Medical and Behavioral Health Policy Activity

Policies Effective: December 2, 2024 Notification Posted: October 1, 2024

Policies Developed

None

Policies Revised

- ## Amino Acid-Based Elemental Formulas, II-69

  NOTE: Coverage may be subject to legislative mandates, including but not limited to the following, which applies prior to the policy statements:

  - Minnesota Statute 62Q.531 Amino Acid-Based Formula Coverage.

  I. Patients with a Definitive Diagnosis

  The use of oral amino acid-based elemental formula may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

  - The formula contains 100% free amino acids as the protein source; **AND**
  - The patient has a definitive diagnosis, as supported by laboratory and/or diagnostic test results, of **ONE** of the following conditions:
    - Cystic fibrosis;
    - Amino acid, organic acid, and fatty acid metabolic and malabsorption disorders (e.g., phenylketonuria, maple syrup urine disease, homocystinuria, tyrosinemia, methylmalonic acidemia, and propionic acidemia);
    - IgE-mediated allergies to food proteins;
    - Food protein-induced enterocolitis syndrome;
    - Eosinophilic esophagitis;
    - Eosinophilic gastroenteritis;
    - Eosinophilic colitis;
    - Short gut syndrome;
    - Mast cell activation syndrome;

    AND
  - The condition was diagnosed by a physician.

  II. Patients with a Presumptive Diagnosis

  The use of oral amino acid-based elemental formula may be considered **MEDICALLY NECESSARY AND APPROPRIATE** for up to 90 days when requested by a physician while actively seeking a confirmatory diagnosis and documentation of **ALL** of the following:

  - Presumptive diagnosis of one of the conditions defined in the policy statement in section I; **AND**
  - Patient's symptoms are consistent with a digestive disorder; **AND**
  - Minimum of two prior failed formula alternatives.

- ## Wheelchairs- Mobility Assistive Equipment, VII-04

  I. Criteria for Medical Necessity

  A. All of the following criteria must be met for any mobility assistive equipment (i.e., wheelchair or power-

operated vehicle) to be considered **MEDICALLY NECESSARY AND APPROPRIATE:**

- The patient has a mobility limitation that significantly impairs his or her ability to participate in mobility related activities of daily living (MRADLs) appropriate to the patient's needs and abilities. These activities include toileting, dressing, personal hygiene and eating. A mobility limitation is one that:
  - Prevents the patient from accomplishing the MRADLs entirely; OR
  - Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs. Weakness and fatigue alone are not considered significant impairments in the ability to participate in MRADLs;

  AND
- The patient has a home mobility limitation that cannot be sufficiently resolved by use of an appropriately fitted cane or walker; **AND**
- Features of the mobility assistive equipment are based upon the patient's physical and functional capabilities and body size as assessed by a qualified professional or professionals and appropriate to the type of device requested; **AND**
- An assessment of the patient's home demonstrated that the home provides adequate access between rooms, maneuvering space, and surfaces for use of the mobility assistive equipment provided.

AND

B. Criteria for one of the following must be met:

- **Manual (Non-Motorized) Wheelchair:** A manual (non-motorized) wheelchair may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when:
  - The patient meets one of the following:
    - Has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided; and patient is willing and able to self-propel a standard manual wheelchair; OR
    - A caregiver has been trained and is willing and able to assist with or operate the manual wheelchair when the patient's condition precludes self-operation of the manual wheelchair.

