



CODING GUIDELINES AND POLICY UPDATE

Important Note:

The medical policies referenced in this document apply to all HMO, POS, and PPO products of Independence Blue Cross ("IBC"), including its affiliates, as well as to traditional indemnity products to the extent the applicable covered services are underwritten by IBC or its affiliates. Please note that some of IBC's traditional indemnity products are jointly underwritten by Highmark Blue Shield and therefore Highmark's medical policy may apply. You may refer to the member's ID card for the entity that is responsible for underwriting the product.

This document was developed to assist IBC in administering the provisions of its benefits programs and does not constitute medical advice. Professional providers are responsible for providing medical advice and treatment. Even though this document may conclude that a particular service or item is medically necessary, such conclusion is NOT based upon the terms of a particular member's benefit plan. Members must refer to their specific benefit program for the terms, conditions, limitations and exclusions of coverage.

Please note that the Policy Bulletins which are referenced herein describe the status of a specific topic at the time the Policy Bulletin was created. Policy Bulletins are updated biennially and when new medical evidence becomes available, therefore, they are subject to change.

Please be aware that the actual Policy Bulletins which are discussed herein are used as a guide only. Coverage decisions are made on a case-by-case basis by applying Policy Bulletin criteria to the member's medical history, condition, and proposed course of treatment as well as the member's benefit program. Providers should review Policy Bulletins with Members as treatment options are discussed, as the Policy Bulletins are designed to be used by our professional staff in making coverage determinations and can be highly technical.

Information contained in this document and the actual Policy Bulletin does not constitute an offer of coverage, medical advice, or guarantee of payment. Please note that, if there is a conflict between the Policy Bulletin and a member's benefit program, the terms of the benefit program will govern.

Please note that providers who opted out of the class action settlement may not be entitled to certain claim payment policy changes. Therefore, any payments made pursuant to such policy changes to providers who opted out of the class action settlement are subject to retroactive adjustments.

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Special Note

Due to the frequent release of CPT®, HCPCS, and ICD-9-CM coding updates, code ranges will no longer be included in the *Coding Guidelines and Policy Update*. An up-to-date list of appropriate billing, diagnostic, and procedure codes, with their respective narratives, can be found in the individual policies at www.ibx.com/medpolicy under the Medical section. Please check the website frequently, as policies are updated often.

Medical Policies

Abdominoplasty and/or Panniculectomy (11.08.06c)

COVERED: ACCORDING TO CERTAIN CRITERIA

Abdominoplasty is a surgical procedure that is performed to tighten a lax abdominal wall and involves the removal of excess skin and fat from the middle and lower abdomen. Panniculectomy is a surgical procedure in which a large, redundant apron of subcutaneous fat and abdominal skin is removed from the lower abdomen. On occasion, abdominoplasty is performed concurrently with panniculectomy in order to achieve the best therapeutic result.

Under most circumstances, abdominoplasty and/or panniculectomy are cosmetic services and benefit contract exclusions. However, the procedures are medically necessary in clinical situations when both of the following criteria are met:

- The panniculus hangs to or below the level of the pubis.
- The individual's medical record documents that the hanging panniculus causes skin irritation and/or infection that results in pain, ulceration, superpubic intertrigo, monilial infestation, and/or panniculitis that is chronic, persistent, and refractory to medical treatment for at least six months. Examples of agents that may be used for conservative treatment are: topically-applied skin barriers, supportive garments, and antifungal, antibacterial, and moisture-absorbing agents.

Abdominoplasty and/or panniculectomy for the repair of diastasis recti are not medically necessary because diastasis recti is not a true hernia and is of no clinical significance. Therefore, these services are not covered.

Prophylactic or preventive panniculectomy that is performed in conjunction with an abdominal hernia repair to prevent the occurrence of future complications, such as infection, seroma, and/or ischemia, is considered cosmetic unless the above criteria for panniculectomy are met (panniculus hangs to or below the level of the pubis and documentation of failed medical treatment for skin irritation, infection, etc., from a hanging panniculus).

Panniculectomy that is performed in conjunction with a hernia repair is considered medically necessary if the above criteria for panniculectomy are met (panniculus hangs to or below the level of the pubis and documentation of failed medical treatment for skin irritation, infection, etc. from a hanging panniculus).

Panniculectomy that is performed to minimize the risk of hernia formation or recurrence is considered cosmetic because the available published literature does not indicate that pannus contributes to hernia formation. The main cause of hernia formation is an abdominal wall weakness or defect, not a pulling effect from a redundant or large pannus.

All requests for abdominoplasty/panniculectomy require a review by the Company's cosmetic review team and must include:

- Dated photographs of the panniculus hanging over the pubis and of the panniculus elevated to expose the chronic, persistent, and refractory skin infection or irritation.
- Office notes from the treating physician that reflect the chronic, persistent, and refractory skin infection or irritation that persists despite optimal medical care over a six-month period.
- A listing of the medications that were prescribed during a six-month period and the length of time the agents were used.

Blepharoplasty with or without a Brow Lift/Repair of Blepharoptosis (11.05.02c)

COVERED: ACCORDING TO CERTAIN CRITERIA

Blepharoptosis is the condition of droopiness of the upper eyelid due to underlying eye muscle dysfunction (e.g., levator muscle or Muller's muscle). Surgical repair of this condition, including repair of the eye muscle, is performed in conjunction with the blepharoplasty procedure. A blepharoplasty procedure includes the removal of redundant skin of the upper and/or lower eyelids and the removal of protruding periorbital fat. This procedure can be performed for either cosmetic or reconstructive purposes. When performed for cosmetic reasons, the surgery reshapes eye-related structures in order to improve appearance and self-esteem; when provided as part of a reconstructive procedure, the surgery reshapes eye-related structures in order to improve functional ability. Blepharoplasty can be performed alone or in conjunction with other procedures such as a brow lift.

Under most circumstances, a blepharoplasty with or without a brow lift and/or repair of blepharoptosis is a cosmetic service and a benefit contract exclusion. However, each of these procedures is medically necessary when performed as functional or reconstructive surgeries in certain clinical situations.

Blepharoplasty

Blepharoplasty is medically necessary when performed to correct:

- Prosthetic difficulties in an anophthalmic (without an eye) socket.
- Disorders of visual impairment caused by redundant skin of the eyelid or eyebrow that include, but are not limited to:
 - Visual impairment due to dermatochalasis, blepharochalasis, or ptosis of the eyelid.
 - Symptomatic, redundant skin that is resting on the upper lashes.
 - Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper eyelid skin.

Lower eyelid blepharoplasty is generally not medically indicated to treat conditions that cause visual field obstruction because the lower eyelids are not usually associated with visual impairment. In the absence of visual impairment, lower eyelid blepharoplasty is considered a cosmetic service and, therefore, not covered.

Requests for lower eyelid blepharoplasty are considered on an individual basis when documentation (including the individual's chief complaint and preoperative photographs) demonstrates that the procedure is medically necessary for reconstructive reasons.

Blepharoptosis Repair

Blepharoptosis repair is medically necessary when performed as functional/reconstructive surgery to correct a visual impairment due to drooping or displacement of the upper eyelid.

Brow Ptosis Repair

Brow ptosis repair is medically necessary when performed as functional/reconstructive surgery to correct either of the following:

- Visual impairment due to droop or displacement of the brow.
- Brow malposition that would prevent adequate correction of dermatochalasis, blepharochalasis, or blepharoptosis.

Documentation Requirements

All requests for any of the procedures listed above require a letter of medical necessity that describes the individual's chief complaints and that justifies the need for surgery to correct the functional impairment.

Additionally, when blepharoplasty is to be performed as a functional/reconstructive surgery to correct visual impairment, the following additional documentation is required:

- Preoperative color photographs that include a view of the individual: in forward gaze, looking up, and

looking down, and that demonstrate one or more of the following:

- The upper eyelid margin is within 2.5 mm (one-fourth of the diameter of the visible iris) of the corneal light reflex (margin-to-reflex distance [MRD] less than 2.5 mm) with the individual in primary gaze.
 - The upper eyelid skin rests on the eyelashes.
 - The upper eyelid indicates the presence of dermatitis.
 - The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmic socket.
 - The brow position is below the superior orbital rim.
- A written interpretation of the results of both the taped and untaped automated visual field studies must be submitted and must demonstrate one of the following:
 - The upper visual field has improved by at least eight degrees or 20 percent with the eyelid taped as compared with the visual field obtained without taping (two sets of visual fields are required).
 - Visual field obstruction by the eyelid limits the upper visual field to within 30 degree of fixation.

If both a blepharoplasty and a brow ptosis repair are planned, the need for both must be documented. This requires photographs showing the affect of the drooping, redundant skin; the skin resting on the upper eyelid; the presence of dermatitis; or the actual presence of blepharoptosis.

Bone Growth Stimulators (05.00.09c)

COVERED: ACCORDING TO CERTAIN CRITERIA

Noninvasive bone growth stimulators consist of an external power supply and externally applied coils or a transducer that generate a weak electrical current through the site where bone growth is desired. Noninvasive devices use pulsed electromagnetic fields (PEMFs), capacitative coupling, or combined magnetic fields technology to generate the current. Ultrasonic bone growth stimulators are noninvasive devices that accelerate fracture healing by emitting low-intensity, pulsed ultrasound signals on the skin surface over the fracture site. Ultrasonic bone growth stimulators are used in conjunction with cast immobilization.

Electrical bone growth stimulators are used for nonunion fracture(s) of long bone, which is defined by Medicare to include the following: the clavicle, humerus, radius, ulna, metacarpal, femur, tibia, fibula, malleolus, and metatarsal. Studies of bone growth stimulators in the treatment of fresh fractures (less than seven days) and in delayed union and nonunion fractures of both long and short bone indicate that insufficient scientific evidence exists to demonstrate the effectiveness of electrical bone growth stimulators in fresh and delayed union fractures. In addition, the safety and effectiveness of electrical bone growth stimulators in individuals under the age of 17 has not been established in clinical trials.

Electrical bone growth stimulators (noninvasive/invasive) are considered medically necessary and, therefore, covered for individuals 17 years of age or older when **one** of the following conditions is present:

- A fracture secondary to congenital pseudarthrosis (755.8).
- A nonunion fracture (733.82) of a long bone (includes the following: the clavicle, humerus, radius, ulna, metacarpal, femur, tibia, fibula, malleolus, metatarsal).
 - Nonunion fracture is defined as the point at which healing has stopped (three months or greater from the initial fracture) and further healing (as evidenced by serial radiographic documentation) has ceased.

