	Wheelchair; Pediatric size, tilt-in-space, rigid, adjustable, without seating system
E1234	Wheelchair; Pediatric size, tilt-in-space, folding adjustable with seating system
E1235	Wheelchair; Pediatric size, folding, adjustable, with seating system
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	Wheelchair, Pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, Pediatric size, folding, adjustable, without seating system
E1240	Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating largest
E1250	Lightweight wheelchair; fixed full-length arms, swing-away, detachable footrests
E1260	Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests



Code	Description
E1270	Lightweight wheelchair; fixed full-length arms, swing-away, detachable elevating leg rests
E1280	Heavy duty wheelchair; detachable arms, desk or full-length, elevating leg rests
E1285	Heavy duty wheelchair; fixed full-length arms swing-away, detachable footrests
E1290	Heavy duty wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests
E1295	Heavy duty wheelchair; fixed full-length arms, elevating leg rests
E1399	Durable medical equipment, miscellaneous
E2227	Manual wheelchair accessory, gear reduction drive wheel, each
E2230	Manual wheelchair accessory, manual standing system
E2292	Seat, planar, for pediatric size wheelchair including fixed attaching hardware
E2295	Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware
E2341	Power wheelchair accessory, non-standard seat frame width, 24-27 inches
E2342	Power wheelchair accessory, non-standard seat frame width, 20 or 21 inches
E2343	Power wheelchair accessory, non-standard seat frame width, 22-25 inches
E2351	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface
E2398	Wheelchair accessory, dynamic positioning hardware for back
E2609	Custom fabricated wheelchair seat cushion, any size
E2610	Wheelchair seat cushion, powered
E2617	Custom fabricated wheelchair back cushion, any size, includes any type mounting hardware
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 in., any height, including any type mounting hardware
E2621	Positioning wheelchair back cushion, planar back with lateral supports, width 22 in. or greater, any height, including any type mounting hardware
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 in, any depth
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 in or greater, any depth



Code	Description
K0004	High strength, lightweight wheelchair
K0005	Ultralight weight wheelchair
K0008	Custom manual wheelchair/base
K0009	Other manual wheelchair/base
K0010	Standard – weight frame motorized/power wheelchair
K0011	Standard – weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lightweight portable motorized/power wheelchair
K0013	Custom motorized/power wheelchair base
K0014	Other motorized/power wheelchair base
K0108	Wheelchair component or accessory, not otherwise specified
K0669	Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from SADMERC
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0816	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0824	Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0825	Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds



Code	Description
K0826	Power wheelchair, group 2 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0827	Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0828	Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0829	Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0836	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0837	Power wheelchair, group 2 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0838	Power wheelchair, group 2 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0839	Power wheelchair, group 2 very heavy-duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0840	Power wheelchair, group 2 extra heavy-duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0842	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0843	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0850	Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0851	Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds
K0852	Power wheelchair, group 3 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds



Code	Description
K0853	Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0854	Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0855	Power wheelchair, group 3 extra heavy duty, captain's chair, patient weight capacity 601 pounds or more
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0857	Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0858	Power wheelchair, group 3 heavy-duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds
K0859	Power wheelchair, group 3 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0860	Power wheelchair, group 3 very heavy-duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0862	Power wheelchair, group 3 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0863	Power wheelchair, group 3 very heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0864	Power wheelchair, group 3 extra heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0869	Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0870	Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0871	Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0878	Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds





Code	Description
K0879	Power wheelchair, group 4 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0880	Power wheelchair, group 4 very heavy-duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0885	Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0886	Power wheelchair, group 4 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0898	Power wheelchair, not otherwise classified
K0900	Customized durable medical equipment, other than wheelchair

**Note:** CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

## Related Information

Medical necessity is determined by the individual's current condition and not by probable deterioration in the future. There are varying degrees of medical conditions, and these medical conditions may be contributing factors to the mobility limitation.

Individuals who qualify for coverage of a wheelchair may use that device outside the home; however, **coverage of a wheelchair is determined solely by the individual's mobility needs in the home setting.**

Request for options/accessories that are not defined by coverage rules/criteria in this medical policy will be reviewed on an individual basis. The physician's order must include a statement describing why the option/accessory is medically necessary for the individual (see [Documentation Requirements](#)).