    AND
  - Patient meets criteria for one of the manual wheelchair types described in **Table 1.**

  OR
- **Group 1 Power-Operated Vehicle (POV) (i.e., Scooter or motorized 3-4 wheeled vehicles may be considered MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:
  - Patient is unable to self-propel a manual wheelchair; **AND**
  - Patient is able to safely transfer in and out of the POV; **AND**
  - Patient is cognitively and physically able to safely maintain stability and position for adequate operation; **AND**
  - The patient's weight does not exceed the weight capacity of the POV being requested and greater than or equal to 95% of the weight capacity of the next lower weight class POV (i.e., a Heavy Duty POV generally indicated for patient weighing 285-450 pounds; a Very Heavy Duty POV generally indicated for a patient weighing 428-600 pounds); **AND**
  - Use of a POV will significantly improve the patient's ability to participate in MRADLs, and the patient will use it in the home; **AND**
  - The patient is agreeable to the use of a POV in the home; **AND**
  - The POV meets the needs of the patient in lieu of a power wheelchair.

  OR
- **Motorized/Power Wheelchair (PWC)** may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria have been met:
  - An optimally-configured manual wheelchair (i.e., appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories) is determined to be inadequate to address the patient's need for mobility inside the patient's home; **AND**
  - The patient 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 (e.g., limitations of strength, endurance,

range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities); **AND**
    - The patient's home mobility limitations cannot be sufficiently resolved by the use of POV (i.e., Patient is not able to safely operate a POV or maintain postural stability and position while operating a POV); **AND**
    - The patient is capable of safely operating the controls of a PWC or has a caregiver who cannot push a manual chair but who is available, willing, and able to safely propel the power chair using an attendant control; **AND**
    - The patient must be able to safely transfer, or be transferred, in and out of the PWC and have adequate trunk stability to be able to safely ride in the wheelchair; **AND**
    - The patient's weight is less than or equal to the weight capacity of the PWC that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class PWC (i.e., a Heavy Duty PWC is generally indicated for patient weighing 285-450 pounds; a Very Heavy Duty PWC is generally indicated for a patient weighing 428-600 pounds); an Extra Heavy Duty PWC is indicated for a patient weighing 570 pounds or more); **AND**
    - Use of a PWC will significantly improve the patient's ability to participate in MRADLs, and the patient will use it in the home; **AND**
    - The patient is willing to use a PWC in the home; **AND**
    - The patient has been evaluated and found to be developmentally capable of operating a power chair; **AND**
    - Patient meets criteria for one of the power wheelchair types described in **Table 2.**

  OR
- **IBOT® Mobility System**
    - Standard function of the (IBOT®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when a patient meets **ALL** criteria for a power wheelchair;
    - Additional features including but not limited to (4-wheel, balance, stair, and remote functions) are considered an **UPGRADE** and are **NOT COVERED**.

II. Specialized Seating

Specialized wheelchair seating may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when:
- The patient meets all criteria for the specific type of wheelchair being requested; **AND**
- Criteria for one or more specific seating, options or accessories in **Table 3** are met.

III. Options and Accessories

Options and accessories may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when:
- The patient meets all criteria for the specific type of wheelchair being requested;
- Criteria for one or more option or accessory in **Table 4** are met.

IV. Repair or Replacement

- Repair of mobility assistive equipment, including options or accessories, may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following are met:
    - Patient continues to meet medical necessity criteria for the equipment; **AND**
    - Repair needed to keep the equipment operational due to normal wear or accidental damage; **AND**
    - Cost of repair does not exceed the replacement cost; **AND**
    - The equipment is not covered under warranty.
- Replacement of mobility assistive equipment, including options or accessories, may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following are met:
    - Average useable life of 5 years has been exceeded; AND
    - Patient continues to meet medical necessity criteria for the equipment; **AND**

- At least one of the following is met:
  - Change in the physiologic condition or functional level of the patient which necessitates replacement of the requested equipment; OR
  - There is an irreparable change in the condition of the equipment that is not a result of misuse or neglect;

  AND
- The condition of the equipment requires repairs which would exceed the cost of purchasing a new wheelchair, POV, or option/accessory; **AND**
- The equipment is not covered under warranty.

