Independence
care system

1.877.ICS.2525
info@icsny.org
www.icsny.org

WHEELED MOBILITY IN NYS MEDICAID COVERAGE

A carefully evaluated and properly configured wheelchair brings freedom and independence for people with physical disabilities who have limited or no ability to walk. It allows them to work, play, socialize and maintain their health and independence. The right wheelchair can also help prevent pressure wounds that are painful, dangerous and cost millions of dollars each year for treatment.

New York State's Medicaid policy guidelines for wheeled mobility recognize both the need for and the value of the proper equipment. They also clearly state that the equipment is intended for use in the home and/or the community – the difference between being restricted to life in your home and true independence. However, there are key State documents that contradict and undermine the policy guidelines that results in a substantial number of people with physical disabilities being denied proper wheelchair evaluation, purchase of new chairs and repairs of existing ones. This is a systemic issue and not restricted to consumers enrolled in one or two particular health plans.

Aligning Policy and Coverage Criteria

New York State's Medicaid policy guidelines say: "Wheeled mobility equipment (WME) is covered if the member's medical condition(s) and mobility limitation(s) are such that without the use of the WME, the member's ability to perform mobility related activities of daily living (MRADL) in the home and/or community is significantly impaired and the member is not ambulatory or functionally ambulatory."

The following language regarding coverage of wheelchairs in State documents allow the clear guidelines above to be significantly restricted and distorted.

- The State's managed long-term care contract states (on page 140) that coverage for wheelchairs is for "use in the home," without mention of the community.
- The Medicaid coverage criteria for manual wheelchairs states that it is "for use in the home and community setting," omitting the critical "and/or" phrase found in the policy guidelines.[1] The criteria for Power Operated Vehicles (e.g. scooters) and power wheelchairs uses similar language.
- The Medicaid coverage criteria for skin protection and positioning cushions refers to a list of qualifying diagnoses for eligibility and includes the words "due to but not limited to." The criteria for all seating and mobility devices that list qualifying diagnoses do not include this "not limited to" language.

As a result, it is common for Medicaid plans to misinterpret the need for a wheelchair to use in the community as a non-covered benefit. This often happens with someone who is able to get around without a wheelchair within his or her home but needs one for anything beyond that.

People with disabilities with the same diagnosis often have different needs and abilities, which are accounted for in the individual wheelchair evaluation process. For example, an individual with a disability such as cerebral palsy may have some ability to walk short distances with the assistance of a walker in their home. However, when out in the community, they may lack the strength and stamina to ambulate more than a few feet. Under the current language, this person is likely to be denied a wheelchair.

For individuals with degenerative diseases that affect the nervous system such as Multiple Sclerosis the functional limitations can vary greatly from day to day and week to week. On some days, they may have the ability to walk short distances while on others they cannot go any distance without a wheelchair. Unfortunately, this person is also likely to be denied a wheelchair.

The policy guidelines take into account the difference between home and community need with the "in the home and/or community" language. The contract and coverage criteria needs to be changed to do the same. Otherwise, persons with physical disabilities will continue

[1] *eMedNY*, DMEPOS Procedure Code Ver 2020-1, page 60

to be denied the equipment needed to leave home to go to medical appointments, work, attend school, attend religious services or simply enjoy being outside.

It is also common for consumers to be denied services because their specific condition, however debilitating, is not on the diagnosis list prescribed by DOH policy. Right now, individuals who are not functionally ambulatory in the home and/or community due to a chronic condition that is not on the list (e.g. adult onset orthopedic impairments) are denied the complex rehab equipment they need because that diagnosis is not specifically named.[2]

Finally, there is a glaring omission in coverage of substitute wheelchairs when the consumer's chair needs substantial repair. The current coverage criteria authorizes rental of a manual wheelchair on a temporary basis. However, this is not a viable option for a consumer who uses a power wheelchair that has been custom purchased and fitted for their use.

Consider, for example, a person with quadriplegia who is dependent on a ventilator and uses a power chair with a specially configured control system for mobility. When this person's chair is broken, New York's current rules allow only for the provision of a manual back up chair, which they cannot use. For the weeks, or more likely months, that it takes to get their chair repaired, the rules force them to remain in bed most of the time, a situation that will almost certainly contribute to a decline in their physical and mental health.

The existing coverage criteria should allow for repair of power chairs that are being used as an emergency backup. This does not mean that power chairs should be purchased as a backup, but it would allow for a new wheelchair to be purchased, if deemed necessary, and the current power wheelchair would be maintained, as a backup.

A backup power chair is not currently mentioned in the State's coverage guidelines or fee schedules and is, therefore, considered by Medicaid plans to be a non-covered item, even though it is the equivalent of a rental chair substituting for a manual wheelchair under repair.

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[2] eMed NY, DMEPOS Procedure Codes Ver 2020-1, page 78

The Solution

Each of the issues outlined above is easily fixed by aligning the contradictory language in State documents to:

- Clarify that coverage for manual and power wheelchairs is for use in the home **and/or** the community.
- Provide flexible language that enables additional criteria outside a list of specific diagnoses to justify the need for seating and mobility devices.
- Provide language to cover the temporary replacement of a consumer's power wheelchair consistent with coverage for a manual wheelchair user – i.e. ongoing support and maintenance for an existing backup chair.

Without clear direction all of the wheelchair procurement and repair stakeholders ─ people with disabilities, Medicaid plans, administrative law judges, physical and occupational therapists, and consumer advocates – are forced to engage in a request, denial, Fair Hearing loop that is both administratively costly and poses very real health threats to people that rely on wheeled mobility.

It is essential that the Department of Health clarify existing policy and also provide a clear directive to both health plans and providers to end the prevailing practice of denying covered services for wheeled mobility equipment. It is matter of maintaining an individual's health and their independence.