Medical Necessity Guidelines:

Power Wheelchairs for Tufts Health Together, Tufts Health RITogether, and Tufts Health One Care

Effective: December 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required 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 MCO Plan and 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 type of power mobility device (PMD) which provides a safe mobility alternative for an individual with the inability to transfer or ambulate safely, timely, and functionally. The appropriate type of power wheelchair is determined by assessment and evaluation of medical and functional needs, activities of daily living (ADLs or IADLs) needs and individual's physical condition.

Clinical Guideline Coverage Criteria

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations where available. For **Tufts Health One Care, RITogether, and MATogether plan members** the following criteria is used: Power Mobility Devices LCD L33789, Wheelchair Operations and Accessories LCD L33792, Seat Elevation Equipment (Power Operated) on Power Wheelchairs NCD 280.16, and Mobility Assistive Equipment (MAE) NCD 280.3

The following Clinical Coverage Criteria applies to **Tufts Health Together, Tufts Health One Care and Tufts Health**

RITogether:

1. Durable medical equipment (DME) is defined as equipment that:
    a. is fabricated primarily and customarily to fulfill a medical purpose;
    b. is generally not useful in the absence of illness or injury;
    c. can withstand repeated use over an extended period; **and**
    d. is appropriate for use in any setting in which normal life activities take place, including, but not limited to, the member's home. [5,7,9]
2. Documentation of a trial/evaluation in setting where power mobility device is to be used primarily (e.g. home, school) must attest to the power mobility device fit in the setting, including secure storage and charging, adequate access between rooms, adequate maneuvering space, and ability to safely maneuver as needed on setting terrains, surfaces

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

COVERAGE CRITERIA FOR POWER-ASSISTED STANDING SYSTEM

The Plan may authorize coverage of power-assisted standing system for Tufts Health Together, Tufts Health RITogether and Tufts Health One Care Members when **ALL** the following criteria is met.

1. Member is unable to stand or ambulate independently due to conditions such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities; **and**
2. Member is at high risk for lower-limb or trunk contracture(s) **or** has non-fixed contracture(s) that have not improved with other interventions (e.g., stretching, splinting, serial casting, medications, or other modalities); **and**
3. Power-assisted standing component is required for standing throughout the day as a means alleviate or reduce additional symptoms such as pain or increased tone requiring standing throughout the day; **and**
4. The alignment of Member's lower extremity is such that the foot, ankle, knee, and hip can tolerate a standing or upright position; **and**
5. Member has demonstrated the ability to tolerate standing for a therapeutic length of time, a minimum of 30 minutes or more at one time, during a documented trial period; **and**
6. Member has demonstrated safe (member has proper safety awareness) and independent (without physical assistance or cueing) use the requested device; **and**
7. Member has improved or maintained status in mobility, ambulation, or physiologic symptoms with the use of the requested device; **and**
8. Member is able to independently follow prescribed home standing program incorporating the use of requested device; **and**
9. Member has documented clinical justification for why a power assisted standing component will meet Member's medical needs and why a static stander or tilt table will not meet Member's medical needs

COVERAGE CRITERIA for WHEELCHAIR SEAT CUSHION, POWERED (E2610)

The Plan may authorize coverage of a wheelchair seat cushion, powered for Tufts Health Together, Tufts Health RITogether and Tufts Health One Care when **ALL** of the following criteria are met:

1. The Member is at high risk for development of a pressure ulcer and is unable to perform an independent functional weight shift; **and**
2. Maintenance of skin integrity has failed with the proper use of skin protection and/or positioning wheelchair seat cushion(s).

Limitations

The Plan considers coverage of a power wheelchair and/or accessories not medically necessary for Tufts Health Together and Tufts Health RITogether in the following circumstances:

1. when used for convenience of Member and/or Member's caregiver
2. when used primarily for recreation or leisure
3. when requested in addition to a power operated vehicle

The Plan will only cover access ramps, vehicle modifications, and certain home modifications for Tufts Health Together and Tufts Health One Care members when provided to eligible MassHealth members who are enrolled as participants in the HCBS waiver, as required by 130 CMR 630.403. See (the Home Accessibility Adaptions MNG for more details)

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

1. Snow tires
2. Stair climbing wheelchair (A9270 NS CMS & MassHealth); e.g., iBOT® Mobility System (iBALANCE® Technology)
3. Environmental control unit
4. Wheelchair backup camera

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

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

LIMITATIONS: TUFTS HEALTH RITOGETHER ONLY

1. The Plan considers coverage of a power wheelchair and/or accessories in addition to Member's primary mobility device (e.g., manual wheelchair, power operated vehicle) for Tufts Health RITogether not medically necessary
2. In addition to Member's primary mobility device (e.g., manual wheelchair, power operated vehicle)