V. Not Medically Necessary

The following are considered **NOT MEDICALLY NECESSARY:**

- Group 2 POV
- Group 4 PWC
- Wheelchair-mounted assistive robotic arm/dynamic support devices

Table 1. Manual Wheelchair Types

Manual Wheelchair Type	Criteria
Standard manual wheelchair	No additional requirements when criteria in section IA and IB1 are met
Standard hemi wheelchair	Paires lower seat height (17" - 18") due to short stature or to enable the patient to place his/her feet on the ground
Light weight wheelchair	• Patient cannot self-propel in a standard wheelchair but can, and does, self-propel in a light-weight wheelchair
High strength lightweight wheelchair	• Patient self-propels in the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair; OR • Requires a seat width, depth, or height that cannot be accommodated in a standard lightweight or hemi-wheelchair and spends at least 2 hours per day in the wheelchair
Ultra-lightweight manual wheelchair	• Patient must be a full-time manual wheelchair user **AND ALL** of the following must be met: o Cannot self-propel in a in a standard or lightweight wheelchair, but is able to self-propel in an ultra-lightweight wheelchair (30 pounds or less) o Requires individualized fitting and adjustments for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a standard, lightweight, or high strength lightweight wheelchair; AND o Specialty evaluation performed by a licensed/certified medical professional such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features; and who has no financial relationship with the supplier. o 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 patient.

Heavy duty manual wheelchair	Patient weighs 285-450 pounds OR has severe spasticity
Very Heavy Duty	Patient weighs 428-600 pounds
Extra heavy-duty wheelchair	Patient weighs 570 pounds or more
Customized basic or adaptive pediatric stroller	• Child is non-ambulatory; **AND** • Either of the following conditions apply: o The child requires more support than is available in a standard pediatric wheelchair, OR o The child is too small to safely use a standard pediatric wheelchair
Manual wheelchair with tilt in space/rotation in space	• Has had a specialty evaluation that was performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation, and experience in wheelchair evaluations and its special features and who has no financial relationship with the supplier; **AND** • 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 patient.
Push-rim activated power assisted device for a manual wheelchair	• Was self-propelling in a manual wheelchair but no longer has sufficient upper extremity function to self-propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day (e.g., limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities). An optimally configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories; **AND** • Has had a specialty evaluation that was performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation, and experience in wheelchair evaluations and its special features and who has no financial relationship with the supplier; **AND** • 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 patient.

Table 2. Power Wheelchair Types

Group 1 or Group 2 standard PWC	• Wheelchair is appropriate for the patient's weight. • No additional requirements when criteria for PWC are met.
	• The patient meets one of the following: o Requires a drive control interface other than a hand- or chin-operated standard proportional joystick (e.g., head control, sip and puff, switch control) OR o Meets criteria for a power tilt, power recline, or combination power tilt/power recline seating system (Table 3) and the system is to be used on the PWC **AND**

Group 2 single power option	• The patient has had a specialty evaluation that was performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation, and experience in wheelchair evaluations and its special features and who has no financial relationship with the supplier; **AND** • 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 patient
Group 2 with multiple power options	• The patient meets one of the following: o Criteria for a power tilt and recline seating system (Table 3) and the system is to be used on the wheelchair; OR o Uses a ventilator which is mounted on the wheelchair **AND** • The patient has had a specialty evaluation that was performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation, and experience in wheelchair evaluations and its special features and who has no financial relationship with the supplier; **AND** • 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 patient;
Group 3 PWC with no power options	• The patient has a mobility limitation due to a neurological condition, myopathy, or congenital skeletal deformity; **AND** • The patient has had a specialty evaluation that was performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation, and experience in wheelchair evaluations and its special features and who has no financial relationship with the supplier; **AND** • 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 patient;
	• The patient's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; **AND** • The patient meets one of the following: o Requires a drive control interface other than a hand- or chin-operated standard proportional joystick (e.g., head control, sip and puff, switch control) OR