For additional information that may not be contained in this medical policy, please refer to Medicare Administrative Contractor-Jurisdiction D at: <http://www.noridianmedicare.com/dme/>. Accessed February 4, 2025.

## Definition of Terms

**Activities of daily living (ADLs):** These are self-care activities which are done daily within an individual's place of residence and include:

- Ambulating (walking)
- Dressing/bathing
- Eating
- Hygiene (grooming)
- Toileting
- Transferring

**Convenience items:** These are items that do not provide medical benefit. These items are used for the comfort and/or convenience of the individual or the individual's family.

**Mobility-related activity of daily living (MRADLs):** This is a term established by Medicare. MRADLs are personal care tasks that result in a negative effect on the individual's health when they are unable to perform them on their own. Some examples include grooming, feeding, and bathing.

**Mobility limitation is one that:**

- Entirely prevents the individual from accomplishing an MRADL

**OR**

- Places the individual at heightened risk of morbidity or mortality when they attempt to perform a MRADL.

**OR**

- Prevents the individual from completing a MRADL within a reasonable time frame



**iBot 3000, 4000, or PMD Mobility Systems (Mobius Mobility LLC):** Described by CMS as: “A battery-powered mobility device that relies on a computerized system of sensors, gyroscopes, and electric motors to allow indoor and outdoor use on stairs as well as on level and uneven surfaces. The mobility system incorporates a number of different functions, including: a) Standard Function that provides mobility on smooth surfaces and inclines at home, work, and in other environments; b) 4-Wheel Function that provides movement across obstacles, uneven terrain, curbs, grass, gravel, and other soft surfaces; c) Balance Function that provides mobility in a seated position at an elevated height; d) Stair Function that allows for ascent and descent of stairs, with or without assistance; and e) Remote Function that assists in the transportation of the product while unoccupied. In Standard Function, the Mobius Mobility iBOT 4000 Mobility System functions like a traditional power wheelchair. The mobility device can be programmed for Standard Function only to meet the assessed needs of the user.”

## Wheelchair Repairs and Replacements

Repair or replacement of a member-owned back-up or second wheelchair/stroller that is not the primary wheelchair/stroller used to meet the individual’s functional needs may not be covered by some benefit plans (see [Scope](#))

In order for repair and/or replacement to be covered, the following indications will be considered in making the benefit determination:

### Indications for the Repair of a Wheelchair

- Repairs are needed to make the wheelchair functional, due to reasonable wear and usage
- The member owns the wheelchair that needs repair
- The wheelchair needs repair and the manufacturer’s warranty has expired
- The repair cost is less than the replacement cost
- The repair is needed due to a change in the individual’s condition



## Indications for the Replacement of a Wheelchair

- The wheelchair cannot be repaired due to reasonable deterioration over time or accidental damage
- The member owns the wheelchair that needs to be replaced
- The wheelchair cannot be repaired, and the manufacturer's warranty has expired
- The replacement cost is less than the repair cost
- The replacement is needed due to a change in the individual's condition that makes the current wheelchair no longer useable/repairable
- The wheelchair is lost or stolen and not otherwise covered by another insurance (such as a homeowner's policy)

**Note:** The wheelchair supplier's documentation must explain why the current wheelchair cannot be repaired and should be replaced. Examples are that the chair is so old that parts are no longer available, or areas of the frame are so worn/cracked that the structure is at risk of failure and individual injury and new metal cannot be added, or a child has outgrown the current chair and needs a larger wheelchair, etc.

## Rental During Repair or Replacement

One-month rental of a wheelchair may be covered while a member-owned wheelchair is being repaired or while waiting for a replacement of the current member-owned wheelchair.

## Batteries for Powered (Electric) Wheelchairs

A single deep cycle lead acid battery OR a gel cell battery generally provides adequate power for a power wheelchair. Up to two (2) batteries are allowed at one time.

