NORTH Dakota Be Legendary. | Health & Human Services	**WHEELCHAIR MANUAL OR POWER AND ACCESSORIES** Reference the Look-Up Tool to determine if a code requires a Service Authorization.
DURABLE MEDICAL EQUIPMENT MANUAL	COVERAGE AND LIMITATION CRITERIA AND POLICIES
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Effective April 1st, 2026, all service authorization requests must be submitted via Acentra's web portal using this policy and InterQual.

Indications and limitations of coverage appropriateness:

- Mobility devices are covered for eligible NDMA members with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved using an appropriately fitted cane or walker. Daily living refers to activities such as toileting, feeding, and grooming.
- Coverage will be provided for one manual or powered wheelchair. Having more than one mobility device is considered a matter of convenience for the member and their family. No coverage for a backup wheelchair will be provided, except for a one-month rental, if the owned wheelchair is being repaired
- A wheelchair must be suitable for the member's disability, size, weight, activity level, and home environment.

Repair/Replacement:

- Replacement of wheelchairs may be covered when: the cost of the repair is more than the replacement cost; other extenuating medical circumstances occur that require special consideration; or the current wheelchair no longer meets the member's needs.
- If an upgrade in equipment is requested, the member's functional status (diagnosis, prognosis, and severity of condition) must be reviewed for special consideration in accordance with the justification for medical necessity described above.
- For more related information, refer to the DMEPOS Manual Repair and Replacement section.

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Documentation Requirements:

- Practitioner prescription.
- Practitioner exam/visit 180 days before the service authorization request's start date.
- Coverage of wheelchair and accessories/special features requires documentation by the member's practitioner of medical necessity. Documentation must include:
  - Diagnosis, prognosis, and severity of condition.
  - Seating and mobility evaluation by a trained professional familiar with seating, positioning, and wheeled mobility options, considering the current functional abilities and disabilities of the member, as well as potential long-term needs.
  - A comprehensive written evaluation by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), clearly explains why a prefabricated seating system is not sufficient to meet the member's seating and positioning needs. The PT or OT may have no financial relationship with the supplier.
  - Documented assessment of the home environment for accessibility and its ability to accommodate (e.g., door frame size).

Non-Covered:

- Power Operated Vehicles (POV)
- Stroller-type devices that are readily available without a prescription in commercial or retail stores
- Used solely for social or recreational.
- A headrest for a power wheelchair with a captain's chair seat.
- Ultra-light titanium frame has a marginal weight advantage over an aluminum frame.
- Vehicle modifications to accommodate a wheelchair.

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- Back-up wheelchairs will not be allowed, as they are not medically necessary.
    - Canopy/sunshades.
    - Crutch/cane holder.
    - Vehicle modifications to accommodate a wheelchair are non-covered/no exceptions.
    - Adaptive items for daily living.
    - Environmental control items.
    - Building modifications.
    - Automobile modifications.
    - Back-up wheelchairs will not be allowed, as they are not medically necessary.
    - Accessory options that allow the member to perform leisure or recreational activities are non-covered/ no exceptions.
    - Labor charges will be denied as included for any new wheelchair setups.
    - Power seat elevation feature and power standing feature are not primarily medical in nature.
    - Non-medically necessary power wheelchair features, including but not limited to: stair climbing (A9270), electronic balance (A9270), ability to balance on two wheels (A9270), remote operation (A9270), attendant control, and (E2331), provided in addition to a member-operated drive control system.