Group 3 PWC with single power option	○ Meets criteria for a power tilt, power recline, or combination power tilt/power recline seating system (Table 3) and the system is to be used on the PWC; **AND** • The patient has had a specialty evaluation that was performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation, and experience in wheelchair evaluations and its special features and who has no financial relationship with the supplier; **AND** • 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 patient.
Group 3 PWC with multiple power options	• The patient's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; **AND** • Patient meets one of the following: ○ Criteria for a power tilt and recline seating system (Table 3) and the system is to be used on the wheelchair; OR ○ Uses a ventilator which is mounted on the wheelchair. **AND** • Patient has had a specialty evaluation that was performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation, and experience in wheelchair evaluations and its special features and who has no financial relationship with the supplier; **AND** • 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 patient
Group 4 PWC	Considered **NOT MEDICALLY NECESSARY** due to added capabilities that are not needed for use in the home.
Group 5 pediatric PWC with single power option	• The patient is expected to grow in height; **AND** • The patient meets one of the following: ○ Requires a drive control interface other than a hand- or chin-operated standard proportional joystick (e.g., head control, sip and puff, switch control); OR ○ Meets criteria for a power tilt, power recline, or combination power tilt/power recline seating system (Table 3) and the system is to be used on the PWC **AND** • The patient has had a specialty evaluation that was performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in

	rehabilitation, and experience in wheelchair evaluations and its special features and who has no financial relationship with the supplier; **AND** • 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 patient;
Group 5 pediatric PWC with multiple power options	• The patient is expected to grow in height **AND** • Meets one of the following: o Criteria for a power tilt and recline seating system (Table 3) and the system is to be used on the wheelchair; OR o Uses a ventilator which is mounted on the wheelchair **AND** • The patient has had a specialty evaluation that was performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation, and experience in wheelchair evaluations and its special features and who has no financial relationship with the supplier; **AND** • 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 patient;
Customized motorized power wheelchair base	• Specific configurational needs of the patient cannot be met using wheelchair cushions, or options or accessories (prefabricated or custom fabricated), which may be added to a power wheelchair base (Tables 3 and 4); **AND** • The patient has had a specialty evaluation that was performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation, and experience in wheelchair evaluations and its special features and who has no financial relationship with the supplier; **AND** • 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 patient;

Table 3. Specialized Seating

Specialized Seating, Options/Accessories (list is not all-inclusive)	**Criteria**

Power wheelchair tilt and/or recline seating systems	Tilt only, recline only, or a combination tilt and recline with or without power elevating leg rests when **ALL** of the following criteria are met: • The patient meets medical necessity criteria for a power wheelchair; **AND** • One of the following criteria are met: o Patient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; OR o The patient uses intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; OR o The power seating system is needed to manage increased tone or spasticity; OR o Patient is transported by wheelchair in a van or bus; **AND** • A specialty evaluation was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or physician who has specific training and experience in rehabilitation wheelchair evaluations documents the patient's seating and positioning needs. • 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 patient
Back Support	• Meets the criteria above for a wheelchair; **AND** • Requires trunk or body support due to neurological impairments, flexible asymmetrical/symmetrical deformities, or fixed asymmetrical/symmetrical deformities
Adjustable or non-adjustable prefabricated skin protection or positioning seat or back cushion, and positioning accessories	• Patient is at high risk for development for a pressure ulcer, or has a current pressure ulcer or history of a pressure ulcer on the area of contact with the seating surface; **OR** • Absent or impaired sensation in the area of contact with the seating surface; due to one of the following diagnoses: spinal cord injury, other etiology of quadriplegia or paraplegia, multiple sclerosis, other demyelinating disease, anterior horn cell diseases including g amyotrophic lateral sclerosis, post-polio paralysis, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; **OR** • Any significant postural asymmetries that are due to spinal cord injury resulting in quadriplegia or paraplegia, hemiplegia, or monoplegia of the lower limb due to stroke or other etiology, (e.g., multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, muscular dystrophy, traumatic brain injury, childhood cerebral degeneration; torsion dystonia); **AND** • A captain's chair is not being utilized

