Medical Necessity Guidelines: Power Operated Vehicles (POVs) for Tufts Health Together and Tufts Health RITogether

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:

COMMERCIAL Products

☐Tufts Health Plan Commercial products; Fax: 617.972.9409

☐Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☐Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) **–** Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

This guideline is for the review of Power Operated Vehicles (POVs). A power-operated vehicle is a 3- or 4-wheeled device with tiller steering and limited seat modification capabilities. (CMS, 2006)

For Tufts Health Together and Tufts Health Unify, please refer to **Local Coverage Determination (LCD):Power Mobility Devices (L33789)** and related **Policy Article A52498** at med.noridianmedicare.com/documents/2230703/7218263/Power+Mobility+Devices/18b2db50-5276-44d0-8424-0596dcc01976 for coverage guidelines

For Tufts Health RITogether, please use the following clinical coverage criteria.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may authorize coverage of a power-operated vehicle for members when all of the following criteria are met:

- The Member's functional impairments must be documented and managed by a physician with a rehab-related specialty, such as physical rehabilitation medicine, orthopedics, neurology or rheumatology.
- The Member has a mobility limitation that is permanent and it has been determined that a power operated vehicle will be needed for 12 months or longer.
- The Member is not able to walk more than 150 feet.
- The Member is not able to walk sufficient distances to manage within the community, including but not limited to attending appointments, working and managing household responsibilities, at least three times per week.
- The Member has sufficient strength to safely transfer to and from a POV either independently or with contact guard or minimal assist of 1.
- The Member has postural stability and cognition to operate a power operated vehicle safely and without support or assistance.

- The Member has impairments of their upper extremities that prevent them from being able to maneuver a manual wheelchair for more than 150 feet.
- The primary purpose of the power operated vehicle is for use in the home. A home evaluation, including a home accessibility survey and seating evaluation is required. This evaluation may be completed by either a physical therapist or an occupational therapist who have no financial relationship with the supplier **or** a RESNA-certified Assistive Technology Professional (ATP).

Requests for POV replacements will be considered on case-by-case basis when the current POV has been in use for at least 5 years, the Member meets the above criteria for a power operated vehicle, and one of the following criteria is met:

- A decline in the Member's functional status has been documented.
- Repair or replacement parts are no longer available or cost effective.

LIMITATIONS: ALL PRODUCTS

Tufts Health Plan will not authorize the coverage of a power-operated vehicle in the following circumstances:

- Group 2 POVs (K0806-K0808) have added capabilities that are not needed for use in the home. Therefore, if a Group 2 POV is requested it will be denied as not reasonable and necessary.
- when used for convenience
- when used primarily for recreation or leisure
- when used for community mobility only
- in addition to a power wheelchair

LIMITATIONS: Tufts Health RITogether Product

- In addition to a wheelchair (manual or power) Tufts Health Plan will not cover access ramps, home or vehicle wheelchair lifts or home adaptations.

CODES

The following HCPCS codes require prior authorization:

Code	Description
E1230	Power operated vehicle (three or four wheel non-highway) specify brand name and model number
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds Power operated vehicle codes
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
K0812	Power operated vehicle, not otherwise classified

REFERENCES

1. Centers for Medicare and Medicaid. NCD for Mobility Assistive Equipment (MAE) Retrieved on May 10, 2008 from cms.hhs.gov/mcd/viewncd.asp
2. Centers for Medicare and Medicaid. Local Coverage Determination (LCD) L33789 Power Mobility Devices accessed on October 3, 2016 from https://www.cms.gov/medicare-coverage-database/details/lcddetails.aspx?LCDId=33789&ver=11&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Massachusetts&KeyWord=mobility+device&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d&
3. Center for Medicare and Medicaid National Coverage Determination (NCD) for Mobility Assistive Equipment 280.3 accessed on October 3, 2016 from cms.gov/medicare-coverage-database/details/ncd-details.aspx
4. Centers for Medicare and Medicaid LCD for Manual Wheelchair Bases (L33788) accessed on October 3, 2016 from cms.gov/medicare-coverage-database/details/lcd-details.aspx
5. Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment, 130 CMR 409.420
6. Executive Office of Health and Human Services, State of Rhode Island. Coverage Guidelines for Durable Medical Equipment. Accessed February 2, 2017.

eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/DME/CoverageGuidelinesforDurableMedicalEquipment.aspx.
7. Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. Durable Medical Equipment Bulletin 21. mass.gov/files/documents/2018/10/26/dme-21-bulletin.pdf. accessed January 6, 2019

APPROVAL HISTORY

July 14, 2006: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:

- February 28, 2007: Additional requirement for replacement power operated vehicle added: Member must meet the criteria for coverage of a power operated vehicle.
- May 16, 2008: Criteria updated and simplified without substantive changes.
- April 6, 2009: Reviewed and renewed without changes.
- April 14, 2010: Clarified without substantive changes.
- April 2011: Reviewed at MSPAC, no changes.
- April 11, 2012: Reviewed and renewed at Integrated Medical Policy Advisory Committee (IMPAC), no changes.
- September 11, 2013: Reviewed by IMPAC, renewed without changes.
- December 3, 2014: Adopted by Tufts Health Plan – Network Health Commercial Plans and Tufts Health Plan – Network Health Medicaid Plans.
- December 10, 2014: Reviewed by IMPAC, changes to coverage guideline for transfer to/from a POV.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- December 9, 2015: Reviewed by IMPAC, renewed without changes
- October 24, 2016: Reviewed by IMPAC. For effective date April 1, 2017, criteria changes to allow seating and home evaluations to be performed by OT, PT and/or ATP providers. Removal of criteria requirement "must have the ability to transport device". Added to limitations group 2 POV's and removed limitation in addition to a manual wheelchair. This MNG, specific to Tufts Health Together only, effective April 1, 2017.
- December 14, 2016: Reviewed by IMPAC, renewed without changes
- May 10, 2017: Reviewed by IMPAC. For effective date of August 1, 2017, limitations section for RITogether product added.
- July 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- November 8, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- May 15, 2019: Reviewed by IMPAC. For effective date July 1, 2019, LCD L33789 will be used for prior authorization review for Tufts Health Together and Tufts Health Unify products. Link to LCD added to Medical Necessity Guideline.
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 10, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.