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WHEELCHAIR MANUAL OR POWER AND ACCESSORIES

Model/Description	Coverage Criteria
Standard-Manual-Adult (K0001) Weight: greater than 36 lbs. Seat width: 16-18” Seat depth: 16” Seat height: equal to or greater than 19” or equal to or less than 21” Back height: 16-17” Arm style: fixed or detachable	• Impaired mobility in performance of mobility-related activities of daily living (MRADLs) in the home, which the mobility device would alleviate; **and** • Able to self-propel a wheelchair; **and** • Member’s mobility limitation cannot be resolved by use of an appropriately fitted assistive device (e.g., cane or walker); **or** • The member has a medical condition for which weight-bearing or ambulation is contraindicated. **or** • The member has a disease process or injury that precludes the use of the lower extremities. The member is not ambulatory, functionally ambulatory, and would otherwise be confined to a bed or chair
Standard-Manual-Pediatric	The pediatric member **must meet** the qualifications in relation to his/her age-appropriate developmental stages and mobility limitations for all qualifications for the Manual – Standard Adult Size section above. • Pediatric wheelchairs are covered only for a pediatric member (or an adult of very small stature). A member’s weight cannot exceed 125 pounds. • The member has not mastered age-appropriate sensory and motor development requirements (e.g., a two-year-old is unable to ambulate/walk). All pediatric device requests must include the growth capabilities of the requested equipment and address how that equipment can accommodate the member’s growth over the 60-month period following approval.

NORTH Dakota Be Legendary. | Health & Human Services	**WHEELCHAIR MANUAL OR POWER AND ACCESSORIES** Reference the Look-Up Tool to determine if a code requires a Service Authorization.
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS & SUPPLIES MANUAL	COVERAGE AND LIMITATION CRITERIA/POLICIES
EFFECTIVE: March 2007	REVISED: March 2026

WHEELCHAIR MANUAL OR POWER AND ACCESSORIES

Model/Description	Coverage Criteria
Standard-Manual-Adult (K0001) Weight: greater than 36 lbs. Seat width: 16-18” Seat depth: 16” Seat height: equal to or greater than 19” or equal to or less than 21” Back height: 16-17” Arm style: fixed or detachable	• Impaired mobility in performance of mobility-related activities of daily living (MRADLs) in the home, which the mobility device would alleviate; **and** • Able to self-propel a wheelchair; **and** • Member’s mobility limitation cannot be resolved by use of an appropriately fitted assistive device (e.g., cane or walker); **or** • Member has a medical condition for which weight-bearing or ambulation is contraindicated; **or** • The member has a disease process or injury that precludes the use of the lower extremities. • The member is not ambulatory, functionally ambulatory, and would otherwise be confined to a bed or chair.
Standard-Manual-Pediatric	• The pediatric member **must meet** the qualifications in relation to his/her age-appropriate developmental stages and mobility limitations for all qualifications for the Manual–Standard Adult Size section above. • Pediatric wheelchairs are covered only for a pediatric member (or an adult of very small stature). A member’s weight cannot exceed 125 pounds. • The member has not mastered age-appropriate sensory and motor development requirements (e.g., a two-year-old is unable to ambulate/walk). • All pediatric device requests must include the growth capabilities of the equipment requested and address how that equipment can accommodate the member’s growth over the 60-month period that follows approval.

WHEELCHAIR MANUAL OR POWER AND ACCESSORIES

Model/Description	Coverage Criteria
Manual Hemi - (K0002) Weight: greater than 36 lbs. Seat width: 16-18” Seat depth: 16” Seat height: 17-18” Back height: 16-17” Arm style: fixed or detachable Enables short in stature members to place their feet on the ground for propulsion.	• Meets criteria for a standard manual wheelchair; **and** • Unable to propel a manual wheelchair with upper extremities; **or** • Has paralysis in one arm and/or leg and is able to self-propel a manual wheelchair.
Manual Lightweight - K0003) Weight: equal to or less than 36 lbs. Seat width: 16-18” Seat depth: 16” Seat depth: 16” Seat height: equal to or greater than 17” or equal to or less than 21” Back height: 16-17” Arm style: fixed or detachable	• Meets criteria for a standard manual wheelchair; **and** • Unable to self-propel a standard manual wheelchair.

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Model/Description	Coverage Criteria
Manual High-Strength Lightweight Wheelchair (K0004) **Note**: This type of wheelchair is rarely medically necessary if the expected duration of need is less than three months. (for example: postoperative recovery).	• Covered when the member meets the basic manual wheelchair qualifications as indicated above; **and** ➢ When a member's medical condition and the weight of the wheelchair affect the member's ability to self-propel, **or** ➢ For a member with marginal propulsion skills. ➢ A member's medical condition, such as spasticity or seizures, requires a high-strength wheelchair. ➢ The member spends a maximum of six hours each day in the wheelchair.
Manual Ultra-lightweight Wheelchair (K0005)	• Covered when the member meets the basic manual wheelchair qualifications as indicated above, **and** • The member's medical condition and the weight of the wheelchair affect the member's ability to self-propel while engaging in frequent MRADLs that cannot be performed in a standard, lightweight, or high-strength lightweight wheelchair; **and** • The member spends a maximum of six hours each day in the wheelchair.