Custom fabricated seat or back cushion	• Meets **ALL** of the coverage criteria for a prefabricated skin protection or positioning seat or back cushion; **AND** • There is a comprehensive written evaluation by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), which clearly explains why a prefabricated seating system is not sufficient to meet the patient's seating and positioning needs.
Power seat elevation systems	• Motorized/Power Wheelchair (PWC) criteria above are met **AND** • A specialty evaluation has been performed by a licensed/certified medical professional (e.g., physical therapy, occupational therapist, or physician with specific training in rehabilitation wheelchair evaluations of seating and positioning needs); **AND** • One of the following: ○ The patient performs weight-bearing transfers to/from the wheelchair while in the home, using the upper extremities during a non-level sitting transfer and/or lower extremities during a sit to stand transfer; or ○ The patient requires a non-weight-bearing transfer (e.g., dependent transfer) to/from the power wheelchair while in the home.
Reinforced back upholstery or reinforced seat upholstery	Patient weighs more than 200 lbs. **Note:** When used in conjunction with heavy duty or extra heavy-duty wheelchair base, the allowance for reinforced upholstery is included in the allowance for the wheelchair base. Reinforced back and seat upholstery if used in conjunction with other manual wheelchair bases is **INELIGIBLE FOR COVERAGE**.
Solid seat insert	**Note:** There is no separate payment for a solid insert that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion. Separate solid seat insert is **INELIGIBLE FOR COVERAGE**.

Table 4. Options and Accessories

Adjustable Arm Height Option	• Patient requires arm height that is different than that available using non-adjustable arms; **AND** • Spends at least two hours per day in the wheelchair
Arm Trough	Patient has quadriplegia, hemiplegia, or uncontrolled arm movements
Batteries	Up to 2 batteries at one time if required for the power wheelchair
Detachable Arms	Patient must transfer from wheelchair to bed/chair by "sliding over" and cannot walk or stand and pivot to transfer
Elevating Leg Rests	Patient meets one of the following: • Musculoskeletal condition, cast or brace that prevents 90 degrees of knee flexion; OR

	• Below knee amputation and is in an early rehabilitation phase; OR • Edema of the lower extremities that requires having an elevated leg rest; OR • Meets criteria for and uses reclining wheelchair (Table 3)
Hook-On Head Rest Extension	Patient has weak neck muscles and needs a head rest for support OR patient meets the criteria for and has reclining back on the wheelchair
Shoulder Harness, Safety Belt/ Pelvic Strap	Patient has weak upper body muscles, upper body instability or muscle spasticity requiring a harness, belt, or strap to maintain proper positioning
Tray	Tray is primarily required for support or positioning.
Vehicle Tie-Downs	Transport of the patient using the wheelchair outside the home is required
Standing features	Patient meets **ALL** of the following: • The patient has a mobility limitation that involves inability to walk or loss of walking ability due to ONE of the following: o cerebral palsy; o spinal cord injuries; o neuromuscular disease; **AND** • Patient has sufficient residual strength in the lower extremities (e.g., hips and legs) to allow for use of the standing device; **AND** • Use of the standing device is expected to allow meaningful improvement in at least ONE of the following: o Performance of MRADLs; o Functional use of the arms or hands; o Functional head and trunk control; o Digestive function; o Circulatory function; o Respiratory function; o Skin integrity (by off-loading weight and/or relief of pressure sores) that cannot be accomplished by other means; **AND** • Patient has not been provided a separate stander for long-term use; **AND** • The patient has completed a one-month trial using a standing device/gait trainer and has shown meaningful improvement after the trial period.