- A failed joint fusion.
 - Post-surgical joint fusion failure is defined as radiologic documentation of nonunion nine months or more after surgical fixation of the fracture.

Electrical bone growth stimulators (noninvasive/invasive) are considered medically necessary and, therefore, covered **following spinal surgery** (V45.4) when **one** of the following criteria is met:

- A failed spinal fusion when the surgery was performed a minimum of nine months from the last surgery.
- A multilevel spinal fusion surgery (e.g., L3-L5, L4-S1, etc.).
- Revisional spinal fusion surgery due to a previously failed spinal fusion at the same level.

Unless any exclusion criteria exists, low-intensity ultrasonic bone growth stimulators (noninvasive) are considered medically necessary and, therefore, covered for **any** of the following:

- Fresh (less than seven days), closed or Grade I open, tibial diaphysis fracture (823.20, 823.30) when used as an adjunct to closed reduction and cast immobilization.
- Fresh, closed fracture of the distal radius (Colles fracture [813.41, 813.42]) when used as an adjunct to closed reduction and cast immobilization.
- Nonunion fractures (733.82) of the clavicle, scapula, humerus, radius, ulna, carpal, metacarpal, phalanges (fingers or toes), femur, patella, tibia, fibula, malleolus, talus, calcaneus, cuboid, navicular, cuneiform, tarsal, metatarsal, rib(s), sternum, and pelvis.
 - Nonunion fracture is defined as the point at which healing has stopped (three months or greater from the initial fracture) and further healing (as evidenced by serial radiographic documentation) has ceased.

If **one or more** of the following **exclusion criteria** exist, low-intensity ultrasonic bone growth stimulators are considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of this device for these conditions cannot be established by review of the available published literature:

- For a fracture of the skull or vertebrae.
- For a fracture that is tumor-related.
- For concurrent use with any other noninvasive osteogenic stimulator.
- In individuals under the age of 17.
- For a fresh fracture other than one of the tibial diaphysis or distal radius.
- For a delayed union fracture (a recent fracture [three months or less from the initial fracture], where healing has not advanced at the “average” rate for the location and type of fracture).

For all other indications, electrical bone growth stimulators and low-intensity ultrasonic bone growth stimulators are considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of these devices cannot be established by review of the available published literature. Examples of other indications include, but are not limited to: individuals under the age of 17, fresh fractures (except ultrasonic stimulator use for fractures of the tibial diaphysis or distal radius) and delayed union fractures.

Excision of Redundant Skin (11.08.10c)

COVERED: ACCORDING TO CERTAIN CRITERIA

Extensive redundancy of skin and fat folds can appear in areas such as the medial aspect of the upper arms, breasts, abdomen, buttocks, and thighs and may create environments that are susceptible to skin infection. Excessive skin and fat are excised using appropriate incisions and techniques that allow for the direct removal of the redundant skin with the subsequent approximation and suturing of the remaining skin.

In the majority of circumstances, the excision of redundant skin is a cosmetic service and a benefit contract exclusion. However, this procedure is medically necessary in certain clinical situations in which the following criteria are met:

The individual's medical record must document that the redundant skin causes chronic irritation and/or infection and results in pain, ulceration, superpubic intertrigo, monilial infestation, and/or panniculitis that is chronic, persistent, and refractory to medical treatment for at least six months.

All requests for excision of redundant skin require review by the Company's Cosmetic Review Team and must include:

- Dated photographs of the chronic, persistent, and refractory skin infection or irritation.
- Office notes from the treating physician that reflect the chronic, persistent, and refractory skin infection and/or irritation, despite optimal medical care over a six-month period.
- A listing of the medications that were prescribed during the six-month period and the length of time that the agents were used.

High-Frequency Chest Wall Oscillation Devices (05.00.14c)

COVERED: ACCORDING TO CERTAIN CRITERIA

A high-frequency chest wall oscillation device is designed to enhance the mobilization of bronchial secretions. The device is an inflatable vest that is connected by two tubes to a small air-pulse generator. Oscillating positive air pressure causes the vest to inflate and deflate up to 25 times a minute, creating a vibratory motion that aids in the mobilization of secretions. The action of the device creates mini-coughs that dislodge mucus from the bronchial walls, thus increasing mobilization of the mucus toward the central airways. The oscillating action also thins the secretions and makes them easier to remove by coughing or suctioning. High-frequency chest wall oscillation devices can be used for individuals who have cystic fibrosis or bronchiectasis and require chest physiotherapy, manual chest percussion, postural drainage, and device-assisted coughing to help them clear their lungs.

A four-to six-week trial of a high-frequency chest wall oscillation device is considered medically necessary and, therefore, covered for the treatment of individuals with a documented history that confirms a failure of standard treatments (e.g., manual chest percussion, postural drainage) to adequately mobilize retained bronchial secretions and **one** of the following diagnoses:

- Cystic fibrosis.
- Bronchiectasis confirmed by computed tomography (CT) scan and documentation of one of the following:
 - Daily productive cough for at least six continuous months.
 - Frequent (i.e., more than two per year) exacerbations of respiratory infection requiring antibiotic therapy.

Continued coverage of the device after the trial is considered medically necessary and, therefore, covered when the effectiveness of the device has been demonstrated by:

- Documentation that the device has been used daily or as prescribed.
- Documentation of increased expectoration of mucus.

If the trial of the device is successful and the individual wishes to continue using the device, continued authorization for the device must be obtained. The ordering physician must provide a letter of medical necessity to the Company stating compliance with the above requirements.

High-frequency chest wall oscillation devices for any diagnosis other than cystic fibrosis or bronchiectasis are considered not medically necessary and, therefore, not covered because the available published literature does not support the use of this device for the treatment of any other diagnosis.

Hospital Beds and Accessories (05.00.56a)

COVERED: ACCORDING TO CERTAIN CRITERIA

A hospital bed is a bed with head and leg elevation and height adjustment features that are used to assist individuals who require adjustment or repositioning to alleviate pain, prevent contractures, prevent respiratory infections, and to allow individuals to transfer to and from bed with increased independence. Hospital bed accessories are additions to a bed that are not provided as part of the original bed. Accessories that may be needed for the essential functioning of the hospital bed in relation to the individual's condition include trapeze bars, bed cradles, or side rails.

Medically Necessary

Fixed Height Hospital Beds

A fixed height hospital bed (E0250, E0251, E0290, E0291) is medically necessary when the individual meets one or more of the following medical necessity criteria:

- The individual has a medical condition that requires positioning of the body in ways that are not feasible in an ordinary bed. The elevation of the head/upper body of less than 30 degrees does not usually require the use of a hospital bed.
- The individual requires head elevation of more than 30 degrees most of the time due to congestive heart failure (CHF), problems with aspiration, or chronic pulmonary disease. Pillows or wedges must have been considered and ruled out.

- The individual requires positioning of the body in ways that are not feasible in an ordinary bed to alleviate pain.
- The individual requires traction equipment, which can only be attached to a hospital bed.

Variable Height Hospital Beds

A variable height hospital bed (E0255, E0256, E0292, E0293) is medically necessary for individuals with severely debilitating diseases and conditions (including, but not limited to severe cardiac conditions, spinal cord injuries, amyotrophic lateral sclerosis [ALS], and multiple sclerosis) when all of the following apply:

- The individual meets one or more of the medical necessity criteria for a fixed height hospital bed.
- The individual requires a bed height that cannot be attained with a fixed hospital bed and that allows them to be transferred to a chair, wheelchair, or standing position.

Semi-Electric Hospital Beds

A semi-electric hospital bed (E0260, E0261, E0294, E0295) is medically necessary when the individual meets one or more of the medical necessity criteria for a fixed height hospital bed and both of the following criteria:

- The individual's condition requires that their body position be changed frequently and/or that their body position may be changed immediately when necessary (i.e., no delay can be tolerated).
- The individual is able to operate the controls and cause the adjustments. Exceptions to this requirement can be made in cases of spinal cord injury (SCI) and brain injury.

Heavy Duty Hospital Beds

A heavy duty hospital bed (E0301, E0303) is medically necessary when the individual meets one or more of the medical necessity criteria for a fixed height hospital bed and when the individual's weight exceeds 350 lbs but is less than 600 lbs.

Extra Heavy Duty Hospital Beds

An extra heavy duty hospital bed (E0302, E0304) is medically necessary when the individual meets one or more of the medical necessity criteria for a fixed height hospital bed and when the individual's weight exceeds 600 lbs.

Pediatric Hospital Beds

A pediatric hospital bed is medically necessary when the individual meets all of the medical necessity criteria for one of the hospital beds specified above.

Not Medically Necessary

Total Electric Hospital Beds

A total electric hospital bed (E0265, E0266, E0296, E0297) is considered not medically necessary and, therefore, not covered because the electric height adjustment feature does not aid in the treatment of the individual's condition.

Institutional Hospital Beds

An institutional hospital bed (E0270) is considered not medically necessary and, therefore, not covered because it is deemed inappropriate for home use. These beds include oscillating beds, circulating beds, and Stryker frame beds.

Hospital Bed Accessories

Medically Necessary

The following hospital bed accessories are considered medically necessary when the individual meets the medical necessity requirement for the specified bed and meets the additional criteria as indicated below:

- Bed cradle (E0280): When the individual has a medical condition that requires the prevention of contact with bed coverings (i.e., burns, diabetic ulcers, gout).
- Trapeze equipment (E0910, E0940): When the individual requires this device to do any one of the following:
 - Sit up because of a respiratory condition.
 - Change body position for other medical reasons.
 - Get in or out of bed.

- Heavy duty trapeze equipment (E0911, E0912): When the individual meets both of the following criteria:
 - The individual meets the criteria for regular trapeze equipment.
 - The individual weighs more than 250 pounds.
- Side rails (E0305, E0310): When the individual's condition requires that they have bed side rails and the rails are a part of or an accessory to the hospital bed.

Not Medically Necessary

The following hospital bed accessory is considered not medically necessary:

- Trapeze bars (E0910, E0911) will be considered not medically necessary and, therefore, not covered when they are used on an ordinary bed.

