Policy: Power Operated Vehicles (POV) are considered a covered benefit for those members who have mobility impairment to the degree that they are unable to perform MRADLs. The POV is considered to be appropriate if this tool then allows them to perform these ADLs. It is not considered to be appropriate as an adjunct to improving independence and mobility outside of the domicile.

Procedure:
1. Each request for a POV must be accompanied by documentation of a clinical workup that demonstrates at minimum:
   a. An evaluation of the patient’s condition including progress notes from the primary care physician and/or specialist(s) providing for the member’s care; and
   b. How the POV fits into the overall treatment regimen to maintain/improve the patient’s health
      1. An exercise program for the patient to focus on upper body strength, core body tone and aerobic health
      2. A nutrition program focused on a healthy diet and achieving/maintaining appropriate weight/body mass
2. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living (MRADL) in the home as defined by CMS:
   a. For those beneficiaries who have limited ability in one or more MRADLs MHP will require certification of an individualized exercise (PT) and nutrition counseling (dietary compliance) evaluation for any individual requesting a POV along with a follow-up individualized exercise and nutrition program 3 months after delivery of the POV.
3. The functional mobility deficit cannot be sufficiently resolved by the prescription of a cane or walker.
4. Beneficiary requires use of a wheelchair for at least 4 hours per day.
5. The beneficiary lacks sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day.
   a. There are no other conditions that limit the beneficiary’s ability to safely operate, and maneuver a power operated vehicle within their home environment, including ability to negotiate doorways, thresholds, etc. Some examples of potential limiting conditions include, but are not limited to, significant cognitive, intellectual, or visual impairments, insufficient truncal control/balance, etc.
6. There is documentation confirming beneficiary has sufficient cognitive ability, visual acuity, strength and postural stability to safely operate a POV/scooter.
7. The beneficiary’s typical environment supports the use of wheelchairs including scooters/power-operated vehicles (POVs):
   a. A home assessment is required
   b. The home is to be able to accommodate the power operated vehicle being requested
8. There are additional features needed that only a power wheelchair can accommodate (as opposed to scooter):
   a. Joy stick control
   b. Reclining ability
   c. Lower seat height for transfers
   d. Extremity elevation
9. Options and accessories for wheelchairs are covered if the patient has a wheelchair that meets CMS coverage criteria AND the option/accessory itself is medically necessary. Coverage criteria for specific items are described below. If these criteria are not met, the option/accessory will be denied as not reasonable and medically necessary.
   a. **Arm of Chair:** Adjustable arm height option (E0973, K0017, K0018, K0020) is covered if the patient requires an arm height that is different than that available using nonadjustable arms and the patient spends at least 2 hours per day in the wheelchair. An arm trough (E2209) is covered if the patient has quadriplegia, hemiplegia, or uncontrolled arm movements.
   b. **Footrest/ Legrest:** Elevating leg rests (E0990, K0046, K0047, K0053, K0195) are covered if:
      1. The patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or
      2. The patient has significant edema of the lower extremities that requires an elevating leg rest; or
      3. The patient meets the criteria for and has a reclining back on the wheelchair.
   c. **Nonstandard Seat Frame Dimensions:**
      A nonstandard seat width and/or depth for a manual wheelchair (E2201-E2204) is covered only if the patient's physical dimensions justify the need.
   d. **Wheels/Tires for Manual Wheelchairs:**
      A gear reduction drive wheel (E2227) is covered if all of the following criteria are met:
      1. The patient has been self-propelling in a manual wheelchair for at least one year; and
      2. The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the need for the device in the patient’s home. The PT, OT, or physician may have no financial relationship with the supplier; and
      3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.
e. **Batteries/Chargers:** Up to two lead batteries (E2361, E2363, E2365, E2371, K0733) at any one time are allowed if required for a power wheelchair. A non-sealed battery (E2360, E2362, E2364, E2372) will be denied as not reasonable and medically necessary. A single mode battery charger (E2366) is appropriate for charging a sealed lead acid battery. If a dual mode battery charger (E2367) is provided as a replacement, it will be denied as not reasonable and necessary. The usual maximum frequency of replacement for a lithium-based battery (E2397) is one every 3 years. Only one lithium battery is allowed at any one time.

f. **Power Tilt and/or Recline Seating Systems (E1002-E1010):** A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered ONLY if criteria 1, 2, and 3 are met. If those criteria are satisfied then authorization will be based on the documentation on meeting criterion 4, 5, or 6 is met:

1. The patient meets all the coverage criteria for a power wheelchair described in the Power Mobility Devices LCD; and
2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or physician who has specific training and experience in rehabilitation wheelchair evaluations of the patient’s seating and positioning needs. The PT, OT, or physician may have no financial relationship with the supplier; and
3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient

AND

4. The patient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; OR
5. The patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; OR
6. The power seating system is needed to manage increased tone or spasticity.