Documentation Submission:

- The patient's practitioner must submit documentation of a face-to face examination by a licensed/certified medical professional to support medical necessity for the mobility assistive equipment options or accessories (within 6 months of written order). This documentation must include ALL of the following:
    - The patient's diagnosis, prognosis, and severity of the condition; AND

- Narrative description including functional impairments that necessitate use of the requested wheelchair and any requested non-standard features; AND
- Relevant medical records including pertinent laboratory tests, radiology reports or other diagnostic tests.

- For POVs and PWC a detailed narrative chart note by the treating practitioner. The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.
  - History of the present condition(s) and past medical history that is relevant to mobility needs
  - Symptoms that limit ambulation
  - Diagnoses that are responsible for these symptoms
  - Medications or other treatment for these symptoms
  - Progression of ambulation difficulty over time
  - Other diagnoses that may relate to ambulatory problems
  - How far the beneficiary can walk without stopping
  - Pace of ambulation
  - What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
  - What has changed to now require use of a power mobility device
  - Ability to stand up from a seated position without assistance
  - Description of the home setting and the ability to perform activities of daily living in the home
  - Physical examination that is relevant to mobility needs:
    - Weight and height
    - Cardiopulmonary examination
    - Musculoskeletal examination
    - Arm and leg strength and range of motion
  - Neurological examination
    - Gait
    - Balance and coordination
- Requests for repair or replacement of any mobility assistive equipment, an option or accessory addressed in the policy must include the following documentation:
  - Documentation of a written order or prescription for replacement mobility assistive equipment from the patient's practitioner **Note:** Replacement of options/accessories or repair of any equipment, options or accessories addressed in the policy do not generally require a written or order or prescription from the provider, but do require documentation described in this section.
  - Date that the current equipment was delivered to the member; AND
  - Cost of repair;' AND
  - Estimated life of the equipment if repaired; AND
  - Cost of a replacement.
- The following written reports may be required and must be available on request:
  - On-site evaluation of the patient's home by the supplier or practitioner verifying that the patient can adequately maneuver the device provided considering physical layout, doorway width, doorway thresholds, and surfaces.
  - Specialty evaluation required for patients who receive a Group 2 Single Power Option or Multiple Power Options PWC and any Group 3 PWC or a push-rim activated power assist device.
  - Supplier verification of a supplier that a RESNA-certified ATP is employed who specializes in wheelchairs and has direct, in-person involvement in the wheelchair selection for the patient.

NOTE: Forms created from suppliers that have not been approved by CMS are not considered part of the medical record. Even if the practitioner completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above.

- **Panniculectomy/Excision of Redundant Skin or Tissue, IV-24**

NOTE:
- The scope of this policy does not address primary circumcision of newborns or infants.
- Coverage may be subject to legislative mandates, including but not limited to the following, which apply prior to the policy statements:
  - Federal Women's Health and Cancer Rights Act (WHCRA)
  - Minnesota Statute 62A.25 Reconstructive Surgery

I. Panniculectomy

- Panniculectomy with or without abdominoplasty may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

  - The pannus/panniculus extends at or below the level of the symphysis pubis; **AND**
  - The treating physician has documented that the pannus/panniculus is associated with:
    - Chronic or recurrent infection, intertrigo or skin necrosis refractory to at least three months of medical management (e.g., antifungal, antibacterial, and moisture-absorbing agents; supportive garments, topically applied skin barriers); **OR**
    - Chronic or recurrent ulcerations, accompanied by skin deterioration, that are nonresponsive to aggressive wound management;

  AND
  - Patient is a never smoker OR has abstained from smoking, use of smokeless tobacco, and/or nicotine products (not including nicotine replacement therapy (NRT)) for a minimum of 6 weeks prior to planned surgery; **AND**
  - When the panniculectomy is associated with significant weight loss, weight has remained stable for a minimum of six months.

- Panniculectomy with or without abdominoplasty may be considered **MEDICALLY NECESSARY AND APPROPRIATE** as an adjunct to a medically necessary procedure when needed for exposure to improve surgical access or wound healing following surgery.