Not Primarily Medical In Nature (Benefit Exclusion)

- Safety enclosures (E0316) (nylon netting that encloses the top and sides of a hospital bed) are considered benefit exclusions and, therefore, not covered as these devices are not primarily medical in nature. Additionally, these devices have safety concerns associated with them. For Medicare members, safety enclosures are considered not medically necessary, and therefore, not covered; these devices have safety concerns associated with them.
- A bed board (E0273, E0315) (a device placed under a mattress to make the mattress firmer) is considered a benefit exclusion and, therefore, not covered because its use is not primarily medical in nature.
- An over bed table (E0274, E0315) is considered a benefit exclusion and, therefore, not covered because its use is not primarily medical in nature.

Lower Limb Prostheses (05.00.59)

COVERED: ACCORDING TO CERTAIN CRITERIA

A lower limb prosthesis is an artificial leg for an amputee. The design of the prosthesis is dependent on the functional level of the recipient and is geared toward comfort and minimizing limitations. Component parts of a lower limb prosthetic include a prosthetic foot, knee, and ankle, a pylon (to provide vertical support), and a socket (to hold the residual limb). Selection of prosthetic components varies according to the functional level of the individual. Accessories include a stump stocking and a harness.

Functional Levels

A determination of medical necessity for certain components/additions to the prosthesis is based on the individual's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist and treating physician, considering factors including, but not limited to:

- The individual's past history (including prior prosthetic use, if applicable).
- The individual's current condition (including the status of the residual limb and the nature of any other medical problems).
- The individual's desire to ambulate.

Clinical assessments of an individual's potential functional ability must be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

Level 2: Has the ability or potential for prosthetic ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.

Level 3: Has the ability or potential for prosthetic ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

A lower limb prosthesis is considered medically necessary and, therefore, covered for an amputee who is motivated to ambulate **and** whose functional level is 1 or greater when the prosthesis is prescribed by any eligible health care provider and fitted/made by an orthotist or prosthetist.

A lower limb prosthesis is considered not medically necessary and, therefore, not covered for an amputee whose functional level is 0.

A limit of one prosthetic limb will be covered for the unilateral amputee. Prosthetics may be eligible for repair and/or replacement.

If a prosthesis is denied as not medically necessary, related components and accessories will also be denied as not medically necessary and, therefore, not covered.

Components and/or accessories that do not serve a functional purpose are considered not medically necessary and, therefore, not covered.

Types of Prostheses

An immediate postoperative prosthesis (IPOP) (L5400, L5410, L5420, L5430, L5450, L5460) is considered medically necessary and, therefore, covered:

- In the initial postoperative period
 - Cast changes are necessary as the residual limb muscles atrophy, usually at 7-10 day intervals.

A preparatory prosthesis (L5510, L5520, L5530, L5535, L5540, L5560, L5570, L5580, L5585, L5590, L5595, L5600) is considered medically necessary and, therefore, covered:

- For use between the IPOP and the definitive prosthesis (from approximately six weeks to six months postoperatively).
 - The type of preparatory prosthesis used for each individual is based on the physician's clinical judgment, considering the status of the residual limb and the individual's history, current condition, and desire to ambulate.

An initial definitive prosthesis (coded by component) is considered medically necessary and, therefore, covered:

- For an individual whose residual limb is no longer changing shape or volume
 - Component selection for the definitive prosthesis is based on the individual's functional level.

Components of a Definitive Prosthesis

Prosthetic Foot Component

A basic lower extremity prosthesis includes a solid ankle cushion heel (SACH) foot. Other prosthetic feet are considered medically necessary and, therefore, covered based upon functional classification.

- An external keel SACH foot (L5970) or single-axis ankle/foot (L5974) is considered medically necessary and, therefore, covered for individuals whose functional level is 1 or above.
- A flexible keel foot (L5972) or multiaxial ankle/foot (L5978) is considered medically necessary and, therefore, covered for individuals whose functional level is 2 or above.
- A flex-foot system (L5980), energy storing foot (L5976), multiaxial ankle/foot, dynamic response (L5979), flex-walk system or equal (L5981), or shank foot system with vertical loading pylon (L5987) is considered medically necessary and, therefore, covered for individuals whose functional level is 3 or above.

Prosthetic Knee Component

A basic lower extremity prosthesis includes a single-axis, constant friction knee. Other prosthetic knees are considered medically necessary and, therefore, covered based upon functional classification.

- A high-activity knee control frame (L5930) is considered medically necessary and, therefore, covered for individuals whose functional level is 4.
- A fluid or pneumatic knee (L5610, L5613, L5614, L5722-L5780, L5814, L5822-L5840) is considered medically necessary and, therefore, covered for individuals whose functional level is 3 or above.
- Other knee systems (L5611, L5616, L5710-L5718, L5810-L5818) are considered medically necessary and, therefore, covered for individuals whose functional level is 1 or above.

Prosthetic Ankle Component

- An axial rotation unit (L5982-L5986) is considered medically necessary and, therefore, covered for individuals whose functional level is 2 or above.

Prosthetic Sockets

- No more than two test (diagnostic) sockets (L5618-L5628) for an individual prosthesis are considered medically necessary and, therefore, covered without additional documentation. Test sockets are considered not medically necessary and, therefore, not covered for IPOPs (L5400-L5460).
- No more than two of the same socket inserts (L5654-L5665, L5673, L5679, L5681, L5683) are allowed per individual prosthesis at the same time.
- Socket replacements are considered medically necessary and, therefore, covered if there is adequate documentation of functional and/or physiological need. Documentation may include, but is not limited to, the following: changes in the residual limb; functional need changes; or irreparable wear-and-tear damage due to excessive patient weight or prosthetic demands of very active amputees.

Accessories (e.g., Stump Stockings and Harnesses)

- Accessories are considered medically necessary and, therefore, covered when they are essential to, or aid in, the effective use of the artificial limb (L5654-L5699, L5704-L5707, L7367, L7368, L8400).

Below-Knee Prosthesis

When an initial below-knee prosthesis (L5500) or a preparatory below-knee prosthesis (L5510-L5530, L5540) is provided, prosthetic substitutions and/or additions of procedures and components are considered medically necessary and, therefore, covered, in accordance with the functional level assessment, with the exception of codes L5629, L5638, L5639, L5646, L5647, L5704, L5785, L5962, and L5980, all of which will be denied as not medically necessary and, therefore, not covered.

When a below-knee preparatory prefabricated prosthesis (L5535) is provided, prosthetic substitutions and/or additions of procedures and components are considered medically necessary and, therefore, covered in accordance with the functional level assessment, with the exception of codes L5620, L5629, L5645, L5646, L5670, L5676, L5704, and L5962, all of which will be denied as not medically necessary and, therefore, not covered.

Above Knee Prostheses

When an above-knee initial prosthesis (L5505) or an above-knee preparatory prosthesis (L5560-L5580, L5590-L5600) is provided, prosthetic substitution and/or additions of procedures and components are considered medically necessary and, therefore, covered in accordance with the functional level assessment, with the exception of codes L5610, L5631, L5640, L5642, L5644, L5648, L5705, L5706, L5710-L5780, L5790-L5795, L5964, L5980, all of which will be denied as not medically necessary and, therefore, not covered.

When an above-knee preparatory prefabricated prosthesis (L5585) is provided, prosthetic substitutions and/or additions of procedures and components are considered medically necessary and, therefore, covered in accordance with the functional level assessment, with the exception of codes L5624, L5631, L5648, L5651, L5652, L5705, L5706, L5964, and L5966, all of which will be denied as not medically necessary and, therefore, not covered.

Manual Wheelchairs (05.00.12a)

COVERED: ACCORDING TO CERTAIN CRITERIA

Manual wheelchairs are components of a category of durable medical equipment (DME) known as mobility assistive equipment (MAE). MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, rolling chairs, power wheelchairs, and power operated vehicles. There is wide variability in functional status among individuals who may benefit from MAE. Providers must assess an individual's physical and psychological status, the availability of other support (i.e., the presence of a caregiver), and the physical characteristics of the individual's home (e.g., private residence/domicile, assisted living facility, long-term care facility, skilled nursing facility at a custodial level of care) to determine which type of MAE is most appropriate.

Medical Necessity Criteria for all Manual Wheelchairs

When medical necessity criteria are met, a member is eligible for **only one** of the following:

- Manual wheelchair.
- Power wheelchair.
- Power operated vehicle (POV).
- Rolling chair.

A manual wheelchair is considered medically necessary and, therefore, covered when **all** of criteria **1-5** are met **and** either criteria **6 or 7** is met:

1. The individual has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs), such as toileting, feeding, dressing, grooming, and bathing, in customary locations in the home.
 - A mobility limitation is one that:
 - Prevents the individual from accomplishing an MRADL entirely
 - Places the individual at reasonably determined heightened risk of morbidity or mortality, secondary to the attempts to perform an MRADL, or

- Prevents the individual from completing an MRADL within a reasonable time frame.
- 2. The individual’s mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- 3. The individual’s home provides adequate access between rooms, ample maneuvering space, and surfaces that enable the operation of the manual wheelchair.
- 4. The manual wheelchair will significantly improve the individual’s ability to participate in MRADLs, and the individual will use it on a regular basis in the home.
- 5. The individual has not expressed unwillingness to use the manual wheelchair in the home.

AND EITHER

- 6. The individual has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair in the home during a typical day.
 - Limitations of strength, endurance, range of motion, coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

OR

- 7. The individual has a caregiver who is available, willing, and able to provide assistance with the manual wheelchair.

Additional Medically Necessary Criteria for Specialty Manual Wheelchairs

A standard hemi-wheelchair (K0002) with a lower seat height (17 inches to 18 inches) is considered medically necessary and, therefore, covered when an individual meets **one** of the following criteria:

- The individual is of short stature.
- The individual can only place his/her feet on the ground for adequate propulsion when the wheelchair seat height is lowered.

A lightweight wheelchair (K0003) is considered medically necessary and, therefore, covered when an individual meets **all** of the following criteria:

- The individual cannot self-propel in the home with a standard manual wheelchair.
- The individual can and will self-propel in a lightweight wheelchair.

Typically, a high-strength lightweight wheelchair (K0004) is considered not medically necessary and, therefore, not covered if the expected duration of need is less than three months (e.g., postoperative recovery). A high-strength lightweight wheelchair is only considered medically necessary when the individual meets one of the following criteria:

- The individual self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.
- The individual requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight, or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

The medical necessity of an ultra-lightweight wheelchair (K0005) is determined on an individual consideration basis. Documentation for individual consideration must include a description of the individual’s routine activities and whether the individual is fully independent in the use of the wheelchair, as well as a description of the features of the K0005 base which are needed for the individual but are unavailable with the K0004 base.

