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UTILIZATION MANAGEMENT GUIDELINE– 1.01.527

Power Operated Vehicles (Scooters) (Excluding Motorized Wheelchairs)

Effective Date:	Feb. 1, 2026
Last Revised:	Jan. 12, 2026
Replaces:	N/A

RELATED MEDICAL POLICIES:

1.01.501	Wheelchairs (Manual or Motorized)
1.01.519	Patient Lifts, Seat Lifts and Standing Devices
1.01.526	Durable Medical Equipment Repair/Replacement
1.01.529	Durable Medical Equipment

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RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

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Introduction

A power operated vehicle, also called a mobility scooter or scooter, can run either on batteries or electronically. There are many different types of scooters based on use. They may be made for use in the home, outdoors, when traveling, indoors and outdoors, and for shopping or other activities. Scooters may be used by people who have problems with movement and may be helpful to those who have a tough time using a manual wheelchair due to lack of strength or flexibility. To use a scooter, the user must be able to sit upright without support and be able to control the steering. This policy outlines when scooters may be covered.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Coverage Guidelines

Note: Member benefits may vary by plan. Member benefit language should be reviewed before applying the terms of this medical policy.

Topic	Medical Necessity

Power operated vehicles (POVs) for home use	**Power operated vehicles (POVs), also known as scooters, may be considered medically necessary durable medical equipment for home use when ALL of the following criteria are met:**
	• There must be documentation that the individual has a physical/functional deficit in mobility that impairs their ability to do mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home; **and**
	• The individual's mobility deficit cannot be sufficiently resolved using an appropriately fitted cane or walker; **and**
	• There must be documentation of the health condition that makes the POV medically necessary for long-term use (i.e., 6-12 months or more); **and**
	• There must be documentation that the individual's upper extremity strength is inadequate to self-propel a manual wheelchair or the individual's medical condition does not allow the individual to self-propel a manual wheelchair; **and**
	• There must be documentation that the individual is capable of **ALL** of the following:
	  ○ Safe and independent operation of the controls of a POV, **and**
	  ○ Able to safely transfer to/from a POV, with or without someone's help, **and**
	  ○ Able to self-support an upright position when using the POV; **and**
	• The individual's home allows for adequate access between rooms with maneuvering space and surfaces for operation of a POV; **and**
	• The POV is prescribed by a qualified, licensed healthcare provider after the individual had a clinical evaluation by an appropriate medical professional (PT/OT or physician) that documented its therapeutic purpose

Topic	Medical Necessity
Power operated vehicles (POVs)	**A power operated vehicle (POV) is considered NOT medically necessary for any of the following:** • If the individual can safely ambulate with a cane or walker a distance that would allow access to all necessary rooms in their home and allow them to perform their activities of daily living • If the POV is only for use outside the home • When a POV exceeds the basic mobility requirements for the individual's condition • When a POV is only used when the primary mobility device (e.g., manual/power wheelchair) requires repair • When the individual already has a manual or power wheelchair • When used for convenience • When used solely for recreational/leisure activities • When the individual is unable to safely operate the POV independently • When the POV is purchased without a clinical evaluation and without a health care provider's prescription
Options / accessories	**Options/accessories are considered not medically necessary when they are used primarily for convenience or to assist the individual with leisure or recreational activities.**

Clinical Evaluation

Individuals should have a face-to-face clinical evaluation with a physician, physical therapist, or other rehabilitation professional about whether a powered wheelchair or power operated vehicle (scooter) is appropriate to meet their mobility needs.

Documentation Requirements

Documentation from the clinical evaluation should include ALL the following:

- Details of the individual's functional impairment related to completing mobility-related activities of daily living (ADLs) without the POV; **and**
- The individual's medical condition that requires a POV device for long term use (i.e., 6-12 months or more); **and**
- The individual's physical and cognitive ability to safely operate the POV; **and**

Documentation Requirements

- What assistive devices (e.g., canes, walkers, manual wheelchairs) the individual has trialed and found inadequate/unsafe or contraindicated to completely meet their functional mobility needs; **and**
- Findings from a home visit assessment detailing the accessibility of the individual's living environment for using a POV; **and**
- An order/prescription from the physician/health care provider responsible for the individual's care that states the therapeutic purpose of the POV

Coding

Code	Description
HCPCS	
E1230	Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds
K0801	Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds
K0802	Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds
K0807	Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds
K0808	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds
K0812	Power operated vehicle; not otherwise classified
K0899	Power mobility device, not coded by DME PDAC or does not meet criteria

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Related Information

Definition of Terms

Accessory items: Accessory items are not covered. Car/van lifts and vehicle ramps are considered accessory items and are not covered.

Convenience items: Durable medical equipment that serves no medical purpose or that is primarily for comfort or convenience is excluded under most health plan benefits.

Durable Medical Equipment (DME): DME consists of items that are:

- Primarily and normally used to serve a medical purpose
- Not useful to a person without an illness or injury
- Ordered or prescribed by a physician
- Reusable
- Long-lasting and can stand repeated use
- Appropriate for and primarily used in the home setting
- Not implantable in the body

Mobility Limitation: A mobility limitation is one that:

- Prevents an individual from accomplishing mobility related activities of daily living entirely

OR

- Places the individual at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a mobility related activity of daily living

OR

- Prevents the individual from completing a mobility related activity of daily living within a reasonable time frame.

