Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

# Power Wheelchairs

*Effective: January 1, 2026*

| | |
|---|---|
| **Prior Authorization Required**<br>If REQUIRED, submit supporting clinical documentation pertinent to service request. | Yes ☒ No ☐ |
| **Notification Required**<br>IF REQUIRED, concurrent review may apply | Yes ☐ No ☒ |

**Applies to:**

**Commercial Products**

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409

**Public Plans Products**

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care – A dual-eligible product; 857-304-6304

**Senior Products**

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

**Note:** While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

## Overview

This guideline is for the review of power wheelchairs. A power wheelchair (PWC) is a wheelchair, a wheeled mobility device in which the user sits, that is powered by an automated system, such as a power motor.

## Clinical Guideline Coverage Criteria

### Basic Power Wheelchair Clinical Coverage Criteria

The Plan may authorize coverage of a power wheelchair for Members when **ALL** of the following criteria are met:

1. The Member's functional impairments must be documented and managed by a physician with a rehab-related specialty, such as a physical rehabilitation medicine, orthopedics, neurology, or rheumatology; **and**
2. The Member has a mobility limitation that is permanent, and it has been determined that a power wheelchair will be needed for 12 months or longer; **and**
3. The Member is not able to safely walk resulting in confinement to a bed or a chair; **and**
4. The Member cannot propel a manual wheelchair more than 50 feet; **and**
5. The Member is not able to propel a manual wheelchair sufficient distances to manage within the community, including but not limited to attending appointments, working, and managing household responsibilities, at least three times per week; **and**
6. The Member does not meet the criteria for or is unsafe to use a power operated vehicle; **and**
7. The Member has sufficient cognitive and motor ability to operate a power wheelchair safely and without assistance;

**and**

8. The Member must be able to use the power wheelchair in their home. A home evaluation, including a home accessibility survey and seating evaluation is required. This evaluation may be completed by either a physical therapist or an occupational therapist who has no financial relationship with the supplier or a RESNA-certified Assistive Technology Professional (ATP); **and**
9. All requested power wheelchair components/accessories must be primarily for use in the home; **and**
10. AND when additional coverage guidelines listed below, specific to Group 2 and Group 3 power wheelchairs and power tilt/recline seating systems, are met.

**Additional Coverage Guidelines for Specific Power Wheelchairs**

A Group 2 Single Power Option PWCs (K0835 – K0840) are covered when basic power wheelchair coverage guidelines (above) are met **AND** when the **ALL** of following criteria are met:

1. Member meets **ONE** of the following:
   a. The Member requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); **or**
   b. The Member meets coverage criteria for a power tilt and/or a power recline seating system (refer to **Coverage Criteria for Power Tilt and/or Recline Seating Systems**) and the system is being used on the wheelchair.
2. The Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its' specific features. The PT, OT, or physician may have no financial relationship with the supplier; **and**
3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the Member.

A Group 2 Multiple Power Option PWCs (K0841-K0843**)** are covered when basic power wheelchair coverage guidelines (above) are met **AND** when **ALL** of the following criteria are met:

1. The Member meets **ONE** of the following:
   a. The Member meets coverage criteria for a power tilt and recline seating system (refer to **Coverage Criteria for Power Tilt and/or Recline Seating Systems**) **and** the system is being used on the wheelchair; **and**
   b. The Member uses a ventilator which is mounted on the wheelchair.
2. The Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its' specific features. The PT, OT, or physician may have no financial relationship with the supplier; **and**
3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the Member.

A Group 3 PWCs with no power options (K0848-K0855) are covered when basic power wheelchair coverage guidelines (above) are met; **AND** when **ALL** of the following criteria are met**:**

1. The Member's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; **and**
2. The Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT, OT, or physician may have no financial relationship with the supplier; **and**
3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the Member.

A Group 3 PWCs with Single Power Option (K0856-K0860**)** or with Multiple Power Options (K0861-K0864**)** are covered when **ALL** of the following are met:

1. The Group 3 PWC coverage criteria is met; **and**
2. The Group 2 Single Power Option **or** Multiple Power Options coverage criteria are met.

**Coverage Criteria for Power Tilt and/or Recline Searing Systems (E1002-E1010)**

A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered when **ALL** of the following criteria are met:

1. Basic power wheelchair coverage guidelines are met; **and**
2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or physician who has specific training and experience in rehabilitation wheelchair evaluations of the Member's seating and positioning needs. The PT, OT, or physician may have no financial relationship with the supplier; **and**
3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the Member; **and**
4. The Member meets **ONE** of the following:
    a. The Member is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; **or**
    b. The Member utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; **or**
    c. The power seating system is needed to manage increased tone or spasticity.

