Power Operated Vehicles (Scooters) (excluding motorized wheelchairs)

Effective Date: Feb. 1, 2019
Last Revised: Jan. 22, 2019
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 (Excluding Wheelchairs)
1.01.529 Durable Medical Equipment

Select a hyperlink below to be directed to that section.

COVERAGE GUIDELINES | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

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 hard 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
<table>
<thead>
<tr>
<th>Topic</th>
<th>Medical Necessity</th>
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</table>
| 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 patient 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  
  - There must be documentation of the health condition that makes the POV medically necessary  
  AND  
  - There must be documentation that the patient's upper extremity strength is inadequate to self-propel a manual wheelchair or the patient's medical condition does not allow the patient to self-propel a manual wheelchair  
  AND  
  - There must be documentation that the patient is capable of ALL of the following:  
    o Safe and independent operation of the controls of a POV  
    o Able to safely transfer to/from a POV, with or without someone's help  
    o Able to self-support an upright position when using the POV |
| Power operated vehicles (POVs)            | **A power operated vehicle (POV) may be considered not medically necessary for any of the following:**  
  - If the patient is able to safely ambulate with a cane or a walker a distance that would allow access to all necessary rooms in their home and allow them to perform their activities of daily living  
  OR  
  - If the POV is only for use outside the home  
  OR  
  - When a POV exceeds the basic mobility requirements for the patient's condition |
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<tr>
<th>Topic</th>
<th>Medical Necessity</th>
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<tr>
<td>OR</td>
<td>When a POV is only used when the primary mobility device (e.g., manual/power wheelchair) requires repair</td>
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<tr>
<td>OR</td>
<td>When the patient already has a manual or power wheelchair</td>
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<td>OR</td>
<td>When used for convenience</td>
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<td>OR</td>
<td>When used solely for recreational/leisure activities</td>
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<tr>
<td>OR</td>
<td>When the patient is unable to safely operate the POV independently</td>
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<tr>
<td>OR</td>
<td>When the POV is purchased without a clinical evaluation and without a health care provider’s prescription</td>
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| Options / accessories | Options/accessories are considered not medically necessary when they are used primarily for convenience or to assist the patient with leisure or recreational activities. |

**Clinical Evaluation**

Patients 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 most appropriate to meet their mobility needs.

**Documentation Requirements**

**Documentation from the clinical evaluation should include the following:**

- Details of the patient’s functional impairment related to completing mobility-related activities of daily living (ADLs) without the POV

**AND**

- The patient’s medical condition that requires a POV device for long term use (i.e., 6-12 months or more)

**AND**

- The patient’s physical and cognitive ability to safely operate the POV

**AND**
Documentation Requirements

- What assistive devices (eg, canes, walkers, manual wheelchairs) the patient 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 patient’s living environment for using a POV

AND

- An order/prescription from the physician/health care provider responsible for the patient’s care that states the therapeutic purpose of the POV

Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>E1230</td>
<td>Power operated vehicle (three or four wheeled non-highway)</td>
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<tr>
<td>K0800</td>
<td>Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds</td>
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<tr>
<td>K0801</td>
<td>Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0802</td>
<td>Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td>K0806</td>
<td>Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0807</td>
<td>Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0808</td>
<td>Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td>K0812</td>
<td>Power operated vehicle; not otherwise classified</td>
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<tr>
<td>K0899</td>
<td>Power mobility device, not coded by DME PDAC or does not meet criteria</td>
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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 the patient from accomplishing a mobility related activities of daily living entirely

OR

- Places the patient 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 patient 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 patient’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 patient’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 patients 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 changing unit (most common) or a separate battery charger. Recharging is accomplished by plugging the battery pack in to a standard electric power outlet for a specified length of time.

Medicare National Coverage


References


History

<table>
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<th>Date</th>
<th>Comments</th>
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<tr>
<td>02/10/14</td>
<td>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.</td>
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<tr>
<td>05/02/14</td>
<td>Update Related Policies. Add 1.01.529.</td>
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<td>Date</td>
<td>Comments</td>
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<td>02/25/15</td>
<td>Annual Review. No change in policy statement.</td>
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<tr>
<td>01/12/16</td>
<td>Annual Review. No change in policy statement.</td>
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<tr>
<td>02/01/17</td>
<td>Annual Review, approved January 10, 2017. No change in policy statement. Policy moved to new format.</td>
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<tr>
<td>04/14/17</td>
<td>Coding update; added HCPCS code K0899. Minor formatting update.</td>
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<td>02/01/18</td>
<td>Annual Review, approved January 9, 2018. No change in policy statement.</td>
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<tr>
<td>02/01/19</td>
<td>Annual Review, approved January 22, 2019. References updated. No change to guideline statement.</td>
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**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. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2019 Premera All Rights Reserved.

**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.
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  • Written information in other formats (large print, audio, accessible electronic formats, other formats)
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  • Qualified interpreters
  • Information written in other languages

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You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)


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Iloko (Ilocano): Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalini nga adda ket naglaon iti napateg nga impormanis naipanggep iti aplikasyon no coverage baben a Premera Blue Cross. Daytoy ket mabalini dagiti importante a pelta iti daytoy a pakdaar. Mabalini nga adda rumbeg nga aramidewi nga adda sambay dagiti particular a naituding nga adda aldaw tapno mapagatidneyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormanis ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).