WHEELCHAIR MANUAL OR POWER AND ACCESSORIES

Model/Description	Coverage Criteria
Manual Full or Semi-Reclining Full-(E1060, E1070) Semi-(E1100, E1110) Weight: less than 30 lbs. Seat width: 14-18” Seat depth: 14 - 16” Seat height: equal to or greater than 17” or equal to or less than 21” Back height: varies Arm style: fixed or detachable	• Meets criteria for a standard manual wheelchair, except the member may not be able to self-propel a manual wheelchair. **and** • Member is: ➢ quadriplegic/tetraplegic; **or** ➢ has a trunk of lower extremity cast; **or** ➢ braces that require special positioning; **or** ➢ has a fixed hip angle; **or** ➢ has excess extensor tone of the trunk muscles; **or** ➢ prior history of skin breakdown.
Manual Tilt-in-Space Adult - (E1161) Pediatric - (E1232-E1234) Lightweight wheelchairs. Custom-designed frames that allow the wheelchair's position to be adjusted.	• Meets criteria for a standard manual wheelchair, except may not be able to self-propel a manual wheelchair; **and** • Member: ➢ Has fixed hip angle; **or** ➢ Has excess extensor tone of the trunk muscles; **or** ➢ Has cerebral palsy; **or** ➢ Has a spinal cord injury.

WHEELCHAIR MANUAL OR POWER AND ACCESSORIES

Model/Description	Coverage Criteria
Manual Heavy Duty - (K0006) Weight: varies Seat width: 18” Seat depth: 16 - 17” Seat height: equal to or greater than 19” or equal to or less than 21” Back height: 16-17” Arm style: fixed or detachable Includes reinforced back and seat upholstery.	• Meets criteria for a standard manual wheelchair; **and** • Member weight **greater than 250 lbs**.
Manual Extra Heavy Duty (K0007) Weight: greater than 36 lbs. Seat width: 16-18” Seat depth: 16” Seat height: equal to or greater than 19” or equal to or less than 21” Back height: 16-17” Arm style: fixed or detachable Includes reinforced back and seat upholstery.	• Meets criteria for a standard manual wheelchair; **and** • Member’s weight is **greater than 300 lbs.**

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Model/Description	Coverage Criteria
Power Wheelchairs (PWC) - Adult	• Covered when the member meets **all** the following criteria: • The member's mobility limitation cannot be sufficiently resolved using an appropriately fitted cane(s), crutches, walker, or an optimally configured manual wheelchair. • The member would be unable to move about their residence without the power wheelchair, otherwise be confined to bed without it. • The member does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair in the home to perform MRADLs throughout the course of a normal day. Limitations of strength, endurance, range of motion, coordination, presence of pain, deformities, or the absence of one or both upper extremities must be noted in the assessment of upper extremity function. • The member does have the mental and physical capabilities to operate the power wheelchair that is requested/provided safely. • The member's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is requested/provided. • Use of a power wheelchair will significantly improve the member's ability to participate in MRADLs. • The member will use it on a regular basis in the home;

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Model/Description	Coverage Criteria
Power Wheelchairs (PWC) - Adult	• The member or their caregiver has not expressed an unwillingness to use the power wheelchair that is requested/provided in the home. • The member's weight is within the established weight limitations of the power wheelchair requested/provided.
Power Wheelchair – Pediatric	• The member is expected to grow in height with a maximum weight of 125 pounds; **and** • The outcome of the mobility assessment has determined this item to be the most appropriate for the individual over the 60-month period following approval.
Standard Group 1, 2, or 3 Power Wheelchair	• Member meets qualifications for Power Wheelchair.
Group 2 Power Wheelchair "Single Power Option" (K0835 – K0840)	• Member requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); **or** • The member meets the qualifications for a power tilt or recline seating system, and the system is being used on the wheelchair.