## Benefit Application

Payment is made for no more than one wheelchair or stroller at a time. Depending upon the limits and conditions of the member's benefit plan, services for a wheelchair or stroller that is used as a backup to the primary device may not be covered (see [Scope](#))



### Medicare National Coverage

For detailed information please refer to Medicare Administrative Contractor-Jurisdiction D<sup>6</sup> guidance on wheelchairs

### References

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## History

Date	Comments
11/05/97	Add to Durable Medical Equipment Section - New Policy
12/21/00	Replace Policy - Updated and revised to include gel cell batteries.
07/01/02	Replace Policy - Policy updated with no criteria changes, language clarification.
05/13/03	Replace Policy - Policy updated with HCPC codes updated. Policy guidelines for an articulating elevating leg rest may be considered medically necessary if it is necessary to prevent hip rotation.
1/01/04	Replace Policy - HCPC code updates only.
05/11/04	Replace Policy - Policy updated with no criteria changes.
09/01/04	Replace Policy - Policy renumbered from PR.1.01.101. No changes to dates.
05/10/05	Replace Policy - Policy reviewed; no change to policy statement. Policy status changed from PR to AR.
12/13/05	Replace Policy - Policy statement criteria updated to be in line with Medicare; reference added. Scheduled revision changed to November 2006
02/06/06	Codes Updated - No other changes.
05/26/06	Update Scope and Disclaimer - No other changes.
11/14/06	Replace Policy - Policy updated with literature search; reference updated; no change in policy statement.
02/26/07	Codes Updated - No other changes.
05/21/07	Codes Updated - No other changes.



Date	Comments
08/23/07	Codes Updated - No other changes.
10/09/07	Replace policy - Policy status changed from AR to PR. Policy reviewed with literature; reference added. No change in Policy statement.
10/30/07	Codes Updated - No other changes
11/27/07	Codes Updated - HCPCS codes E2227, E2228, E2397, E2312, and E2313 added. No other changes.
08/12/08	Replace Policy - Policy updated with literature search; no change to the policy statement.
01/13/09	Code Updates - Codes added, E2230, E2231, E2295; effective 1/1/09.
05/12/09	Replace Policy - Policy updated with literature search. Policy statement updated to include Tilt-In-Space option to accessories that may be medically necessary.
02/09/10	Replace Policy - Policy updated with literature search. No change to policy statement.
03/08/11	Replace Policy - Policy updated with literature review. Policy Guidelines and Policy sections reorganized; no change in policy statements. Codes added.
02/14/12	Replace Policy – Policy updated with literature search. Rollabout/transport chairs, trays, skin protection seat cushions and positioning seat cushions added as medically necessary when criteria are met. Wheelchair seat lift mechanism and powered wheelchair seat cushion added as not medically necessary. DME items considered extra cost convenience items added to Guidelines section.
02/11/13	Replace Policy. Policy updated with literature search; reference added. Clarifying sentences regarding wheelchair rental and replacement added to Benefit Application.
09/09/13	Replace Policy. Moved two medically necessary/not medically necessary statements to the Policy section from the Policy Guidelines section. Clarification added to the Benefit Application that coverage for backup or second wheelchairs/strollers whether purchase or repair/replacement of duplicate items, are subject to the member’s health plan benefits. Policy statement updated as noted. HCPCS codes K0008, K0013 and K0900 added to the policy.
02/21/14	Update Related Policies. Add 1.01.527. HCPCS codes K0800-K0808 and K0812 removed from this policy; they are now addressed in 1.01.527 – Power Operated Vehicles.
08/11/14	Annual Review. Policy statement added stating Push-rim activated power assist devices may be medically necessary when criteria are met. Added Policy Guidelines statement that DME is not covered when experimental/investigational, for athletic/scholastic/vocational training purposes, or OTC without an RX. Policy reviewed through June 2014; no new reference added, reference 5 updated. Policy statement added as noted.
01/05/15	Coding update. Descriptor for HCPCS code E0986 updated; the word “push-rim” added.