A heavy-duty wheelchair (K0006) is considered medically necessary and, therefore, covered if the individual weighs more than 250 pounds or has severe spasticity.

An extra heavy-duty wheelchair (K0007) is considered medically necessary and, therefore, covered if the individual weighs more than 300 pounds.

A rolling (“rollabout”) chair (E1031) is a wheeled, reclining chair specifically designed to meet the needs of ill, injured, or otherwise impaired individuals. It must have casters of at least five inches in diameter. Rolling chairs with casters less

than five inches in diameter found in general use in homes, offices, and institutions for purposes not related to the care of ill, injured, or otherwise impaired persons are considered not medically necessary and, therefore, not covered, because they are not primarily medical in nature.

Documentation that the medical necessity criteria have been met must be present in the individual's medical record. Information must be available to the Company on request.

Wheelchair Replacement

A replacement manual wheelchair must be equivalent to the previously approved wheelchair. A replacement manual wheelchair is considered medically necessary and, therefore, covered when an individual meets **one** of the following criteria:

- There is a change in the individual's condition that requires a replacement (e.g., weight loss or gain, growth).
- The wheelchair does not function properly because it has reached or exceeded its life duration as determined by the manufacturer.

The Company may determine the reasonable useful lifetime of a specific item based on the manufacturer's recommendation or the U.S. Food and Drug Administration (FDA)-approved labeling. In the absence of the manufacturer's recommendations or FDA labeling, the Company may determine the reasonable useful lifetime of a specific item, but in no case can it be less than five years. Replacement due to wear is not covered during the reasonable useful lifetime of the item; however, the Company will cover repair up to the cost of replacement for medically necessary equipment owned by the individual.

Requests for a different type of wheelchair due to a change in medical and/or functional status such that the individual can no longer operate his/her present manual wheelchair are considered new requests, **not** requests for replacement. These requests are evaluated against the medical necessity criteria for the new type of wheelchair requested.

A customized (including for medical necessity) wheelchair to assist or replace ambulatory functions may be a contract exclusion. Individual benefits must be verified.

Not Medically Necessary

If the manual wheelchair will only be used outside the home, it is considered not medically necessary and, therefore, not covered. A manual wheelchair that is beneficial primarily in allowing the individual to perform vocational, educational, leisure, or recreational activities is considered not medically necessary and, therefore, not covered.

If the manual wheelchair will be used inside the home but the medical necessity criteria listed in this policy are not met, the wheelchair is considered not medically necessary and, therefore, not covered.

More than one wheelchair is considered not medically necessary and, therefore, not covered. Backup wheelchairs are also considered not medically necessary and, therefore, not covered. If a manual wheelchair is covered, a power wheelchair or a power operated vehicle (POV) provided at the same time is considered not medically necessary and, therefore, not covered.

A wheelchair that has been customized for purposes other than medical necessity is considered not medically necessary and, therefore, not covered. Examples of customization for purposes other than medical necessity include, but are not limited to, modification for transportation, adaptation for travel over rough terrain, and enhancement for recreational purposes.

Additional Reimbursement Information

Codes for wheelchair reimbursement include all labor charges involved in the assembly of the wheelchair, as well as support services such as emergency services, delivery, setup, education, and ongoing assistance with the use of the wheelchair.

A loaner wheelchair may be required when repair to a wheelchair requires the removal of the wheelchair from the individual for more than one day.

- When repairs are required during a **rental period**, the Company-contracted DME provider who supplied the rental wheelchair must supply a loaner wheelchair. The loaner wheelchair is **not** eligible for reimbursement.
- When a **purchased** wheelchair requires repair, one month's rental of a wheelchair is considered medically necessary and, therefore, covered.

- A loaner wheelchair should be billed using the specific code for the wheelchair being loaned.
- Requests for loaner wheelchairs for periods greater than one month are subject to review.

For individuals requiring heavy-duty or extra heavy-duty wheelchair bases, the reimbursement for reinforced back and/or seat upholstery is included in the reimbursement for the wheelchair base.

- Reinforced back and seat upholstery is not covered when used in conjunction with other manual wheelchair bases.

The following features are included in the reimbursement allowance for all adult manual wheelchairs:

- Seat width: 15 inches to 19 inches.
- Seat depth: 15 inches to 19 inches.
- Arm style: Fixed, swingaway, or detachable; fixed height.
- Footrests: Fixed, swingaway, or detachable.

Codes K0003-K0007 and E1161 include any seat height.

A wheelchair that is customized for medical necessity should be reported with the appropriate code for the wheelchair base and the appropriate code(s) for any additional wheelchair options and/or accessories. If the frame of the wheelchair is modified in a unique way to accommodate the individual, the wheelchair should be reported with the appropriate code for the wheelchair base, and the modification(s) should be reported with the code K0108 (wheelchair component or accessory, not otherwise specified).

Any replacement item should be billed using the specific wheelchair option or accessory code if one exists. If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified).

Microprocessor-Controlled Prosthetic Knees (11.14.21)

COVERED: ACCORDING TO CERTAIN CRITERIA

Following a lower limb amputation and after the appropriate healing of the surgical site, an individual may consider the use of a prosthetic leg to begin rehabilitation efforts in learning to ambulate. There are many different component types of a prosthetic limb, with more than 100 different prosthetic knee designs currently available on the market. More recently, prosthetic devices with a microprocessor-controlled knee have become available. These instruments are equipped with a sensor that can detect when the knee is in full extension and will automatically adjust the swing phase of the individual's gait, allowing for a more natural walking pattern at varying speeds.

For members enrolled in all commercial products, the microprocessor-controlled knee prosthesis is considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of the device cannot be established by a review of the available published literature.

For members enrolled in Medicare Advantage products, the microprocessor-controlled knee prosthesis is considered medically necessary and, therefore, covered as a component fitting in a lower limb prosthesis when **all** of the following criteria are met:

- The individual is motivated to ambulate.
- The individual will reach and maintain a defined functional state within a reasonable period of time.
- The individual has high mobility and stance stability needs and is at a **functional level of 3 or above** according to Medicare's classification scale of patient potential functional ability as described below:
 - Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance their quality of life or mobility. (Modifier K0).

- Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator. (Modifier K1).
- Level 2: Has the ability or potential for prosthetic ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator. (Modifier K2).
- Level 3: Has the ability or potential for prosthetic ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion. (Modifier K3).
- Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demand of the child, active adult, or athlete. (Modifier K4).

Negative Pressure Wound Therapy (NPWT) Pump (05.00.38a)

COVERED: ACCORDING TO CERTAIN CRITERIA

Negative pressure wound therapy (NPWT), also known as vacuum-assisted closure, is the application of controlled negative pressure (vacuum pressure) to a wound using an electrical pump. The NPWT vacuum pressure pump is used to apply from 25 mm to greater than 200 mm Hg of pressure to a wound, either continuously or intermittently.

Medical Necessity

A negative pressure wound therapy (NPWT) pump and the supplies necessary for its use are considered medically necessary for chronic nonhealing wounds (of at least 30 days duration) as specified below when all of the following applicable conditions are met:

- For chronic nonhealing ulcers or wounds, all of the following program measures should apply or be considered and ruled out by an eligible health care professional prior to the application of a NPWT pump:
 - Any wound specific therapeutic measures.
 - Documentation in the individual’s medical record of the evaluation, wound measurements (length, depth, and width) and general care performed and documented by a health care professional.
 - Wound assessments are performed and documented at least weekly (e.g., size [length, depth, and width], color, exudate type and amount, odor, evidence of healing, sinus tracking or tunneling, pain, type of dressing used).
 - Application of dressings to maintain a moist wound environment.
 - Debridement of necrotic tissue (if present) by a health care professional.
 - Evaluation of and provision for adequate nutritional status.
- The following wound-specific therapeutic measures (if applicable) must be applied or considered and ruled out by an eligible health care professional prior to the application of a NPWT pump for the following specific types of ulcers and wounds:
 - Stage III or IV pressure ulcers:
 - o The individual has been appropriately turned and positioned.
 - o The individual has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis. (A group 2 or 3 support surface is not required if the ulcer is not on the trunk or pelvis. For more information on support surfaces, refer to the policy addressing this topic.)
 - o The individual’s moisture and incontinence have been appropriately managed.
 - For neuropathic (e.g., diabetic) ulcers:
 - o The individual has been on a comprehensive diabetic management program.

- o The individual has experienced reduced pressure on a foot ulcer as a result of using the appropriate modalities (such as, but not limited to, the following: total contact casts; removable cast walkers; half shoes; saline wet-to-dry dressings; debridement of all necrotic, callus, and fibrous tissue; crutches).

– For venous insufficiency ulcers:

- o The individual has had compression bandages and/or garments consistently applied.
- o The individual has applied leg elevation.
- o The individual has applied ambulation.

- For complications of surgical, subacute or traumatic wounds (e.g., postoperative flap, dehiscence, skin graft failure, traumatic amputation, gunshot wounds or burns) when accelerated granulation tissue formation cannot be achieved by topical wound treatments and is a medical necessity as demonstrated by documentation of conditions such as, but not limited to, any of the following:

- The presence of excessive wound drainage.
- Large wounds not amenable to primary closure.
- Conditions that slow healing times (e.g., diabetes).
- Infection.
- The wound is a chronic and nonhealing wound of at least 30 days duration.

Initial NPWT pump treatments may begin during an inpatient stay for wounds encountered in the inpatient setting. Treatment with the NPWT pump beyond the inpatient stay may continue (upon discharge) in the home setting, subject to meeting the above medical necessity criteria.

Continued Coverage

For continuing coverage of up to four months, an eligible health care professional must:

- Directly assess the wound(s) being treated with the NPWT pump device and document findings.
- Supervise or directly perform the NPWT pump dressing changes and document findings.

- Document changes in the ulcer’s dimensions and characteristics (e.g., size [length, depth, and width], color, exudate type and amount, odor, and evidence of healing) at least weekly.

For continued coverage beyond four months, continued documentation demonstrating wound healing is required and will be evaluated by a Company medical director.

Not Medically Necessary

Treatment with an NPWT pump and supplies is considered not medically necessary when:

- Adequate wound healing has occurred.
- Any measurable degree of wound healing has failed to occur over the prior month.
- Cancer is present in the wound.
- The equipment or supplies are no longer being used for the individual, regardless of whether it is a result of the health care professional’s orders.
- The eligible health care professional fails to perform and document the following on a weekly basis:
 - Direct assessment of the wound(s) being treated with the NPWT pump.
 - Supervision or directly performing the ulcer/wound dressing changes.
 - Document changes in the ulcer’s dimensions (length, depth, and width) at least weekly.
- Necrotic tissue with eschar is present if debridement has not been attempted.
- There is a fistula to an organ or body cavity within the vicinity of the wound.
- Untreated osteomyelitis exists within the vicinity of the wound.