- The following procedures are considered **COSMETIC** as they are performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function:
  - Panniculectomy with or without abdominoplasty not meeting the medical necessity criteria in the policy statements directly above;
  - Abdominoplasty;
  - Nonfunctional procedures performed in association with a medically necessary panniculectomy (e.g., transposition of the umbilicus, undermining to the costal margin, lateral contouring imbrications, lipectomy);
  - Repair of diastasis recti.

II. Excision of Redundant Skin or Tissue of Other Anatomical Areas

- Excision of redundant skin or tissue of other anatomical areas including but not limited to the upper extremities (e.g., brachioplasty), lower extremities, buttocks, or genitalia may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following are met:

  - Redundant skin is associated with **ONE** of the following:
    - Chronic or recurrent infection, intertrigo or skin necrosis refractory to at least three months of medical management (e.g., antifungal, antibacterial, and moisture-absorbing agents; supportive garments, topically applied skin barriers); **OR**

- Chronic or recurrent ulcerations, accompanied by skin deterioration, that are nonresponsive to aggressive wound management;

AND

- Patient is a never smoker OR has abstained from smoking, use of smokeless tobacco, and/or nicotine products (not including nicotine replacement therapy (NRT)) for a minimum of 6 weeks prior to planned surgery.

- Excision of redundant skin or tissue of other anatomical areas may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when the redundant skin is associated with a biopsy or removal of a premalignant or malignant skin lesion.

- Excision of redundant skin or tissue performed primarily to enhance or otherwise alter physical appearance is considered **COSMETIC**.

Documentation Submission:

Documentation supporting the medical necessity criteria described in the policy must be included in prior authorization requests when prior authorization is required. In addition, the following documentation must be submitted with the prior authorization request:

- Clinical notes documenting diagnosis and description of redundant skin or pannus/panniculus supporting the medical necessity of the procedure.
- Photographs of the affected area, including a lateral photograph of the panniculus.
- Documentation from the medical records of the treating provider of the measures that were used to treat the chronic or recurrent skin infection.
- If applicable, documentation that the patient is a never-smoker OR has abstained from smoking, use of smokeless tobacco and/or nicotine products (not including nicotine replacement therapy (NRT)) for a minimum of 6 weeks prior to surgery.

- **Smoking Cessation Updates to Several Policies:**
  - **Blepharoplasty and Brow Ptosis Repair, IV-17**
  - **Bunionectomy, IV-171**
  - **Gender Affirming Procedures, IV-123**
  - **Gynecomastia Surgery, IV-71**
  - **Hysterectomy Surgery for Non-Malignant Conditions, IV-168**
  - **Orthognathic Surgery, IV-16**
  - **Penile Prosthesis Implantation, IV-166**
  - **Reduction Mammoplasty, V-32**
  - **Responsive Neurostimulation for the Treatment of Refractory Focal (Partial) Epilepsy, IV-161**
  - **Rhinoplasty, Septorhinoplasty, and Septoplasty, IV-73**
  - **Risk-Reducing Mastectomy IV-27**
  - **Sacral Nerve Neuromodulation/Stimulation for Selected Conditions, IV-83**
  - **Sacroiliac Joint Fusion, IV-126**
  - **Treatment of Obstructive Sleep Apnea and Snoring in Adults, IV-07**

The following policy criteria were amended with consistent statements for the above policies. The criterion will read as follows:

- Patient is a never-smoker OR has abstained from smoking, use of smokeless tobacco and/or nicotine products (not including nicotine replacement therapy (NRT)) for a minimum of 6 weeks prior to surgery.

If the policy is managed by prior authorization, an addition to the documentation submission section was added and will read as follows:

- Documentation that the patient is a never-smoker OR has abstained from smoking, use of smokeless tobacco and/or nicotine products (not including nicotine replacement therapy (NRT)) for a minimum of 6 weeks prior to surgery.

Policies Delegated to eviCore

None

Policies Inactivated

None