Date	Comments
03/11/15	Update Related Policies. Add 1.01.529.
05/27/15	Annual Review. Policy updated with literature review through March, 2015, hyperlinks for several references updated. Minor formatting changes. Definition of Terms added to Policy Guidelines. Policy Statements unchanged.
01/12/16	Annual Review. Policy statement unchanged.
10/01/16	Interim Review, approved September 13, 2016. Minor wording revision. Removed ICD9 CM codes. Added HCPCS codes to the options/accessories subheadings for ease of use. Policy moved into new format.
10/14/16	Coding update. Added HCPCS code E1012 effective date 1/1/16.
12/16/16	Formatting update. Clarified specialty positioning seat cushion coverage criteria.
03/01/17	Annual Review, approved February 14, 2017. Policy updated with literature review through Feb. 2, 2017. References 1 and 5 deleted. Coding update. HCPCS codes E1391-E1392, and E1634 removed as not related to policy. HCPCS codes K0734 – K0737 removed from policy as codes were terminated 01/2011. Minor clarifications to policy statements but intent unchanged.
04/11/17	Coding update; added HCPCS code E0988.
01/01/18	Coding update; added HCPCS codes E0953 and E0954 (new codes effective 1/1/18).
03/01/18	Annual Review, approved February 13, 2018. Minor editing to policy for clarity. Added tie downs for manual wheelchairs, to convenience items not covered. Added policy statements to say gear reduction drive wheel, lever activated wheel drives, custom fabricated cushions, non-standard wheelchairs, powered attendant control, and leg elevation systems are medically necessary when criteria are met and powered add on accessory, powered seat elevation systems and seat elevator power wheelchairs, and manual standing systems are not medically necessary.
03/01/19	Annual Review, approved February 5, 2019. References 7-8 added. Minor policy edits for clarity.
06/01/19	Interim Review, approved May 23, 2019. Clarified transport tie downs for all wheelchairs are considered convenience items and not covered.
01/01/20	Coding update, added HCPCS code E2398 (new code effective 1/1/20).
03/01/20	Annual Review, approved February 4, 2020. Policy reviewed. References updated. Added medical necessity criteria for headrest accessory. Removed one arm attachment and reinforced upholstery; otherwise, policy statements unchanged. Removed HCPCS codes E1015, E1016, E1017, E1018, E2301, E2360, E2362, E2364, E2367, E2372, and E2383 as they are addressed in a separate policy.
04/01/20	Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020, and replaced with InterQual criteria for dates of service on or after July 2, 2020.
07/02/20	Delete policy.





Date	Comments
11/01/20	Policy reinstated effective February 5, 2021, approved October 13, 2020. No changes to policy statements.
12/01/20	Interim Review, approved November 19, 2020. Policy statements on roll about/transport chairs, headrests, trays, certain seat and back cushions, and certain wheelchairs have been removed to coincide with the removal of the above noted HCPCS codes. Coding update. Remove HCPC codes E0950, E0955, E1031, E1037, E1038, E1039, E1092, E1093, E1130, E1140, E1150, E1222, E1225, E1226, E2291, E2293, E2294, E2603, E2604, E2605, E2606, E2607, E2608, E2613, E2614, E2615, E2616, E2624, E2625, K0003 due to low utilization.
04/01/21	Annual Review, approved March 23, 2021. Policy reviewed. References updated. Added stair-climbing wheelchair mobility systems to list of extra-cost convenience items that are not covered; otherwise policy statements unchanged.
02/01/22	Annual Review, approved January 24, 2022. Policy reviewed. References updated. Added policy statement that home and environmental modifications to accommodate wheelchairs are not covered.
02/01/23	Annual Review, approved January 10, 2023. Policy reviewed. References added. Added additional clarification in defining a mobility deficit in the medical necessity criteria for a wheelchair. Added medical necessity criteria for an electronic interface accessory. Added clarifying edits to some existing policy statements and removed some language from policy statements; however, policy intent was unchanged. Changed the wording from "patient" to "individual" throughout the policy for standardization. Removed HCPC code E2228.
06/01/23	Removed HCPCS codes E0985, E2300, E2310, E2311, K0830 and K0831
06/15/23	Update to Related Policies. 1.01.11 is replaced by 1.01.506 Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses.
07/01/23	Interim Review, approved June 13, 2023. Reference added. Removed powered seat elevation systems and seat lift mechanisms from the policy.
11/03/23	Minor correction made. Updated History section to include the coding update that was effective 06/01/23.
03/01/24	Annual Review, approved February 26, 2024. Policy reviewed. Policy statements unchanged.
03/01/25	Annual Review, approved February 24, 2025. Policy reviewed. Policy statements unchanged.

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply.



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**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