Supplies for NPWT

An individual is eligible for a maximum of 15 wound care sets (A6550) per wound per month, unless there is documentation that the wound size requires more than one wound care set for each dressing change. An individual is eligible for a maximum of 10 canisters (A7000) per month, unless there is documentation evidencing a large volume of drainage (90 ml of exudate/day).

An NPWT pump (E2402) must be capable of accommodating more than one wound dressing set for multiple wounds on an individual. Therefore, more than one E2402 billed per individual for the same time period will be denied as not medically necessary.

Paravertebral Facet Joint Nerve Block (11.15.17)

COVERED: ACCORDING TO CERTAIN CRITERIA

A paravertebral facet joint nerve block may be employed for either a diagnostic or therapeutic purpose. An affected individual typically presents with chronic cervical, thoracic, lumbar, or sacral pain that is absent a strong radicular component; associated neurologic deficits are not observed.

- A diagnostic paravertebral facet joint nerve block is medically necessary when there is suspicion that spinal mechanical (non-radicular) pain is caused by the facet joint nerve. This type of presentation may be seen in disorders such as, but not limited to, degenerative disk disease, post-laminectomy syndrome, and failed spine surgery syndrome. This diagnostic test will provide the following information:
 - The assessment of the relative contribution of sympathetic and somatosensory nerves in relation to the pain syndrome.
 - The localization of nerve(s) responsible for the pain or neuromuscular dysfunction, particularly when multiple sources of pain are potentially present.
- A therapeutic paravertebral facet joint nerve block is medically necessary when provided for the management of chronic (three months or longer) mechanical neck/back pain in the cervical, thoracic, or lumbar spine; an anesthetic or corticosteroid substance, or both, may be injected. After confirmation by a diagnostic paravertebral facet joint nerve block, up to four therapeutic injections per level, per side, per year may be approved.

There are no guidelines to support the use of more than four therapeutic injection sessions per level, per side, per year. Additionally, there is little scientific evidence to support a long-term plan of multiple nerve blocks over the course of weeks or months for chronic pain management. Requests in excess of four therapeutic

injections per level, per side, per year should include the following information for review by a medical director: the individual's pain history, including the precipitating factors; the site of injection; the name and dosage of the agent previously injected; the duration of the individual's response to previous injections; the length of time since the last injection; and the physician's plan for long-term pain management.

Power Wheelchairs and Power Operated Vehicles (05.00.54a)

COVERED: ACCORDING TO CERTAIN CRITERIA

Power wheelchairs and power operated vehicles (POVs [scooters]) are devices used to assist individuals in their mobility-related activities of daily living (MRADLs) in the home. POVs are primarily used by individuals who have mobility limitations that cannot be resolved by use of a cane, walker, or manual wheelchair but who do not require the seating and electronic capabilities of a power wheelchair. Power wheelchairs are battery-operated devices used by individuals, including the pediatric population, who are typically nonambulatory and have severe impairment of the upper extremities due to a neurologic or musculoskeletal disease/condition. Power wheelchairs typically have two drive wheels and two or four casters, basic or specialized seating, and may be controlled by a variety of electronic options.

Requests for powered mobility assistive equipment (e.g., POVs and power wheelchairs) are initially evaluated against the medical necessity criteria for a POV. If the request does not meet the medical necessity criteria for a POV, the request will then be evaluated against the medical necessity criteria for a power wheelchair.

When medical necessity criteria are met, a member is eligible for only one of the following:

- Manual wheelchair.
- Power wheelchair.
- POV.
- Rolling chair.

Medical Necessity Criteria for Powered Mobility Assistive Equipment

POVs

A POV is considered medically necessary and, therefore, covered when ALL of the following criteria are met:

1. The individual has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs, such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.
 - A mobility limitation is one that:
 - Prevents the individual from accomplishing an MRADL entirely, or
 - Places the individual at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL, or
 - Prevents the individual from completing an MRADL within a reasonable time frame.
2. The individual's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
3. The individual does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.
 - Limitations of strength, endurance, range of motion, coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
 - A wheelchair is considered optimally-configured when the wheelbase, device weight, seating options, and all nonpowered accessories are appropriate for the individual's needs.
4. The individual has sufficient strength, postural stability, and other physical and mental capabilities needed to safely operate a POV in the home.
5. The individual's home provides adequate access between rooms, ample maneuvering space, and surfaces that enable the operation of the POV.

6. The POV will significantly improve the individual's ability to participate in MRADLs, and the individual will use it on a regular basis in the home.
7. The individual has not expressed unwillingness to use the POV in the home.

Power Wheelchairs

A power wheelchair is considered medically necessary and, therefore, covered if **all** of criteria **1-6** are met, **and** either criteria **7 or 8** is met, **and** either criteria **9 or 10** is met:

1. The individual has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs, such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.
 - A mobility limitation is one that:
 - Prevents the individual from accomplishing an MRADL entirely, or
 - Places the individual at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL, or
 - Prevents the individual from completing an MRADL within a reasonable time frame.
2. The individual's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
3. The individual does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.
 - Limitations of strength, endurance, range of motion, coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
 - A wheelchair is considered optimally-configured when the wheelbase, device weight, seating options, and all nonpowered accessories are appropriate for the individual's needs.
4. The individual's home provides adequate access between rooms, ample maneuvering space, and surfaces that enable the operation of the power wheelchair.

5. The power wheelchair will significantly improve the individual's ability to participate in MRADLs, and the individual will use it on a regular basis in the home.
6. The individual has not expressed unwillingness to use the power wheelchair in the home.

AND EITHER

7. The individual does not have sufficient strength, postural stability, and other physical and mental capabilities needed to safely operate a POV in the home.

OR

8. The individual's home does not provide adequate access between rooms, ample maneuvering space, and surfaces that enable the operation of a POV with a small turning radius.

AND EITHER

9. The individual has the mental and physical capabilities to safely operate the power wheelchair.

OR

10. The individual has a caregiver who is unable to adequately propel an optimally-configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair.

Documentation that the medical necessity criteria have been met must be present in the individual's medical record. Information must be available to the Company on request.

Replacement of Power Wheelchairs and POVs

A replacement power wheelchair or POV must be equivalent to the previously approved wheelchair or POV. A replacement power wheelchair or POV is considered medically necessary and, therefore, covered when an individual meets one of the following criteria:

- There is a change in the individual's condition that requires a replacement (e.g., weight loss or gain, growth).
- The wheelchair or POV does not function properly because it has reached or exceeded its life duration as determined by the manufacturer.

The Company may determine the reasonable useful lifetime of a specific item based on the manufacturer's recommendation or the U.S. Food and Drug Administration (FDA)-approved labeling. In the absence of the manufacturer's recommendations or FDA labeling, the Company may determine the reasonable useful lifetime of a specific item, but in no case can it be less than five years. Replacement due to wear is not covered during the reasonable useful lifetime of the item; however, the Company will cover repair up to the cost of replacement for medically necessary equipment owned by the individual.

Requests for a different type of wheelchair or POV due to a change in medical and/or functional status such that the individual can no longer operate his/her present wheelchair or POV are considered new requests, not requests for replacement. These requests are evaluated against the medical necessity criteria for the type of wheelchair or POV requested.

A customized (including for medical necessity) power wheelchair or POV to assist or replace ambulatory functions may be a contract exclusion. Individual benefits must be verified.

Not Medically Necessary

If the power wheelchair or POV will only be used outside the home, it is considered not medically necessary and, therefore, not covered. A power wheelchair or a POV that is beneficial primarily in allowing the individual to perform vocational, educational, leisure, or recreational activities is considered not medically necessary and, therefore, not covered.

If the power wheelchair or POV will be used inside the home but the medical necessity criteria listed in this policy are not met, the power wheelchair or POV is considered not medically necessary and, therefore, not covered.

More than one wheelchair or POV is considered not medically necessary and, therefore, not covered. Backup wheelchairs are also considered not medically necessary and, therefore, not covered. If a POV is covered, a manual or power wheelchair provided at the same time or subsequently is considered not medically necessary and, therefore, not covered.

A power wheelchair or POV that has been customized for purposes other than medical necessity is considered not medically necessary and, therefore, not covered. Examples of customization for purposes other than medical necessity include adaptation for transportation, addition of computer chips, and wheelchairs that climb stairs or have been modified to travel over rough terrain or for recreational purposes.

Additional Reimbursement Information

Codes for reimbursement of mobility assistive equipment (e.g., power wheelchairs and POVs) include all labor charges involved in the assembly of the equipment, as well as support services such as emergency services, delivery, setup, education, and ongoing assistance with use of the wheelchair.

A loaner wheelchair or POV may be required when repair to a power wheelchair or POV requires removal of the item from the individual for more than one day.

- When repairs are required during a rental period, the Company-contracted durable medical equipment (DME) provider who supplied the rental wheelchair or POV must supply a loaner wheelchair or POV. The loaner wheelchair or POV is not eligible for reimbursement.
- When a purchased wheelchair or POV requires repair, one month’s rental of a wheelchair or POV is considered medically necessary and, therefore, covered.
- A loaner wheelchair or POV should be billed using the specific code for the wheelchair or POV being loaned.
- Requests for loaner wheelchairs or POVs for periods greater than one month are subject to review.

The allowance for a power wheelchair or POV includes all options and accessories that are provided at the time of initial issue including, but not limited to, batteries, battery chargers, and seating systems. If an option or accessory provided at the time of initial issue is billed separately, it must be coded A9900 (miscellaneous DME supply, accessory and/or service component of another HCPCS code).

The following standard features are included in the reimbursement allowance for K0010-K0012 and K0014 power wheelchair bases:

- Seat width: 15 inches to 19 inches.
- Seat depth: 15 inches to 19 inches.
- Arm style: Fixed, swingaway, or detachable; fixed height.
- Footrests: Fixed, swingaway, or detachable.
- A battery charger is included in the reimbursement for a power wheelchair base. A battery charger should be billed separately only when it is a replacement.

A power wheelchair with a seat width and/or depth of 14 inches or less (E1239) is considered a pediatric power wheelchair.

A lightweight, portable power wheelchair (K0012) is characterized by:

- Weight less than 80 pounds with back and seat but without frontriggings or battery.
- Folding back or collapsible frame.