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Model/Description	Coverage Criteria
Group 2 Power Wheelchair "Multiple Power Option" (K0841 – K0843)	• Same as Group 2 Single Power Option qualifications; **and** • The member meets the qualifications for a power tilt. **Note:** Will not cover other components to operate other non-covered multiple power options. • The member uses a ventilator, which is mounted on the wheelchair.
Group 3 Power Wheelchair "No Power Option" (K0848 – K0855)	• The member's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
Group 3 Power Wheelchair "Single Power Option"	• Same as Group 2 Single Power Option qualifications; **and** • The member's mobility limitation is due to a neurological condition, myopathy, or skeletal deformity, in which the mobility limitation cannot be accommodated by a Group 2 option.
Manual and Powered Wheelchair Components and Accessories	• Covered accessories and seating systems when: ➢ The member meets the qualifications for a manual or powered wheelchair, as indicated above. ➢ The device is an appropriate accessory for the type of chair the member has, and when the accessory is not a required component of the mobility device at the time of initial dispensing. ➢ The accessory is not for the convenience of the member or caregiver – such as cup holders, phone holders, baskets, etc. ➢ The accessory is medically necessary.

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Model/Description	Coverage Criteria
Anti-rollback Device - E0974)	• The member propels themselves and needs the device due to ramps.
Arm of Chair/Adjustable Arm Height Option (E0973, K0017, K0018, K0020)	• Member requires an arm height that is different than that available using non-adjustable arms. **and** • The member spends at least 2 hours per day in the wheelchair.
Arm Trough - (E2209)	• The member has quadriplegia, hemiplegia, or uncontrolled arm movements.
Batteries - (E2359, E2361, E2363, E2365, E2371, K0733) And **Battery Chargers** - (E2366)	• Up to two sealed batteries are allowed at any one time if required for a power wheelchair. • A non-sealed battery will be denied as not reasonable and necessary. • A single-mode battery charger is appropriate for charging a sealed lead-acid battery. • If a dual-mode battery charger (E2367) is provided as a replacement, it will be denied as not reasonable and necessary.
Dynamic positioning hardware for a wheelchair back - (E2398)	• The member has increased musculoskeletal tone or spasticity that requires a wheelchair frame that allows for dynamic movement of the seat back or pelvis component.

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Model/Description	Coverage Criteria
Footrest /Leg Rest and **Elevating Leg Rest** (E0990, K0043, K044, K0045, K0046, K0047, K0051, K0553, K0195)	• Member has a musculoskeletal condition or the presence of a cast or brace that prevents 90-degree flexion at the knee; **or** • Member has significant edema in the lower extremities that requires elevation of the leg rest; **or** • Member requires lower extremity support due to muscular weakness, neuromuscular dysfunction, or orthopedic deformity. • Member meets the criteria for and has a reclining back on the wheelchair.
Foot Box (E0954)	• Member's lower extremity posture/positioning needs cannot be met by less costly alternatives, such as standard or angle-adjustable footplates, padding, straps, etc., **and** • History of skin breakdown and/or injury with the use of footplates alone, and there is evidence that less costly alternatives (padding, straps, and other less costly foot boxes) were tried and failed to meet the member's medical needs. • For custom sizes/features, additional evidence that less costly alternatives were tried, with specifics on why they did not meet the member's medical needs.
Foot-Ankle Padded Positioning Straps - (K0108) (e.g., ankle huggers)	• Member has a medical need for stabilization of the foot and ankle due to strong spasticity or exaggerated muscle activity; **and** • Positioning in the wheelchair cannot be met with less costly alternatives, such as any combination of heel loop/holders and or toe/loop/holders, with or without ankle straps.

