Power Operated Vehicle

Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Power Operated Vehicle (POV, Scooter)		
MNG #: 123	☒ CCA Senior Care Options (HMO D-SNP) (MA) ☒ CCA One Care (Medicare-Medicaid) (MA) ☒ CCA Medicare Preferred (PPO) (MA & RI) ☒ CCA Medicare Value (PPO) (MA & RI) ☒ CCA Medicare Maximum (HMO D-SNP) (RI) ☒ Medicare Excel (HMO POS) (MI) ☒ Medicare Maximum (HMO D-SNP) (MI) ☒ Medicare Excel (HMO) (CA)	**Prior Authorization Needed?** ☒ Yes (always required) ☐ Yes (only in certain situations. See this MNG for details) ☐ No
Benefit Type: ☒ **Medicare** ☒ **Medicaid**	**Approval Date: 4/11/2024**	**Effective Date: 9/30/2024**
Last Revised Date:	**Next Annual Review Date: 4/11/2025**	**Retire Date:**

OVERVIEW:

A power operated vehicle, also known as a motorized/electric scooter, is a three- or four-wheeled mobility device that provides a member with mobility impairments access to their environment to allow for completion of Activities of Daily Living (ADLs) and Mobility Related Activities of Daily Living (MRADLs).

SENIOR CARE OPTIONS (SCO) AND ONE CARE

DEFINITIONS: Senior Care Options (SCO) and One Care Plans

Ambulatory Equipment –Durable Medical Equipment (DME) that provides stability and security for members with impaired ambulation.

Durable Medical Equipment (DME): Equipment which;

- Is used primarily and customarily to serve a medical purpose;
- Is generally not useful in the absence of disability, illness or injury;
- Can withstand repeated use over an extended period; and

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- Is appropriate for use in any setting in which normal life activities take place, other than a hospital, nursing facility, ICF/IID, or any setting in which payment is or could be made under Medicaid inpatient services that includes room and board, except as allowed pursuant to 130 CMR 409.415 and 409.419(C).

Home: A member's home may be a dwelling owned or rented by the member, a relative's or other person's home in which the member resides, a rest home, assisted living, or another type of group residence or community setting in which normal life activities take place. A home does not include an institutional setting including but not limited to a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or any setting in which payment is or could be made under Medicaid inpatient services that includes room and board, except for items that are allowable pursuant to 130 CMR 409.415.

Mobility System: A manual or power wheelchair (PWC) or other wheeled device, such as a scooter and power operated vehicle (POV), including a base, a seating system, its components, accessories, and modifications.

DECISION GUIDELINES: Senior Care Options (SCO) and One Care Plans

Clinical Coverage Criteria:

The Plan may cover a power operated vehicle (POV) when all of the following criteria are met:

1. The member has a significant mobility limitation that impairs the member's ability to complete activities of daily living (ADLs) and/or mobility related activities of daily living (MRADLS) in the home and/or community. The mobility limitation is such that ADLs/MRADLs either cannot be completed, cannot be completed safely, or cannot be completed in a reasonable amount of time; and
2. The member's mobility limitation cannot be resolved with use of a cane or walker or an optimally configured manual wheelchair; and
3. The member does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the setting in which normal life activities take place to perform MRADLs during a typical day:
    a. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function; and
    b. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories; and
4. The member is able to:
    - Safely transfer to and from a POV; and
    - Safely operate the tiller steering system; and
    - Maintain postural stability and position while operating the POV in the home and/or community setting; and

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5. The member's mental capabilities (e.g., cognition and judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home and/or community; and
6. The member's weight is less than, or equal to, the weight capacity of the provided POV and greater than, or equal to, 95 percent of the weight capacity of the next lower weight class POV; and
7. The member's use of a POV will significantly improve their ability to participate in ADLs/MRADLs; and
8. The member has not expressed an unwillingness to use a POV in the home and/or community setting; and
9. The member has completed a successful trial of the POV in the primary setting (home and/or community) where POV is to be used. Primary setting provides secure storage and charging of POV, adequate access between rooms and adequate maneuvering space.

LIMITATIONS/EXCLUSIONS: Senior Care Options (SCO) and One Care Plans

A POV will be denied as not reasonable and necessary when:

- The member's underlying condition is reversible, and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).
- The member already has equipment that is able to meet their needs and equipment is in good working order.
- The member's mobility needs could be met with a less costly alternative (e.g. manual wheelchair).
- The member does not have a secure area to store the POV with the ability to charge POV and to protect POV from the elements if not stored inside member's home.
    - The POV charging cord must be plugged into a properly wired standard electrical outlet. The use of extension cords to charge the POV batteries is prohibited and would void the manufacturer's warranty on the electrical components and batteries.
- The Plan does not cover outdoor storage (e.g. shed) for POV.