Code K0014 is used for a power wheelchair base if it has a weight capacity of greater than or equal to 350 pounds and programmable control parameters.

Codes K0010-K0014 should not be used for manual wheelchairs with add-on power packs. To report a manual wheelchair with an add-on power pack, use the appropriate code for the manual wheelchair base provided (K0001-K0009) and code E0983 (manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control).

Code E1230 should be used only for POVs that can be operated inside the home. Code E1230 is not to be used for a manual wheelchair with an add-on tiller control power pack. To report a manual wheelchair with an add-on tiller control power pack, use the appropriate code for the manual wheelchair base provided (K0001-K0009) and code E0984 (manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control).

A wheelchair that is customized for medical necessity should be reported with the appropriate code for the wheelchair base and the appropriate code(s) for any additional wheelchair options and/or accessories. Refer to the policy on wheelchair options and accessories for more information on the medical necessity criteria and appropriate codes for these features. If the frame of the wheelchair is modified in a unique way to accommodate the individual, the wheelchair should be reported with the appropriate code for the wheelchair base, and the modification(s) should be reported with the code K0108 (wheelchair component or accessory, not otherwise specified).

Any replacement item (including replacement batteries) should be billed using the specific wheelchair option or accessory code if one exists; refer to the policy on wheelchair options and accessories for more information. If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified).

Pressure Reducing Support Surfaces (05.00.60a)

COVERED: ACCORDING TO CERTAIN CRITERIA

A pressure reducing support surface is a device (i.e., overlay, mattress, bed) that reduces or eliminates tissue interface pressure to help prevent ulcer formation in individuals who are bedbound. The device conforms to the contours of the body so that the pressure, distributed over a larger surface area, is reduced or eliminated.

Pressure reducing support surfaces are considered medically necessary for individuals who are at high risk for developing or have developed pressure ulcers. The medical necessity criteria for each device group is defined below.

Group 1

Group 1 codes (A4640, E0180-E0183, E0184-E0189, E0196-E0199) include the following:

A nonpowered overlay is considered medically necessary when one of the following criteria is met:

- The individual is completely immobile (i.e., cannot make changes in body position without assistance).
- The individual experiences any of the following: altered sensory perception, compromised circulatory status, impaired nutritional status, and/or incontinence (urinary or fecal) along with one of the following:
 - Limited mobility (i.e., cannot independently make changes in body position significant enough to alleviate pressure).
 - A pressure ulcer (any stage) on the trunk or pelvis.

A powered overlay is considered medically necessary when the individual meets the criteria for a nonpowered overlay and bottoms out on a nonpowered overlay.

A nonpowered mattress is considered medically necessary when the individual meets the criteria for a nonpowered overlay and bottoms out on a powered and a nonpowered overlay.

Group 2

A Group 2 support surface is considered medically necessary when the individual meets one of the following criteria:

- The individual has multiple stage II pressure ulcers on their trunk or pelvis when:
 - They have been on a comprehensive wound treatment program, including an appropriate Group I support surface, for four weeks duration and the ulcer is not healing or has worsened over the four weeks.
- The individual has large or multiple stage III or IV ulcer(s) on their trunk or pelvis.
- The individual received a myocutaneous flap or skin graft within the past 60 days to treat a pressure ulcer on their trunk or pelvis and was on a Group 2 or 3 support surface within the past 30 days prior to being discharged from a hospital or nursing facility.
 - Coverage is generally limited to 60 days from the date of surgery.

Group 2 codes (E0193, E0277, E0371-E0373) include the following:

An advanced nonpowered overlay is considered medically necessary when the individual meets the criteria for a Group 2 support surface.

An advanced nonpowered mattress is considered medically necessary when the individual meets the criteria for an advanced nonpowered overlay and bottoms out on an advanced nonpowered overlay and nonpowered mattress.

A powered mattress is considered medically necessary when the individual meets the criteria for an advanced nonpowered mattress and bottoms out on an advanced nonpowered overlay and advanced nonpowered mattress.

A low-air-loss bed is considered medically necessary when the individual meets the criteria for a powered mattress and bottoms out on an advanced nonpowered overlay, an advanced nonpowered mattress, and a powered mattress.

Continued use of a Group 2 support surface is considered medically necessary when either one of the following applies:

- Until the ulcer is healed.
- If healing does not continue, the treating physician documents that the continued use of a Group 2 support surface is medically necessary for wound management, and the care plan is adjusted to promote wound healing.

Group 3

Group 3 code: E0194

An air-fluidized bed is considered medically necessary when all other alternative equipment has been considered and ruled out and the individual meets all of the following criteria:

- The individual is bedridden or chair bound as a result of severely limited mobility.
- The individual has stage III or IV pressure ulcer(s).
- The individual has failed Group II support surfaces (i.e., after more than four weeks, the ulcer(s) is/are worsening or not healing).
- The air-fluidized bed was prescribed: by the treating physician after a comprehensive assessment and evaluation; within one month of a request to initiate a Group 3 support surface; and after a course of conservative treatment of at least one month that is designed to optimize wound healing, and includes all of the following:
 - Frequent repositioning of the individual to relieve pressure over bony prominences (usually every two hours).
 - Any necessary treatment to resolve any existing wound infection.
 - Optimization of nutritional status to promote wound healing.
 - Debridement by any means (including wet-to-dry gauze dressings), if needed, to remove devitalized tissue from the wound bed.
 - Maintenance of a clean, moist bed of granulating tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals.

- A physician-directed, home treatment regimen that includes a monthly re-evaluation of the need for an air-fluidized bed.
- The individual would require institutionalization in the absence of an air-fluidized bed.
- The individual's home environment can accommodate the equipment.
- A trained adult caregiver is able and willing to provide the type of care the individual requires with the use of an air-fluidized bed (e.g., assistance with activities of daily living, repositioning, dietary needs, fluid balance, skin care, prescribed treatments, recognition and management of altered mental status) and in use/management of the air-fluidized bed and its problems such as leakage.
- The individual has no contraindications related to the use of an air-fluidized bed (e.g., coexisting pulmonary disease [the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions]).

Reduction Mammoplasty (11.08.02c)

COVERED: ACCORDING TO CERTAIN CRITERIA

Reduction mammoplasty is a surgical procedure that excises a portion of the breast, including the skin and underlying glandular tissue to reduce the size, shape, and weight of mammary tissue. In some selected cases (e.g., when the breasts are not too large and the skin has good elasticity), liposuction can be utilized. However, in most cases, only fat, not glandular breast tissue can be successfully removed by liposuction.

For all products except Medicare Advantage, the following criteria are applicable:

Reduction mammoplasty is considered medically necessary and, therefore, covered when all of the following medical necessity criteria are met:

- An individual has macromastia (enlargement of the breasts) or gigantomastia.

- Clinical symptoms of breast, neck, back, or shoulder pain, or painful shoulder grooving are present for a minimum six-week period and have not responded to conservative measures (e.g., support bra, exercises, heat/cold treatment, non-steroidal anti-inflammatory drugs (NSAIDs)/muscle relaxants).
- The individual meets the minimum specimen weight of breast tissue to be removed based on the individual's body surface area (BSA).
 - Simplified formula for calculation of body surface area:
BSA (in m²) = [height (cm)]^{0.718} X [weight (kg)]^{0.427} X .007449
- Any individual 40 years of age or older is required to have a mammogram which is negative for cancer within the year prior to the planned surgery.

When a request is made for reduction mammoplasty, photographs documenting breast size are required.

For Medicare Advantage Members only, the following criteria are applicable:

Reduction mammoplasty is considered reconstructive surgery and medically necessary for symptomatic individuals with macromastia when all of the following criteria are met:

- The individual has significant symptoms that interfere with normal daily activities, including **at least one** of the following:
 - Symptomatic neck, back, or shoulder pain not related to other causes (e.g., poor posture, acute strains, poor lifting techniques).
 - Significant breast pain.
 - Brachial plexus irritation.
 - Clinical, nonseasonal submammary intertrigo.
 - Medicare requires that hypertrophy of breast (611.1) be reported as the primary diagnosis, with one of the following clinical conditions reported as a secondary diagnosis:
 - o Other specified erythematous condition (695.89).
 - o Pain in joint, shoulder region (719.41).
 - o Cervicalgia (723.1).

- o Unspecified musculoskeletal disorders and symptoms referable to neck (723.9).
- o Pain in thoracic spine (724.1).
- o Unspecified backache (724.5).
- o Unspecified osteoporosis (733.00).
- o Senile osteoporosis (733.01).
- o Kyphosis (acquired) (postural) (737.10).
- The amount of breast tissue anticipated to be removed is at least 350 grams per breast.
- Conservative treatment has failed. Examples of conservative treatment include, but are not limited to:
 - Appropriate support bra.
 - Conservative analgesia (NSAIDs).
 - In individuals where obesity is a documented risk factor, a legitimate, medically-based attempt to reduce and maintain weight (e.g., diet, exercise).
 - Appropriate medical management of intertrigo.

Requests for reduction mammoplasty that do not meet medical necessity criteria are considered cosmetic, and therefore are not covered.

Revision of Nonkeloidal, Nonhypertrophic Scars (Simple Scars) (11.08.11b)

COVERED: ACCORDING TO CERTAIN CRITERIA

Scars are a result of the healing process of the skin after a break in the integumentary system whether intentional (as a result of surgery or treatment of disease) or accidental (as a result of trauma). Scars are classified as simple, hypertrophic, or keloidal. Scars can be improved either medically or surgically, and various treatments and techniques differ in success and efficacy.

Under most circumstances, scar revision is a cosmetic service and benefit contract exclusion; however, the revision of nonkeloidal, nonhypertrophic scars is medically necessary in clinical situations when any one of the following criteria are met:

- The scar causes a functional impairment, and scar revision will correct the impairment (e.g., the individual has restricted range of motion due to the scar).

- The scar causes chronic pain that requires the use of analgesic medication, which is documented in the individual's medical record.
- The revision is part of a global reconstructive plan that follows surgery or trauma.
 - Reconstructive treatment is defined as any medical or surgical service designed to restore (normal) bodily function or to correct a deformity that has resulted from surgery or trauma.

All requests for scar revision require review by the Company's Cosmetic Review Team and must include a color photograph and a letter of medical necessity.

Trigger Point Injections (11.14.02c)

COVERED: ACCORDING TO CERTAIN CRITERIA

Trigger point injection is one of many modalities utilized in the management of chronic pain. Myofascial trigger points are self-sustaining hyperirritative foci that may occur in any skeletal muscle in response to strain produced by acute or chronic overload.

