

Wheelchair Rental Policy*Values*

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Abstract Purpose:

This guideline outlines Network Health's policy, for all lines of business, when claims are submitted for monthly capped rentals of standard and/or lightweight wheelchairs.

Policy Detail:

- I.** In alignment with the Centers for Medicare and Medicaid Services (CMS), Network Health will require providers to submit the appropriate capped rental modifier(s) when the claim is for a standard and/or lightweight wheelchair.
- II.** Claims will be reviewed for reimbursement once per calendar month to the same specialty physician/provider. Reimbursement will not exceed the cap rental period.
- III. HCPC Codes:**
 - A. The following HCPC codes require the appropriate capped rental modifier:
 1. K0001: Standard Wheelchair
 2. K0002: Standard hemi (low seat) wheelchair
 3. K0003: Lightweight wheelchair
 4. K0004: High strength, lightweight wheelchair
- IV. Modifiers:**
 - A. The following modifiers are required when billed with a standard and/or lightweight wheelchair:
 1. KH: DMEPOS item, initial claim, purchase or first month rental
 2. KI: DMEPOS item, second- or third-month rental
 3. KJ: DMEPOS item, parenteral nutrition (PEN) pump or capped rental, months four to fifteen
 4. KX: Requirements specified in the medical policy have been met
 5. KR: Rental item, billing for partial month (optional)
 6. RR: Rental

V. Authorization Requirements:

- A. Network Health will require authorization for standard and/or lightweight wheelchairs beginning with rental month four (4) and/or day ninety-one (91).
- B. Authorization requests must be submitted prior to rental month four (4) and/or day ninety-one (91) to be eligible for claims payment.
- C. Member assessment must be completed thirty (30) days prior to rental month four (4) and/or day ninety-one (91) to be eligible for claims payment.
- D. Clinical criteria must be submitted to support continued rentals.

Definitions:

Capped Rental: A capped rental means monthly payments for the use of Durable Medical Equipment (DME) for a limited period of time, not to exceed thirteen (13) months.

Regulatory Citations:

Centers for Medicare and Medicaid Services (CMS)

Origination Date: 4/1/2022

Update Date: 12/2/2025

Next Review Date: 12/2/2026