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Model/Description	Coverage Criteria
Headrest/Headrest Extension (E0955) (E0966) or	The member has **all** the following: • Weakness or abnormal muscle tone in cervical musculature such that function in those muscles is significantly impaired, and the headrest is needed to support the head. **and** • Is not able to actively maintain proper cervical positioning. The member has a manual tilt-in-space, manual fully reclining back on a manual wheelchair, a manual fully reclining back, or a power tilt on a powered wheelchair. The code for a headrest includes any type of cushioned headrest, fixed, removable, or non-removable.
Swing-away Hardware - (E1028) (E1032) (E1033) or (E1034)	The member needs to move the component out of the way to perform a slide transfer to a bed or chair, or to enable performance of MRADLs, unless the hardware is included in the allowance for the item.
Manual Fully Reclining Back (E1226) (E1014)	The member has **all** the following. • High risk for development of a pressure ulcer and is unable to perform a functional weight shift. • Utilizes intermittent catheterization for bladder management and is unable to transfer from the wheelchair to the bed independently. • Documentation of spinal cord impairments, inability to shift or recline to relieve pressure, or inability to tolerate the full upright position. • Quadriplegia, fixed hip, trunk, or lower extremity cast/brace that requires a reclining back feature. • Excess extensor tone of the trunk muscles. • Need to rest in a recumbent position 2-3 times during the day, and transferring between chair and bed is difficult.

WHEELCHAIR MANUAL OR POWER AND ACCESSORIES

Model/Description	Coverage Criteria
Power Tilt - (E1002)	The member meets the coverage criteria for both a manual tilt-in-space and the powered wheelchair and is able to operate the power tilt system independently, and has **one** of the following. • Is at risk for pressure ulcers and is unable to perform a functional weight shift; **or** • Has a fixed hip angle; **or** • Has increased or excess muscle tone/spasticity related to a medical diagnosis which impairs their ability to tolerate the fully upright sitting position for significant periods of time; **or** • Spends at least six hours in the wheelchair; **or** • Utilizes intermittent catheterization for bladder management and is unable to transfer from the wheelchair to bed independently.
Wheelchair Accessory, power seating system, recline only, without shear reduction (E1003)	A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered if criteria 1, 2, and 3 are met and if criterion 4, 5, or 6 is met: 1. The beneficiary meets all the coverage criteria for a power wheelchair; and 2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or practitioner who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs. The PT, OT, or practitioner may have no financial relationship with the supplier; and

	3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary. 4. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or 5. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 6. The power seating system is needed to manage increased tone or spasticity.
Wheelchair Accessory, power seating system, recline only, with power shear reduction (E1005)	A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered if criteria 1, 2, and 3 are met and if criterion 4, 5, or 6 is met: 1. The beneficiary meets all the coverage criteria for a power wheelchair; and 2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or practitioner who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs. The PT, OT, or practitioner may have no financial relationship with the supplier; and 3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary. 4. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or 5. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 6. The power seating system is needed to manage increased tone or spasticity.

Wheelchair Accessory, power seating system, combination tilt and recline, without shear reduction (E1006)	A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered if criteria 1, 2, and 3 are met and if criterion 4, 5, or 6 is met: 1. The beneficiary meets all the coverage criteria for a power wheelchair; and 2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or practitioner who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs. The PT, OT, or practitioner may have no financial relationship with the supplier; and 3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary. 4. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or 5. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 6. The power seating system is needed to manage increased tone or spasticity.

Wheelchair Accessory, power seating system, combination tilt and recline, with mechanical shear reduction (E1007)	A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating legrests will be covered if criteria 1, 2, and 3 are met and if criterion 4, 5, or 6 is met: 1. The beneficiary meets all the coverage criteria for a power wheelchair; and 2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or practitioner who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs. The PT, OT, or practitioner may have no financial relationship with the supplier; and 3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary. 4. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or 5. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 6. The power seating system is needed to manage increased tone or spasticity.

Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction (E1008)	A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered if criteria 1, 2, and 3 are met and if criterion 4, 5, or 6 is met: 1. The beneficiary meets all the coverage criteria for a power wheelchair; and 2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or practitioner who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs. The PT, OT, or practitioner may have no financial relationship with the supplier; and 3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary. 4. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or 5. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 6. The power seating system is needed to manage increased tone or spasticity.