Trigger point injections are considered medically necessary and, therefore, covered when performed for myofascial pain syndrome (MPS) when at least one of the following situations is present:

- Noninvasive medical management (e.g., analgesics, passive physical therapy, ultrasound therapy, range of motion, and/or active exercises) is unsuccessful.
- Joint movement is mechanically blocked, as when the coccygeus muscle is involved.

Trigger point injections are appropriate when administered to any of the following body regions:

- Head.
- Cervical spine.
- Left upper extremities, including shoulder.
- Right upper extremities, including shoulder.
- Left lower extremities, including hip.
- Right lower extremities, including hip.
- Thoracic spine (including the trapezius and scapular areas).
- Lumbosacral spine.

When a given region is injected, it is considered one injection service, regardless of the number of injections administered within that region.

- It is expected that this procedure would not be performed on more than three body regions on a given date of service.
- Trigger point injections for a specific body region should not be performed more frequently than once a month.
 - Requests for more frequent injections require additional documentation of medical necessity.

Medications listed in the coding table are eligible for separate reimbursement when used for trigger point injections that meet the medical necessity criteria listed in this policy.

- Additional reimbursement will not be made for the injection of water, saline, or local anesthetics.

Dry needling of trigger points is considered medically necessary and, therefore, covered. The medical necessity criteria for dry needling of trigger points are the same as those for trigger point injections.

Wheelchair Cushions and Seating (05.00.55a)

COVERED: ACCORDING TO CERTAIN CRITERIA

A cushion may be manufactured from a single product (e.g., gel, air, foam) or a combination of products. The determination as to which cushion/seating surface an individual chooses is related to what is medically necessary for maintaining or providing for that individual's comfort, skin integrity, pressure relief and/or positional support. Therefore, seat or back cushions are classified as general use cushions, skin protection cushions, positioning cushions, skin protection and positioning cushions, or custom fabricated cushions.

Seat and back cushion items, including positioning accessories, are only considered medically necessary for individuals who meet both the medical necessity criteria for a wheelchair and the medical necessity criteria for the item. If the seat/back cushion, or positioning accessory does not meet medical necessity criteria it is considered not medically necessary and, therefore, not covered.

Medically Necessary Cushions and Seating Items

General Use Seat Cushions and Back Cushions

General use seat cushions (E2601, E2602) and back cushions (E2611, E2612) are medically necessary when an individual meets all of the medical necessity criteria for these items and has a wheelchair.

Nonadjustable Skin Protection Seat Cushions and Adjustable Skin Protection Seat Cushions

A nonadjustable skin protection seat cushion (E2603, E2604) or an adjustable skin protection seat cushion (K0108, K0734, K0735) is medically necessary when an individual meets all of the medical necessity criteria for a wheelchair in addition to all of the following medical necessity criteria:

- The individual has a pressure ulcer or history of a pressure ulcer that was/is located on an area of their body that makes contact with the seating surface.
- The individual experiences absent or impaired sensation in the area where their body makes contact with the seating surface or is unable to carry out a functional weight shift due to one of the following:
 - Alzheimer's disease.
 - Anterior horn cell disease, including amyotrophic lateral sclerosis.
 - Cerebral palsy.
 - Childhood cerebral degeneration.
 - Multiple sclerosis.
 - Other demyelinating disease.
 - Parkinson's disease.
 - Post-polio paralysis.
 - Spina bifida.
 - Spinal cord injury.
 - Traumatic brain injury, resulting in quadriplegia.

Positioning Seat Cushions, Back Cushions, and Accessories

A positioning seat cushion (E2605, E2606), positioning back cushion (E2613, E2614, E2615, E2616, E2620, E2621), and positioning accessory (E0955, E0956, E0957, E0977, E0960, E0980) are medically necessary when the individual meets all of the medical necessity criteria for a wheelchair and has significant postural asymmetries due to one of the following:

- Alzheimer’s disease.
- Anterior horn cell disease, including amyotrophic lateral sclerosis.
- Cerebral palsy.
- Childhood cerebral degeneration.
- Hemiplegia due to stroke, traumatic brain injury, or other etiology.
- Monoplegia of the lower limb.
- Multiple sclerosis.
- Muscular dystrophy.
- Other demyelinating disease.
- Parkinson’s disease.
- Post-polio paralysis.
- Spina bifida.
- Spinal cord injury.
- Spinocerebellar disease.
- Torsion dystonia.
- Traumatic brain injury, resulting in quadriplegia.

Nonadjustable Combination Skin Protection and Positioning Seat Cushions and Adjustable Combination Skin Protection and Positioning Seat Cushions

A nonadjustable combination skin protection and positioning seat cushion (E2607, E2608) or adjustable combination skin protection and positioning seat cushion (K0108, K0736, K0737) is medically necessary when the individual meets all of the medical necessity criteria for a wheelchair in addition to all of the criteria for both a skin protection seat cushion and a positioning seat/back cushion.

Custom Fabricated Seat Cushions

A custom fabricated seat cushion (E2609) is medically necessary when the individual meets all of the medical necessity criteria for a wheelchair in addition to all of the following criteria:

- The individual meets all of the medical necessity criteria for a prefabricated skin protection seat cushion or positioning seat cushion.
- A clinician provided a written evaluation that clearly explains why a prefabricated system is not sufficient to meet the individual’s seating and positioning needs.

Custom Fabricated Back Cushions

A custom fabricated back cushion (E2617) is medically necessary when the individual meets all of the medical necessity criteria for a wheelchair in addition to all of the following criteria:

- The individual meets all of the criteria for a prefabricated positioning back cushion.
- A clinician provided a written evaluation that clearly explains why a prefabricated system is not sufficient to meet the individual’s seating and positioning needs.

Headrests

A headrest (E0955, E0966) is medically necessary when an individual has a covered manual tilt-in-space, manual semi/fully reclining back, or power tilt and/or recline power seating system.

Not Medically Necessary Cushion and Seating Items

The effectiveness of a powered wheelchair seat cushion (E2610) has not been established; therefore, it is considered not medically necessary and is not covered.

A seat/back cushion that is provided for use with a transport chair will be denied as not medically necessary.

Additional Reimbursement Considerations

A loaner wheelchair seat and/or back cushion may be required when a wheelchair seat and/or back cushion needs repair and must be removed from the individual for more than a day. In this case, the following guidelines apply:

- When repairs are required during a **rental period**, the Company-contracted durable medical equipment (DME) provider who supplied the rental wheelchair seat and/or back cushion must supply the loaner wheelchair seat and/or back cushion. The loaner wheelchair seat and/or back cushion is not eligible for reimbursement.
- When a **purchased** wheelchair seat and/or back cushion requires repair, a one-month wheelchair seat and/or back cushion rental is considered medically necessary.
- A loaner wheelchair seat and/or back cushion should be billed using the specific code for this item.

A seat cushion solid support base (E2618) with mounting hardware is eligible for separate reimbursement when it is used on an adult manual wheelchair or lightweight power wheelchair. There is no separate reimbursement when this is used with other types of power wheelchairs because those wheelchairs include a solid seat support base.

A solid base is included in the allowance for a wheelchair seat/back cushion; therefore, a solid insert that is used with a seat/back cushion is not eligible for separate reimbursement.

Mounting hardware for a seat/back cushion is not eligible for separate reimbursement.

If a wheelchair seat/back cushion is billed for use with a rollabout chair, it will be denied as not separately reimbursable.

A captain's seat headrest (E0955, E0966) on a power wheelchair is not eligible for separate reimbursement.

Repair and Replacement

The replacement of a wheelchair cushions/seating item is medically necessary when one of the following criteria is met:

- There is a change in the individual's condition that requires a replacement (e.g., weight loss or gain, growth).
- The item does not function properly because it has reached or exceeded its life duration as determined by the manufacturer.

The Company may determine the reasonable useful life duration of a specific item based on the manufacturer's recommendation or the U.S. Food and Drug Administration (FDA)-approved labeling. In the absence of the manufacturer's recommendations or FDA labeling, the Company may determine the reasonable useful life duration of a specific item, but in no case can it be less than five years. Replacement due to wear is not covered during the reasonable useful life duration of the equipment; however, the Company will cover repair up to the cost of replacement for medically necessary equipment owned by the individual.

A customized item (including for medical necessity) may be a contract exclusion. Individual benefits must be verified.

Wheelchair Options and Accessories (05.00.67)

COVERED: ACCORDING TO CERTAIN CRITERIA

Wheelchair options and accessories are a type of durable medical equipment (DME) used with mobility assistive equipment (MAE), such as manual wheelchairs, power wheelchairs, and power operated vehicles (POVs).

Wheelchair options and accessories may be essential for the functionality of the MAE; they may also be medically necessary for the user's safety and/or ability to perform mobility-related activities of daily living (MRADLs) in the home. MRADLs such as toileting, feeding, dressing, grooming, and bathing customarily take place in specific locations in the home. Mobility limitations may impact the individual's ability to participate in MRADLs in their customary locations within the home and/or perform them in a timely and safe manner. The use of MAE, including options and accessories, may be appropriate to facilitate performance of MRADLs in the home.

Options and accessories for wheelchairs are medically necessary for an individual who has a wheelchair that meets Company coverage criteria and the option/accessory itself is medically necessary.

Also, for certain accessories, additional medical necessity criteria applies. These accessories include:

- Arm of chair:
 - Adjustable arm height option (E0973, K0017, K0018, K0020) is medically necessary when the individual requires an arm height that is different than that available height using nonadjustable arms and the individual spends at least two hours per day in the wheelchair.
 - An arm trough (E2209) is medically necessary when the individual has quadriplegia, hemiplegia, or uncontrolled arm movements.
- Elevating legrests (E0990, K0046, K0047, K0053, K0195) are medically necessary when any one of the following criteria is met:
 - The individual has a musculoskeletal condition or a cast or brace that prevents 90 degree flexion at the knee.
 - The individual has significant edema of the lower extremities that requires having an elevating legrest.