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
K0010-K0014	Power wheelchair and accessories
K0813-K0864	Power wheelchair group 1,2 and 3
K0868-K0886	Power wheelchair group 4
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
E2298	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type
E2301	Wheelchair accessory, power standing system, any type
E2610	Wheelchair seat cushion, powered

References:

1. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD) L33792 Wheelchair Options/Accessories. Accessed August 20, 2025. LCD - Wheelchair Options/Accessories (L33792) (cms.gov)
2. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD) L33789 Power Mobility Devices. Accessed August 20, 2025. LCD - Power Mobility Devices (L33789) (cms.gov)
3. Center for Medicare & Medicaid Services. National Coverage Determination (NCD) 280.3 for Mobility Assistive Equipment.Accessed August 20, 2025. NCD - Mobility Assistive Equipment (MAE) (280.3) (cms.gov)
4. Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment: Subchapter 6; Service Codes last accessed August 20, 2025. Transmittal Letter DME-41 (mass.gov)
5. Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment, 130 CMR 409.420 last accessed August 20, 2025. Durable Medical Equipment Manual for MassHealth Providers | Mass.gov
6. Executive Office of Health and Human Services, State of Rhode Island. Coverage Guidelines for Durable Medical Equipment Wheelchairs/Stroller. Accessed August 20, 2025. Coverage Guidelines For Durable Medical

Equipment | Executive Office of Health and Human Services (ri.gov)
7. Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. Durable Medical Equipment Bulletin 21. Accessed August 20, 2025. download (mass.gov)
8. MassHealth Guidelines for Medical Necessity Determination for Power-Assisted (Dynamic) Standing Components for Wheelchairs. Accessed August 20, 2025. download (mass.gov)
9. Commonwealth of Massachusetts Executive Office of Health and Human Services of Medicaid. Transmittal Letter DME-37. Accessed August 20, 2025. Microsoft Word - DME-37.docx (mass.gov)
10. Centers for Medicare & Medicaid Services. National Coverage Determinations (NCD) 280.15 INDEPENDENCE iBOT 4000 Mobility System. Accessed August 20, 2025. NCD - INDEPENDENCE iBOT 4000 Mobility System (280.15) (cms.gov)
11. Centers for Medicare & Medicaid Services. National Coverage Determinations (NCD) 280.16 Seat Elevation Equipment (Power Operated) on Power Wheelchairs. Accessed August 20, 2025. NCD - Seat Elevation Equipment (Power Operated) on Power Wheelchairs (280.16) (cms.gov)

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
- April 21, 2021: Reviewed at IMPAC. For effective date April 21, 2021: Removed “community use only” from limitations section, added MassHealth definition of DME and MassHealth interpretation of this DME definition. For effective date October 1, 2021: Added backup camera to limitations section all products, added coverage criteria for home evaluation documentation requirements for Tufts Health Together product.
- May 14, 2021: For clarification purposes, Tufts Health Plan Senior Care Options added to Clinical Coverage Criteria regarding MassHealth definition of DME and MassHealth interpretation of this DME definition, effective date April 21, 2021.
- June 16, 2021: Reviewed at IMPAC. Effective June 16, 2021, MassHealth Guidelines for Medical Necessity Determination (MND) for Power-Assisted (Dynamic) Standing Components for Wheelchairs replaces MNG coverage criteria for prior authorization of power-assisted standing system for THP Together, THP RITogether and applies to Tufts Health Unify. Effective January 1, 2022, power-assisted standing components are covered with prior authorization for THP SCO. Refer to Tufts Health Plan Senior Care Options (SCO) Prior Authorization List for applicable Medicare and Medicaid Reference.
- August 18, 2021: Reviewed at IMPAC. Clarification to definition of DME, applicable references added. For effective date November 1, 2021 added coverage criteria for home evaluation documentation requirements for Tufts Health Unify, Tufts Health RITogether and Tufts Health Plan Senior Care Options.
- 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 17, 2021: Tufts Health Unify added to Medical Necessity Guideline title
- February 2, 2022: LCD link updated
- April 7, 2022: Template updated
- November 16, 2022: Reviewed by MPAC, renewed without changes
- September 20, 2023: Reviewed by MPAC, criteria updated to cover power wheelchairs with seat cushions, and power assisted standing systems per CMS, EOHHS MA and EOHHS RI guidelines code E2301 is now covered with prior authorization effective January 1, 2024
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- December 1, 2023: Review and Approved by Utilization Management Committeee effective January 1, 2024
- October 17, 2024: Review by MPAC, consolidated LCD and NCD links for all lines of business, updated links, updated limitations, removed E2300 as it was a deleted code, and added coverage of E2298, 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

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.