If these criteria are not met, the power seating component(s) will be denied as not reasonable and necessary.

g. **Power Wheelchair Drive Control Systems:**
An attendant control is covered in place of a patient-operated drive control system if the patient meets coverage criteria for a wheelchair, is unable to operate a manual or power wheelchair and has a caregiver who is unable to operate a manual wheelchair but is able to operate a power wheelchair.

h. **Other Power Wheelchair Accessories:**
An electronic interface (E2351) to allow a speech generating device to be operated by the power wheelchair control interface is covered if the patient has a covered speech generating device. (Refer to the Speech Generating Devices LCD for details.)

i. **Miscellaneous Accessories:**
Anti-rollback device (E0974) is covered if the patient self-propels and needs the device because of ramps. A safety belt/pelvic strap (E0978) is covered if the patient has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item for proper positioning. A swing away, retractable, or removable hardware (E1028) is covered if it is required to move the component out of the way so that a patient can perform a slide transfer to a chair or bed. A manual fully reclining back option (E1226) is covered if the patient has one or more of the following conditions:

1. The patient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or
2. The patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.
If these criteria are not met, the manual reclining back will be denied as not reasonable and necessary.

10. MHP will apply the following guidelines when reviewing a request for repair/replacement of a POV.

   a. Repair of a POV for Customer Owned DME
      i. Repairs or maintenance as a result of normal use are a covered benefit;
      ii. Repairs or maintenance as a result of misuse or abuse are not a covered benefit and are the responsibility of the member;
      iii. For repairs greater than 60% of the cost of new, replacement will be at the discretion of MHP.

   b. Replacement of POV
      i. Replacement of POV damaged by normal use or required due to body growth is a covered benefit;
      ii. Replacement of POV is covered if equipment is past the useful lifetime period. Useful lifetime is considered to be no less than 5 years beginning with the date of delivery. Functioning POV that meets the clinical need is not eligible for replacement, regardless of the age of equipment;
      iii. Replacement will be at the discretion of MHP if cost of repairs is greater than 60% of the cost of new;
      iv. Replacement of POV as a result of misuse or abuse is not a covered benefit and is the responsibility of the member;
      v. Replacement of lost or stolen POV is not a covered benefit.

   c. If a new vehicle is requested MHP will evaluate the request for continued medical necessity and if the request is being made due to operating malfunctions MHP will evaluate the current condition of the power operated vehicle needing replacement.
      i. MHP reserves the right to deny replacement for any POV requested if we feel that the current POV is repairable.

   d. MHP will conduct re-evaluations for POVs and customizations for POVs

11. The request for a new vehicle with or without accessories/options/modifications must meet MHP policy as outlined above for the medical necessity of the request.

12. Please refer to state specific sections below for additional applicable policies, procedures, and guidance.

**Special Instructions:**

**Medicaid/Iowa:**  [http://dhs.iowa.gov/sites/default/files/medequip_0.pdf](http://dhs.iowa.gov/sites/default/files/medequip_0.pdf)

A power wheelchair **attendant control** requires prior authorization. Approval shall be granted when the member has a power wheelchair and:

- Has a sip-n-puff attachment, or
- The documentation demonstrates that the member has difficulty operating the wheelchair in tight spaces, or
- The documentation demonstrates that the member becomes fatigued.

**Medicaid/Michigan:**

Per the MDCH Provider Manual regarding pediatric power operated vehicle requests (Medical Supplier section, Clause 2.48.C, “Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices”, pages 93-94”) prior authorization is required for:

- Power wheelchairs, power-operated vehicles, seating, and accessories.
- New and replacement custom-fabricated seating systems, and the addition of functions for tilt-in-space and/or recline (power or manual).
- Diagnosis/medical conditions that are not listed as approved to bypass prior authorization for pediatric mobility items
- Replacement of standard wheelchairs beyond established timeframes.

However, prior authorization is **NOT** required for the following if standards of coverage are met*:
• Specific accessory codes and/or repair codes.
• Specific pediatric mobility devices that do not include any accessories if the related diagnosis/condition is one of the following:
  o Spinal Muscular Atrophy
  o Motor Neuron Disease
  o Anterior Horn Cell Disease, Unspecified
  o Other Anterior Horn Cell Disease
  o Hemiplegia and Hemiparesis
  o Infantile Cerebral Palsy
  o Myoneural Disorders, Unspecified
  o Other Specified Myoneural Disorder
  o Spina Bifida with Hydrocephalus
  o Spina Bifida without Mention of Hydrocephalus
  o Spina Bifida (Other Congenital Anomalies of Nervous System)
  o Microcephalus
  o Reduction Deformities of Brain
  o Congenital Hydrocephalus
  o Muscular Dystrophies and Other Myopathies

*NOTE: If prior authorization is required for any component of the mobility device (including accessories), then PA is required for the device as well. For example, if a custom-fabricated seating system is required, then prior authorization for the pediatric mobility device is also required.

CPT/HCPCS Codes:

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Approved by: ____________________________  Date: 10/20/2015
Corporate Chief Operating Officer

Reviewed and approved by Policy and Procedure Committee:  Date: 07/17/2015
Reviewed and approved by Medical Policy Operations Committee:  Date: 07/31/2015
Reviewed and approved by Physician Advisory Committee:  Date: 09/25/2015
Reviewed and approved by Corporate Compliance Committee:  Date: 10/20/2015

References:

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