STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Power Wheelchair Attendant Controls
DME-015

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	11/18/2013
Revision Number:	4	**Last Rev Date:**	1/19/2024
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	1/17/2025
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	10/9/2015

Criteria

Prior authorization is required.

Power wheelchair attendant controls may be considered medically necessary when the member meets criterion #1 with a, b, **OR** c below:

1. Power wheelchair attendant controls can be approved when the member has a power wheelchair; **AND**;
   a. Has a specialty drive control other than a standard joystick (e.g., sip' n puff attachment or head array) to control the wheelchair; **OR**
   b. Medical documentation demonstrates the member would be unable to maneuver the wheelchair in tight spaces (provider should document an example of a situation where this would occur); **OR**
   c. Medical documentation demonstrates that the member becomes fatigued in a short period of time operating the wheelchair under normal operating conditions.

Coding

The following list of codes is provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT code is inappropriate.

HCPCS	Description
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual and as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

Iowa Administrative Code 441 Chapter 78.10(5)i(1)(2)(3).

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
Signature			

Change Date	Changed By	Description of Change	Version
Signature			

Change Date	Changed By	Description of Change	Version
1/19/2024	CAC	Annual review.	4
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
1/20/2023	CAC	Annual review.	3
Signature William (Bill) Jagiello, DO			

Criteria Change History (continued)

Change Date	Changed By	Description of Change	Version
1/21/2022	CAC	Annual review.	2
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
10/9/2015	Medical Director	Formatting changes for clarity. Developed References.	1
Signature William (Bill) Jagiello, DO			