Wheelchair accessory, in addition to a power seating system, a power leg elevation system, including a leg rest, pair (E1010)	A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered if criteria 1, 2, and 3 are met and if criterion 4, 5, or 6 is met: 1. The beneficiary meets all the coverage criteria for a power wheelchair; and 2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or practitioner who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs. The PT, OT, or practitioner may have no financial relationship with the supplier; and 3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary. 4. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or 5. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 6. The power seating system is needed to manage increased tone or spasticity.

Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each (E1012)	A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered if criteria 1, 2, and 3 are met and if criterion 4, 5, or 6 is met: 1. The beneficiary meets all the coverage criteria for a power wheelchair; and 2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or practitioner who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs. The PT, OT, or practitioner may have no financial relationship with the supplier; and 3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary. 4. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or 5. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 6. The power seating system is needed to manage increased tone or spasticity.

Non-Standard Seat Manual Wheelchair Frame (E2201- E2203)	The member has **all** the following criteria: • The member's dimensions justify the need for a wheelchair seat width, depth, or height changes: • The seat width, depth, or height changes are needed to maintain or improve the member's medical, physical, or functional level.
Non-Standard Seat Height for a Manual Wheelchair	A member requires a non-standard seat height for a high-strength lightweight or ultra-lightweight wheelchair is covered when: • The required seat height is at least two inches greater than or less than a standard option. **and** • The member's body dimensions justify the need.
Safety Belts/Pelvic Straps	The member has documented weak upper muscles, upper body instability, or muscle spasticity requiring this device for positioning.
Trunk/Extremity Alignment Support (Including lateral truck or hip supports, abductor or adductor pads, harnesses, straps, or positioning belts)	The member has weakness or abnormal muscle tone in the trunk, body, or extremity musculature, resulting in significantly impaired function in those muscles. **or** The member is unable to maintain proper trunk or extremity positioning actively.
Wheelchair Tray	Member's performance of daily functions, such as eating or fine motor activities, requires this feature.

Seating Systems **General use Wheelchair Cushion** (Prefabricated) - (E2601, 2602)	The member has a manual or power wheelchair with a sling or solid seat and back.
General Use Wheelchair Back Cushion (Prefabricated) - (E2611, E2612)	The member has a manual or power wheelchair with a sling or solid seat and back.
Cushion Seat - Custom Fabricated (E2609)	Meets all qualifications for a prefabricated skin protection seat cushion or positioning seat cushion. **and** The documentation clearly explains why a prefabricated seating system is not sufficient to meet the member's seating and positioning needs.
Back Cushion - Custom Fabricated (E2617)	Meets all qualifications for a prefabricated positioning back cushion. **and** The documentation clearly explains why a prefabricated seating system is not sufficient to meet the recipient's seating and positioning needs.

WHEELCHAIR MANUAL OR POWER AND ACCESSORIES

Model/Description	Coverage Criteria
Seat Cushion - Skin Protection **Prefabricated** (E2603), (E2604)	The member has a manual or power wheelchair with a sling/solid seat/back, and **either** of the following: 1. Current or history of a pressure ulcer on the area of contact with the seating surface. **or** 2. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: • Spinal cord injury resulting in quadriplegia or paraplegia (other spinal cord disease). • Multiple sclerosis. • Other demyelinating disease. • Cerebral palsy. • Anterior horn cell diseases, including amyotrophic lateral sclerosis. • Post-polio paralysis. • Traumatic brain injury resulting in quadriplegia, spina bifida, or childhood cerebral degeneration. • Alzheimer's disease. • Parkinson's disease.

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Model/Description	Coverage Criteria
Positioning Seat Cushion (E2605) And/or **Positioning Back Cushion** (E2613 - E2621)	The member has a manual or power wheelchair with a sling/solid seat/back; **and** 1. Has any significant postural asymmetries that are due to **one** of the following diagnoses. • Spinal cord injury resulting in quadriplegia or paraplegia (other spinal cord disease). • Multiple sclerosis. • Other demyelinating disease. • Cerebral palsy. • Anterior horn cell diseases, including amyotrophic lateral sclerosis. • Post-polio paralysis; Traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration. • Alzheimer's disease. • Parkinson's disease. 2. **Or one** of the following diagnoses: • Monoplegia of the lower limb or hemiplegia due to stroke. • Traumatic brain injury, or other etiology. • Muscular dystrophy, torsion dystonia, spinocerebellar disease.

