MEDI-CAL PROVIDER EDUCATION

SUBJECT: Durable Medical Equipment

No.103

PURPOSE: Provide the necessary guidelines in submitting durable medical equipment requests for Medi-Cal members.

DEFINITION: For Medi-Cal, durable medical equipment (DME), including wheelchairs, is defined as equipment prescribed by a licensed practitioner to meet the medical equipment needs of the patient that:

(a) Can withstand repeated use;

(b) Is used to serve a medical purpose;

(c) Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly; and

(d) Is appropriate for use in or out of the patient's home.

(Title 22, California Code of Regulations [CCR], Section 51160).

Durable Medical equipments must be provided when medically necessary to Medi-Cal members. Medi-Cal covers medically necessary equipment when it **"is appropriate for use in or out of the patient's home"** (Title 22, CCR, and Section 51160).

PROCEDURE:

Durable Medical Equipment can be prescribed by member's provider when the equipment prescribed will preserve bodily functions and or prevent disability. All DME request require prior authorization and some DME services may require pre-service review.

I. DME: Wheelchair/Wheelchair Accessories (Seating and positioning component)

Wheelchair means manual wheelchairs, power mobility devices (PMD) including power wheelchairs (PWC), power operated vehicles (POV) and push rim activated power assist devices (PAD). Seating and positioning components (SPC) describe seat, back and Positioning equipment mounted to the wheelchair base.

Wheelchair is only medically necessary if the members condition and ability to move around are such that without a wheelchair the members ability to perform one or more activities of daily living (ADL) in or out of the home, including access to the community, is impaired and the beneficiary is not ambulatory or functionally ambulatory without static supports such as a cane, crutches or walker.

***** See APL 15-018 for details questions used to Medical necessity of a wheelchair.**

Wheelchairs are not covered when any of the following apply:

A. Not medically necessary.
B. Not used by the beneficiary.
C. Used as a convenience item.
D. Used to replace private or public transportation such as an automobile, bus or taxi.
E. Not generally used primarily for health care and is not regularly and primarily used by persons who do not have a specific medical need for them.
F. Used in a facility that is expected to provide such items to the beneficiary.
G. Used in a skilled nursing facility, unless the beneficiary demonstrates the need for a custom wheelchair under Title 22 of Code of Regulation section 51321(h).
H. Not prescribed by a licensed practitioner, or, in the case of a custom wheelchair, a licensed practitioner and a QRP.

II. DME Authorization Submission

For members in need of a standard wheelchair, the member's PCP or specialist should complete an Authorization Request Form. Authorization can be requested using the online authorization

from located at **www.regalmed.com** under the provider section with their **Regal Express Access**. In completing the form, please be sure to supply the following information:

- Member's name, date of birth, phone number, address and Medi-Cal identification number
- Full name, address, telephone number and signature of the prescribing provider
- Date of request
- Diagnosis codes
- Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes
- Identify rental (short term usage – less than 8 months) versus purchase (long term usage – more than 8 months)
- **Copy of physiatrist or physical therapist evaluation for wheelchair requests only. See Appendix A for evaluation form**
- For power operated wheelchairs and Scooters physician can fill out the pre-Authorization Questionnaire and submit with supporting documents Accompanying APLs\POWER WHEELCHAIR_SCOOTER FORM 11- 2014.pdf

Appendix A

Authorization Guideline: Manual Wheelchair

Patient Name DOB: New Auth ☐ Re-Auth ☐

1. Can the patient's mobility limitation be resolved by a cane or walker? ☐ Yes ☐ No If YES authorize Cane/Walker : Cane HCPCS: E0100 (single point) or E0105 (quad tip) Walker HCPCS: E0135 (no wheels) or E0143 (front wheels)
2. Does the patient's mobility limitation significantly impair his/her ability to toilet, feed, dress, groom, and bathe in customary locations in the home? ☐ Yes ☐ No **AND** **Will the use of a wheelchair significantly improve the patient's ability to participate in these activities?** ☐ Yes ☐ No If either answer is NO, you may authorize a cane/walker, or you may submit to RMG Prior Auth Nurse to review the request for a wheelchair.
3. Does the patient's home provide adequate access between rooms (i.e. the doors are wide enough), maneuvering space, and surfaces for use of the wheelchair that is provided? ☐ Yes ☐ No If NO, submit to Prior Auth Nurse for review.
4. Has the patient expressed a willingness to use the wheelchair in the home? ☐ Yes ☐ No

If NO, submit to Prior Auth Nurse for review.

5. Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day, ☐ Yes ☐ No **OR**
Does the patient have a caregiver who is available, willing and able to provide assistance with the wheelchair? ☐ Yes ☐ No

If both answers are NO, submit to Prior Auth Nurse for review.

If patient meets all of above criteria, you may approve a wheelchair. See #8 to select the appropriate type of wheelchair.

6. Time Period of Authorization: Initial authorization may be for no longer than 3 months, unless RMG Prior Auth Nurse approves a longer time period.

7. Reauthorization criteria: 3 month intervals, unless patient has a chronic condition which is not expected to improve. In this case, get RMG Prior Auth Nurse approval for a 13 month rental.

8. HCPCS Codes:

All authorizations will use K0001: Standard Wheelchair

K0001 ☐

Exceptions may be made as follows :

K0002 Standard Hemi Height Wheelchair: is only covered if the patient needs a lower height due to short stature or to enable the patient to place his/her feet on the ground for propulsion. Does patient meet these criteria YES ☐ NO ☐

K0003 Lightweight Wheelchair: is only covered if a patient cannot self-propel in a standard wheelchair in the home AND the patient can and does self-propel in a lightweight wheelchair. Caregiver strength and ability to move a lightweight wheelchair is primarily convenience in nature and not a consideration in providing a lightweight wheelchair. Does patient meet this criteria YES ☐ NO ☐

K0004 High Strength Lightweight Wheelchair: is only covered if the patient self-propels in the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair OR

the patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-height wheelchair and spends at least two hours per day in the wheelchair. Does the patient meet these criteria YES ☐ NO ☐

K0006 Heavy Duty Wheelchair: is only covered if the patient weighs more than 250 pounds or has a diagnosis that indicates severe spasticity. Does patient meet these criteria YES ☐ NO ☐

K0007 Extra Heavy Duty Wheelchair: is only covered if the patient weighs more than 300 pounds. Does patient meet this criteria YES ☐ NO ☐

Certified: Date ____/___/_____

By: _____(MD/DO/NLP/PA Provider Name)

Signature: _____ Lic.#: _____