

INDEPENDENCE iBOT 4000 Mobility System (NCD 280.15)

Guideline Number: MPG154.06
Approval Date: May 13, 2020

[↪ Terms and Conditions](#)

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<p>Related Medicare Advantage Policy Guideline</p> <ul style="list-style-type: none"> • Mobility Devices (Non-Ambulatory) and Accessories
<p>Related Medicare Advantage Coverage Summaries</p> <ul style="list-style-type: none"> • Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid • Mobility Assistive Equipment (MAE)

Policy Summary

[↪ See Purpose](#)

Overview

The INDEPENDENCE iBOT 4000 Mobility System is a battery-powered mobility device that relies on a computerized system of gyroscopes, sensors, and electric motors to allow indoor and outdoor use on stairs as well as on level and uneven surfaces. The mobility system incorporates a number of different functions, including:

- Standard Function that provides mobility on smooth surfaces and inclines at home, work, and in other environments;
Note: In Standard Function, the INDEPENDENCE iBOT 4000 Mobility System functions like a traditional power wheelchair. The mobility device can be programmed for Standard Function only to meet the assessed needs of the user.
- 4-Wheel Function that provides movement across obstacles, grass, gravel, uneven terrain, curbs, and other soft surfaces;
- Stair Function that allows for ascent and descent of stairs, with or without assistance; and
- Remote Function that assists in the transportation of the product while unoccupied;
- Balance Function that provides mobility in a seated position at an elevated height

Guidelines

Nationally Covered Indications

The Centers for Medicare & Medicaid Services (CMS) finds that the evidence is sufficient to determine that the Standard Function of the INDEPENDENCE iBOT 4000 Mobility System meets the definition of Durable Medical Equipment (DME) under section 1861(n) of the Social Security Act (the Act) as a wheelchair used in the patient's home that is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living (MRADL), such as feeding, dressing, grooming, toileting, and bathing in customary locations in the home.

Nationally Non-covered Indications

CMS has reviewed the evidence and concludes that the 4-Wheel, Balance, Stair and Remote Functions of the INDEPENDENCE iBOT 4000 Mobility System do not meet the definition of DME under section 1861(n) of the Act.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health

service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
K0898	Power wheelchair, not otherwise classified

References

CMS National Coverage Determinations (NCDs)

[NCD 280.15 INDEPENDENCE iBOT 4000 Mobility System](#)

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	DME MAC
L33789 Power Mobility Devices	A52498 Power Mobility Devices - Policy Article	CGS	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV
		Noridian	AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WY
N/A	A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs	CGS	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV
		Noridian	AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WY

CMS Benefit Policy Manual

[Chapter 15: § 110 Durable Medical Equipment - General](#)

CMS Transmittal(s)

[Transmittal 65, Change Request 5372, Dated 02/23/2007 \(INDEPENDENCE iBOT 4000 Mobility System\)](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update <ul style="list-style-type: none"> Reformatted policy; transferred content to new template
05/13/2020	Related Policies <ul style="list-style-type: none"> Removed reference link to the Medicare Advantage Policy Guideline titled <i>Mobility Assistive Equipment (MAE) (NCD 280.3)</i> Supporting Information <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information Archived previous policy version MPG154.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).