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Positioning Accessory (E0955 - E0957, E0960)	The member meets the qualifications for both a Skin Protection Seat Cushion and a Positioning Seat Cushion as indicated above.
Combination Skin Protection and Positioning Seat Cushion (E2607, E2608)	The member meets the qualifications for both a Skin Protection Seat Cushion and a Positioning Seat Cushion as indicated above.
Power seat elevation system (E2298)	The member has demonstrated the mental and physical abilities to safely and independently operate the power seat function that is requested; AND The selection of the power seat elevator system is not based solely on caregiver convenience but on the medical needs of the member. All less costly options have been considered, including reasonable adaptations or modifications to the member's environment. Examples of reasonable adaptation or modification include, but are not limited to, an adjustable-height bed or table, reorganization of a dresser, closet, or cupboard, reorganization of a refrigerator, or the installation of a grab bar for transfer assistance. A seat elevation feature is not covered when requested solely to allow the member to socialize with peers. If a seat elevation feature is approved for a member, the provider must obtain documentation from the member or the member's authorized representative acknowledging that the member understands the seat elevation function may affect future requests for PCA or home care services. This documentation must be obtained before dispensing and billing for this item. This documentation must be made available upon request.

WHEELCHAIR MANUAL OR POWER AND ACCESSORIES

Date Revised	Revisions
April 2017	Revised and reformatted the Manual Wheelchair and accessories. Added Document, Non-Covered, and clarified coverage criteria.
March 2019	Reformatted to the new DMEPOS policy format and renamed to Wheelchair Manual or Power and Accessories. Added Power Wheelchair and accessories coverage criteria. Added to the Non-covered section: Power Operated Vehicles (POV), A headrest for a power wheelchair with a captain's chair seat, adaptive items for daily living, environmental control items, building modifications, automobile modifications, accessory options that allow the member to perform leisure or recreational activities are non-covered/ no exceptions, labor charges will be denied as included for any new wheelchair setups, power seat elevation feature and power standing feature are not primarily medical in nature, non-medically necessary power wheelchair features including but not limited to: stair climbing (A9270), electronic balance (A9270), ability to balance on two wheels, (A9270), remote operation, (A9270) an attendant control, (E2331) provided in addition to a member-operated drive control system.
December 29, 2022	Reviewed and reformatted. Added new logo. Documentation Requirements section replaced 60 with 90. Added Dynamic positioning hardware for a wheelchair back (E2398) and coverage criteria that the member has increased musculoskeletal tone or spasticity that requires a wheelchair frame that allows for dynamic movement of the seat back or pelvis component.
November 17, 2023	Reviewed and reformatted. Added 2021 HCPC E0954 for Foot Box and removed K0108.
November 14, 2024	Reviewed and reformatted. The Documentation Requirements section has been updated to replace 90 days with 180 days.
April 1, 2025	Reviewed and made some grammatical revisions. Added (E1032), (E1033), or (E1034) to the Swing Away Hardware section.

NORTH Dakota Be Legendary. | Health & Human Services	**WHEELCHAIR MANUAL OR POWER AND ACCESSORIES** Reference the Look-Up Tool to determine if a code requires a Service Authorization.
DURABLE MEDICAL EQUIPMENT MANUAL	COVERAGE AND LIMITATION CRITERIA/POLICIES
EFFECTIVE: March 2007	REVISED: March 2026

November 1, 2025	Reviewed and reformatted. Added Look-up Tool. Added codes E1003, E1004, E1005, E1006, E1007, E1008, E1010, E1012 and added coverage criteria.
March 27, 2026	Added: Effective April 1st, 2026, all service authorization requests must be submitted via Acentra's web portal using this policy and InterQual. Added to the Manual and Powered Wheelchair Components and Accessories section: The accessory is not for the convenience of the member or caregiver, such as cup holders, phone holders, baskets, etc., and the accessory is medically necessary.