The Plan has determined the reasonable useful lifetime of a power wheelchair to be 5 years. Computation of the useful lifetime is based on when the equipment is delivered to the Member, not the age of the equipment. Replacement due to wear is not covered during the reasonable useful lifetime of the equipment. The Plan will review requests for power wheelchair replacements on case-by-case basis and may cover a replacement power wheelchair when the following criteria are met:

1. The Member meets the above criteria for a power wheelchair and **ONE** of the following.
    a. A decline in the Member's functional status has been documented and current wheelchair does not support the Member's functional status. Adaptations to current power wheelchair will not meet Member's functional needs and/or are not cost effective; **or**
    b. Current power wheelchair no longer functions, and repair and/or replacement parts are no longer available or cost-effective

## Limitations

The Plan will not authorize the coverage of a power wheelchair and/or accessories and components in the following circumstances:

1. When used for convenience
2. When used primarily for recreation or leisure
3. When used for community mobility only
4. In addition to Member's primary mobility device (e.g., manual wheelchair, power operated vehicle)
5. When deemed not medically necessary
6. **Group 4 PWCs (K0868-K0886)** have added capabilities that are not needed for use in the home. Therefore, if these wheelchairs are provided, they will be denied as not reasonable and necessary.

The Plan will not cover access ramps, home or vehicle wheelchair lifts or home adaptations.

The Plan will not cover the following wheelchair modifications or accessories, including but not limited to:

1. Snow tires
2. Stair climbing wheelchair, e.g., iBOT® Mobility System (iBALANCE® Technology)
3. Power standing system, any type (E2301)
4. Wheelchair seat cushion, powered (E2610)
5. Environmental control unit
6. Wheelchair backup camera

The Plan will not cover the following wheelchair accessory as it is considered investigational. Refer to Medical Necessity Guidelines: Noncovered Investigational Services:

1. JACO assistive robotic arm for use by patients with neuromuscular disease

## Codes

The following code(s) require prior authorization:

**Table 1: CPT/HCPCS Codes**

| Code | Description |
|---|---|
| K0010-K0014 | Motorized/power wheelchair, Motorized/power wheelchair base |
| K0813-K0864 | Power wheelchair group 1,2 and 3 |
| K0890-K0891 | Power wheelchair group 5 |
| K0898 | Power wheelchair, not otherwise classified |
| K0899 | Power mobility device, not coded by DME PDAC or does not meet criteria |
| E1002-E1012 | Wheelchair accessory, power seating system |

**References:**


1. Centers of Medicare & Medicaid. LCD for Wheelchair Options/Accessories Accessed on August 20, 2025 from LCD - Wheelchair Options/Accessories (L33792)
2. Centers of Medicare & Medicaid Benefit Policy Manual Chapter 15 accessed on August 20, 2025. cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
3. Centers for Medicare and Medicaid. Local Coverage Determination (LCD) L33789 Power Mobility Devices accessed on August 20, 2025 from LCD - Power Mobility Devices (L33789)
4. Center for Medicare and Medicaid National Coverage Determination (NCD) for Mobility Assistive Equipment 280.3 accessed on August 20, 2025 from NCD - Mobility Assistive Equipment (MAE) (280.3)
5. Centers for Medicare and Medicaid LCD for Manual Wheelchair Bases (L33788) accessed on August 20, 2025 from LCD - Manual Wheelchair Bases (L33788)
6. Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment, 130 CMR 409.420 130 CMR 409


## Approval And Revision History

October 21, 2020: Reviewed by the Medical Policy Approval Committee (MPAC), renewed without changes

Subsequent endorsement date(s) and changes made:

- November 10, 2020: Fax number for Unify updated
- July 21, 2021: Reviewed at IMPAC. For effective date October 1, 2021: Backup camera added to limitations section
- October 20, 2021: Reviewed by IMPAC. Effective October 20, 2021, JACO assistive robotic arm for use by patients with neuromuscular disease added to limitations section
- November 16, 2022: Reviewed by MPAC, renewed without changes
- December 21, 2022: Reviewed by MPAC with no changes for integration between Harvard Pilgrim Health Care and Tufts Health Plan effective May 1, 2023
- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Unify name changed to One Care effective January 1, 2024
- October 17, 2024: Reviewed by MPAC, references updated effective December 1, 2024
- October 15, 2025: Reviewed by MPAC, updated links effective December 1, 2025
- November 12, 2025: Fax number for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed; Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template
- December 17, 2025: Reviewed by MPAC, updated limitations effective January 1, 2026

## Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.