Replacement of POV

The Plan may cover replacement of member's POV when the following criteria are met:

1. The existing POV exceeds five years of age or is no longer reliable in all settings in which normal life activities take place; or
2. The cost of repairing or modifying the existing POV would exceed the value of POV; or
3. The member's physical condition has changed enough to render current POV ineffective.

Documentation Requirements: SCO and One Care Plans

- CCA Standard Prior Auth Form

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- Standard Written Order (SWO)
- Face to Face encounter that is within six months prior to the order date or the written order.
- Home Assessment: On site evaluation by DME supplier or physical therapist or occupational therapist to verify that the member can adequately use the device in the home and/or community setting.
- Letter of Medical Necessity completed by a licensed/certified medical professional (LCMP), Physical Therapist or Occupational Therapist. The LCMP should not have any financial relationship with the supplier.

MEDICARE ADVANTAGE: MA Medicare Preferred, MA Medicare Value, RI Medicare Preferred, RI Medicare Value, RI Medicare Maximum, MI Medicare Excel, MI, MI Medicare Maximum, CA Medicare Excel

DEFINITIONS: MA Medicare Preferred, MA Medicare Value, RI Medicare Preferred, RI Medicare Value, RI Medicare Maximum, MI Medicare Excel, MI, MI Medicare Maximum, CA Medicare Excel

Ambulatory Equipment –Durable Medical Equipment (DME) that provides stability and security for members with impaired ambulation.

Durable medical equipment: Equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally, is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home.
- The equipment is necessary and reasonable for the treatment of the member's illness or injury or to improve the functioning of his or her malformed body member (§110.1); and
- The equipment is used in the member's home.

Home: A member's home may be their own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution (such as an assisted living facility, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID)).

Mobility System: A manual or power wheelchair (PWC) or other wheeled device, such as a scooter/ power operated vehicle (POV), including a base, a seating system, its components, accessories, and modifications.

DECISION GUIDELINES: MA Medicare Preferred, MA Medicare Value, RI Medicare Preferred, RI Medicare Value, RI Medicare Maximum, MI Medicare Excel, MI, MI Medicare Maximum, CA Medicare Excel

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CCA follows applicable Medicare Power Mobility Devices Local Coverage Determinations (LCD) L33789 and Policy Article (A52498), and InterQual Smart Sheets are used to review prior authorization requests for medical necessity.
Refer to LCD and related Policy Article for Coverage Indications, Limitations, and Documentation requirements for initial POV requests and requests for replacement POV.

CODING:

When applicable, a list(s) of codes requiring prior authorization is provided. This list is 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.

CPT/HCPCS CODE	CODE DESCRIPTION
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

Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual© criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

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. This Medical Necessity Guideline is subject to all applicable Plan Policies

and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

REFERENCES:

1. Medicare Local Coverage Determination (LCD) Power Mobility Devices (L33789)
   https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33789
2. Mass Health Code of Massachusetts Regulations (CMR); 130 CMR 450.204: Medical Necessity; 130 CMR 428.402: Definitions; 130 CMR 409.402: Definitions Home, 130 CMR 409.414: Non-covered services.
   https://www.mass.gov/doc/130-cmr-450-administrative-and-billing-regulations/download
   https://www.mass.gov/doc/130-cmr-409-durable-medical-equipment-services/download
3. Pride Mobility Consumer Safety Guide, page 6 and Universal Travel Scooter Owner's Manual, page 19.
   https://www.pridemobility.com/pdf/owners_manuals/safety_guides/sc_consumer_safety_guide.pdf
   https://www.pridemobility.com/pdf/owners_manuals/us_scooter/us_fc_sp_universal_travel_scooter_series_om.pdf

REVISION LOG:

REVISION DATE	DESCRIPTION

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APPROVALS:

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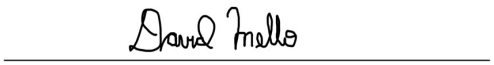
CCA Senior Clinical Lead [Print]	**Title [Print]**
	4/11/2024
Signature	**Date**
Click here to enter text.	
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Signature	**Date**
Nazlim Hagmann	Chief Medical Officer
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