- The individual meets the criteria for and has a reclining back on the wheelchair.
- Nonstandard seat frame dimensions:
 - A nonstandard seat width and/or depth (E2201-E2204, E2340-2343) is medically necessary only if the individual's dimensions justify the need.
- Batteries:
 - Up to two batteries (E2361, E2363, E2365, E2371) at any one time are medically necessary if required for a power wheelchair.
- Power wheelchair drive control systems:
 - An attendant control (E2331) is medically necessary in place of a standard drive control system when the individual meets the medical necessity criteria for a wheelchair, 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.
- Other power wheelchair accessories:
 - An electronic interface (E2351) that operates a speech generating device using a power wheelchair control interface is medically necessary when the individual has a medically necessary speech generating device.
- Miscellaneous accessories:
 - An anti-rollback device (E0974) is medically necessary when the individual propels himself/herself and needs the device because of ramps.
 - A safety belt/pelvic strap (E0978) is medically necessary when the individual has weak upper body muscles, upper body instability, or muscle spasticity, which require the use of this item for proper positioning.
 - One example (not all-inclusive) of a medically necessary indication for swingaway, retractable, or removable hardware (E1028) would be to move the component out of the way so that an individual could perform a transfer to a chair or bed.
 - A manual, fully reclining back (E1226) is medically necessary when the individual has one or more of the following conditions:
 - o The individual is at high risk for developing a pressure ulcer and is unable to perform a functional weight shift.

- o The individual utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.

Not Medically Necessary

An option/accessory that is beneficial primarily in allowing the individual to perform leisure or recreational activities is considered not medically necessary and, therefore, not covered.

A nonsealed battery (E2360, E2362, E2364, E2372) is considered not medically necessary and, therefore, not covered.

A dual-mode battery charger (E2367) is considered not medically necessary and, therefore, not covered.

If an attendant control (E2331) is provided in addition to a patient-operated drive control system, it will be denied as not medically necessary and considered not covered.

An electronic interface (K0108) used to control lights or other electrical devices is not medically necessary because it is not primarily medical in nature. Therefore, this device is not covered.

Not Primarily Medical in Nature (Benefit Contract Exclusion)

The following items are not primarily medical in nature (benefit exclusions) and, therefore, not covered: power seat elevation system (E2300) and power standing system (E2301). Power seat elevators that are included as standard features on a power wheelchair are also not primarily medical in nature (benefit exclusions) and, therefore, not covered. If a wheelchair has an electrical connection device described by code E2310 or E2311 and if the sole function of the connection is for a power seat elevation or power standing feature, it will be considered not primarily medical in nature (benefit exclusion) and, therefore, not covered.

Additional Reimbursement Information

Codes for wheelchair reimbursement include all labor charges involved in the assembly of the wheelchair, as well as the support services such as emergency services, delivery, setup, education, and ongoing assistance with the use of the wheelchair.

A loaner wheelchair accessory may be required when a wheelchair accessory needs a repair and must be removed from the individual for more than one day.

- When repairs are required during a **rental period**, the Company-contracted DME provider who supplied the rental wheelchair accessory must supply a loaner wheelchair accessory. The loaner wheelchair accessory is not eligible for reimbursement.
- When a **purchased** wheelchair accessory requires repair, a one-month wheelchair accessory rental is considered medically necessary.
- A loaner wheelchair accessory should be billed using the specific code for the wheelchair accessory being loaned.
- Requests for loaner wheelchair accessories for periods greater than one month are subject to review.

Elevating legrests that are used with a wheelchair that is purchased or owned by the individual are coded E0990.

Use code E1028 to report swingaway hardware that is used with interfaces described by codes E2320 and E2321, swingaway or flip-down hardware for head control interfaces (E2327-E2330), and/or swingaway hardware for an indicator display box that is related to the multi-motor electronic connection codes E2310 or E2311. Code E1028 is not to be used for swingaway hardware that is used with a sip and puff interface (E2325) because swingaway hardware is included in the allowance for code E2325.

When reinforced back upholstery or reinforced seat upholstery is used in conjunction with heavy-duty or extra heavy-duty wheelchair bases, the reimbursement for reinforced upholstery is included in the reimbursement for the wheelchair base.

Reinforced back and seat upholstery are not covered when used in conjunction with other manual wheelchair bases.

Fixed, swingaway, or detachable footrests and fixed-height, fixed, swingaway, or detachable armrests are included in the reimbursement for the wheelchair base.

A sealed battery (E2361, E2363, E2365, E2371) is eligible for separate reimbursement when billed with a wheelchair base (K0010).

A battery charger (E2366, E2367) is included in the allowance for a power wheelchair base.

Accessories to the wheelchair base must be billed on the same claim as the wheelchair base itself.

The allowance for a power operated vehicle (POV) includes all options and accessories that are provided at the time of initial issue, including, but not limited to, batteries, battery chargers, seating systems, etc. If a patient-owned POV meets coverage criteria, medically necessary replacement items are covered in accordance with the Company's policy.

A replacement option/accessory for a POV is billed using a wheelchair option/accessory code. All options and accessories provided at the time of initial issues of a POV cannot be billed separately.

The allowance for a rollabout chair includes all options and accessories that are provided at the time of initial issue. The allowance for a transport chair includes all options and accessories that are provided at the time of initial issue except for elevating legrests (E0990, K0195). If a rollabout chair or transport chair are covered, medically necessary replacement items are covered.

Accessories provided at the time of initial issue of a rollabout chair cannot be billed separately. Accessories provided with the initial issue of a transport chair cannot be billed separately with the exception of elevating legrests (E0990, K0195). A replacement accessory for a rollabout or transport chair is billed using code E1399.

Wheelchairs with individualized features that meet the needs of a particular individual are reimbursed by selecting the correct code for the wheelchair base and then using the appropriate codes for wheelchair options and accessories. If the frame of the wheelchair is modified in a unique way to accommodate the individual, bill the code for the wheelchair base and bill the modification with code K0108 (wheelchair component or accessory, not otherwise specified).

A replacement item, including, but not limited to, replacement batteries, should be billed using the specific wheelchair option or accessory code if one exists. If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified).

Claim Payment Policies

Revision of a Previous Cosmetic Procedure (11.00.01c)

COVERED: ACCORDING TO CERTAIN CRITERIA

A cosmetic procedure changes the appearance of a body part without improving the physiological functioning of that body part. Performing an additional procedure to improve, correct, or further alter the appearance without improving the physiological function is considered revision of a cosmetic procedure.

A procedure performed to revise the outcome of a previous cosmetic procedure is considered cosmetic and, therefore, a benefit contract exclusion.

Treatment of Medical and Surgical Complications (11.00.02c)

COVERED: ACCORDING TO CERTAIN CRITERIA

A complication is an untoward event that occurs in the course of another condition or during its treatment. Complications may be of either medical or surgical origin, may modify the course of the original condition, and may require revisions to the treatment plan.

Treatment of medical and surgical complications, including but not limited to complications resulting from cosmetic or other noncovered procedures, is covered and eligible for reimbursement consideration by the Company for acute conditions such as, but not limited to:

- Deep vein thrombosis (DVT).
- Hemorrhage.
- Infection.
- Myocardial infarction (MI).
- Wound dehiscence.

Following the onset of the complication, medical and/or surgical treatment related to the complication is covered and eligible for reimbursement consideration by the Company.

Outcomes following cosmetic procedures that have unsatisfactory cosmetic results are not considered medical or surgical complications.

Experimental/Investigational Policies

Artificial Intervertebral Disc Insertion (11.14.19)

NOT COVERED: CONSIDERED EXPERIMENTAL/ INVESTIGATIONAL

The goal of this procedure is to reduce or eliminate back pain while maintaining spinal curvature, flexibility, and load bearing. The artificial intervertebral disc, consisting of two metal endplates and a central free component, is placed between adjoining vertebrae. This device is designed to restore disc height and to all allow for normal motion of the spine.

Artificial intervertebral disc insertion is considered experimental/investigational because the safety and efficacy of this service cannot be established by review of the available published literature. Therefore, this service is not covered.

Prolotherapy (11.14.15b)

NOT COVERED: CONSIDERED EXPERIMENTAL/ INVESTIGATIONAL

Prolotherapy consists of a series of intraligamentous and intratendinous injections of sclerosing agents which alleviate chronic pain by inducing the proliferation of new cells. There are three classes of proliferant solutions used in prolotherapy: chemical irritants (e.g., phenol), osmotic shock agents (e.g., hypertonic dextrose and glycerin), and chemotactic agents (e.g., morrhuate sodium, a fatty acid derivative of cod liver oil). Prolotherapy should not be confused with trigger point injections, which relieve pain by infusing anesthetics and/or anti-inflammatory agents into affected areas.

Prolotherapy is considered experimental/investigational because the safety and/or efficacy of this service cannot be established by review of the available published literature.

Reporting prolotherapy using the trigger point injection CPT procedure code or any other code is a misrepresentation of the actual service rendered. These services are subject to post-payment review and audit procedures.

More Information

Physician Volunteers Needed to Assist in Developing Medical Policies

We are currently recruiting physicians to join our Policy Committee Advisory Panel. This panel is responsible for evaluating the scientific evidence and local standards of care addressed in our medical policies.

Medical policies are research-based documents that allow us to evaluate the medical necessity of services, devices, biologics, and procedures for its members. In addition, medical policies provide guidelines for obtaining benefits and reimbursement in accordance with the member's plan. As a volunteer consultant on the Policy Committee Advisory Panel, you will evaluate proposed medical policies based on your area(s) of expertise. As such, your contributions will significantly impact the care of patients in your region.

At this time, we are seeking physician consultants in the following specialties:

- Neurosurgery
- Orthopedics
- Urology
- Vascular Surgery
- Physical Medicine and Rehabilitation

To qualify as a member of the Policy Committee Advisory Panel, you must:

- Maintain board certification for each specialty or subspecialty for which you wish to consult.
- Maintain an active clinical practice in each specialty or subspecialty for which you wish to consult.
- Understand and agree to adhere to our confidentiality statement.
- Maintain a high ethical standard, evidenced by the absence of any IBC investigation into personal or group claims practices.
- Complete and sign a Conflict of Interest Statement and Confidentiality Agreement prior to becoming a member of the advisory panel.

If you meet the above criteria and have an interest in sharing your expertise as a member of the Policy Committee Advisory Panel, please submit your curriculum vitae to:

Gerald W. Peden, M.D., M.A.
 Medical Director
 Claim Payment Policy Department
 Independence Blue Cross
 1901 Market Street
 Philadelphia, PA 19103-1480

Contact Provider Services

Provider Services	Philadelphia Area	Outside Philadelphia
HMO Policies/Procedures/Eligibility/Claims	(215) 567-3590	(800) 227-3119
PPO Policies/Procedures/Claims	(215) 567-3694	(800) 332-2566