Residential/Home Modifications: Environmental modifications to allow using the POV in the home are not covered. Indoor/outdoor ramps, stair lifts and elevators may require home modification and are not covered (see **Related Policies**).

Vehicle Ramp/Lift: Van lifts (used to lift a wheelchair/scooter into a truck or van), wheelchair lifts, wheelchair/scooter racks, vehicle ramps and other vehicle modifications or additions are excluded from coverage because they do not meet the definition of medical equipment. These devices facilitate transportation and do not serve a primarily medical purpose.

Coverage Considerations

Medical necessity is determined by the individual's current condition and not by probable deterioration in the future. There are varying degrees of medical conditions, and these medical conditions may be contributing factors to the mobility limitation. Benefit coverage determination for a power operated vehicle (POV) is based solely on the individual's mobility needs within the home.

Benefits are paid for no more than one electric mobility device (electric wheelchair or power operated vehicle) at a time. A backup POV that is not the primary electric mobility device used to meet the member's functional needs is subject to the limits and conditions of the member benefit plan and may not be covered (see **Scope**).

Member benefits may vary by plan. Member benefit language should be reviewed before applying the terms of this medical policy.

A pre-service review can be requested by calling the customer service number on the back of the member's ID card.

Evidence Review

Background

Power Operated Vehicles (POVs) also called electric scooters or mobility scooters are three- or four-wheel motorized mobility devices driven by a rechargeable battery pack. POVs are for individuals with a health condition that impairs ambulation in the home and may be an alternative to a power wheelchair.

The POV can be either front-wheel or rear-wheel drive. The unit consists of a seat that may swivel to allow easy transfer to/from the vehicle, a flat area for the feet and handlebars or a tiller that turns the steerable wheels. Movement forward/backward and braking may be controlled by

various controls such as switches, finger controls or thumb paddles. The battery pack is usually at the back of the vehicle with either an onboard charging unit (most common) or a separate battery charger. Recharging is accomplished by plugging the battery pack into a standard electric power outlet for a specified length of time.

Medicare National Coverage

Power-operated vehicles (scooters) and scooters also known as mobility assistive equipment are covered as durable medical equipment (DME) when prescribed for use in the home if the individual meets the Mobility Assistive Equipment clinical criteria. **https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=143&fromdb=true** Accessed December 11, 2025.

References

1. ABLEDATA fact sheet on scooters. [Internet] ABLEDATA. 2006 Jul. Available at URL address: **http://agis.com/SqlFileResource1675.pdf?id=431&resource=pdf** Accessed December 11, 2025
2. Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) Mobility Assistive Equipment (MAE) (280.3)Ver 2; Effective 05/05/2005; Implemented 07/05/2005. Available at URL address: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=219&ncdver=2Accessed December 11, 2025.
3. Centers for Medicare & Medicaid Services (CMS). Medicare Coverage Database. Local Coverage Determination (LCD) Power Mobility Devices (L33789). Effective 10/1/15. Revised 10/01/2025. Available at URL address: **https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33789&ver=35&Date=&DocID=L33789&bc=iAAAAAIAAAAA&=A** Accessed December 11, 2025.

History

Date	Comments
02/10/14	New policy added to the durable medical equipment category. Power operated vehicles may be considered medically necessary DME for home use when mobility impairment criteria are met.
05/02/14	Update Related Policies. Add 1.01.529.
02/25/15	Annual Review. No change in policy statement.

Date	Comments
01/12/16	Annual Review. No change in policy statement.
02/01/17	Annual Review, approved January 10, 2017. No change in policy statement. Policy moved to new format.
04/14/17	Coding update; added HCPCS code K0899. Minor formatting update.
02/01/18	Annual Review, approved January 9, 2018. No change in policy statement.
02/01/19	Annual Review, approved January 22, 2019. References updated. No change to guideline statement.
04/01/20	Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020 and replaced with InterQual criteria for dates of service on or after July 2, 2020.
07/02/20	Delete policy.
11/01/20	Policy reinstated effective February 5, 2021, approved October 13, 2020. References updated. Guideline statements unchanged.
10/01/21	Annual Review, approved September 2, 2021. UM Guideline reviewed. No references added. Guideline statements unchanged.
04/01/22	Annual Review, approved March 7, 2022. UM Guideline reviewed. Guideline statements unchanged.
03/01/23	Annual Review, approved February 14, 2023. UM Guideline reviewed. Added missing medical necessity policy criteria to align with stated documentation requirements: The individual's mobility deficit cannot be sufficiently resolved using an appropriately fitted cane or walker, the individual's home allows for adequate access between rooms with maneuvering space and surfaces for operation of a POV, and the POV is prescribed by a qualified, licensed healthcare provider after the individual had a clinical evaluation by an appropriate medical professional (PT/OT or physician) that documented its therapeutic purpose; policy intent unchanged. Changed the wording from "patient" to "individual" throughout the policy for standardization.
05/01/24	Annual Review, approved April 8, 2024. Utilization management guideline reviewed. No change to guidelines statements. References updated.
04/01/25	Annual Review, approved March 10, 2025. UM guideline reviewed. Guideline statements unchanged.
02/01/26	Annual Review, approved January 12, 2026. UM guideline reviewed. Guideline statements unchanged. References updated. Update descriptor for HCPCS code E1230.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply.

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Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.