

**Contractor Information**

**Contractor Name**

[Tricenturion](#)

**Contractor Number**

77011

**Contractor Type**

DMERC

**LCD Information**

**LCD ID Number**

L11469

**LCD Title**

Power Operated Vehicles

**Contractor's Determination Number**

POV20051001

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**CMS National Coverage Policy**

CMS Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Section 280.3

**Primary Geographic Jurisdiction**

Connecticut  
Delaware  
Massachusetts  
Maine  
New Hampshire  
New Jersey  
New York - Entire State  
Pennsylvania  
Rhode Island  
Vermont

**Oversight Region**

Region III

**CMS Consortium**

Northeast

**DMERC Region LCD Covers**

Region A

**Original Determination Effective Date**

For services performed on or after 10/01/1993

**Original Determination Ending Date**

**Revision Effective Date**

For services performed on or after 05/05/2005

**Revision Ending Date**

**Indications and Limitations of Coverage and/or Medical Necessity**

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

Refer to the related Policy Article for information concerning Orders and a face-to-face examination.

A power operated vehicle is covered if all of the following criteria (A-G) have been met:

A) The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

- A mobility limitation is one that:

- 1) Prevents the patient from accomplishing an MRADL entirely, or
- 2) Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
- 3) Prevents the patient from completing an MRADL within a reasonable time frame.

B) The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

C) The patient does not have sufficient upper extremity function to safely self-propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day.

- 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.

- An optimally configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

D) The patient has sufficient strength, postural stability, and other physical and mental capabilities needed to safely operate the POV that is provided in the home.

E) The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.

F) Use of a POV will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home.

G) The patient has not expressed an unwillingness to use the POV that is provided in the home.

If the POV will be used inside the home and the coverage criteria are not met, it will be denied as not medically necessary.

If the POV will only be used outside the home, see related Policy Article for information concerning coverage.

If a POV is covered, a manual or power wheelchair provided at the same time or subsequently will usually be denied as not medically necessary.

If a patient-owned POV meets coverage criteria, medically necessary replacement items, including but not limited to batteries, are covered.

### **Coverage Topic**

Durable Medical Equipment  
Wheelchairs

## **Coding Information**

### **Bill Type Codes**

### **Revenue Codes**

### **CPT/HCPCS Codes**

**The appearance of a code in this section does not necessarily indicate coverage.**

### **HCPCS MODIFIERS:**

**EY – No physician or other licensed health care provider order for this item or service**  
**GY – Item or service statutorily excluded or doesn't meet the definition of any Medicare benefit category**

### **HCPCS Codes:**

E0984 MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL

E1230 POWER OPERATED VEHICLE (THREE OR FOUR WHEEL NONHIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER

**ICD-9 Codes that Support Medical Necessity**

Not specified.

**Diagnoses that Support Medical Necessity**

Not specified.

**ICD-9 Codes that DO NOT Support Medical Necessity**

Not specified.

**ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation**

**Diagnoses that DO NOT Support Medical Necessity**

Not specified.

**General Information**

**Documentation Requirements**

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (42 U.S.C. section 1395l(e)). It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available to the DMERC upon request.

**CLAIMS WITH DATES OF SERVICE PRIOR TO 10/25/05:**

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DMERC upon request. Items that are delivered before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to the HCPCS code.

Documentation that the coverage criteria have been met must be present in the patient's medical record. The exception is information about whether the patient's home can accommodate a POV (Criterion E), which may be documented by the supplier. Information from the patient's medical record and the supplier must be available to the DMERC on request.

For claims with received by the DMERC prior to 10/1/05, a Certificate of Medical Necessity (CMN), which has been completed, signed, and dated by the treating physician, must be kept on file by the supplier and made available to the DMERC on request. The CMN for POVs is CMS Form 850. This applies to the power add-on code E0984 as well as to code E1230. The initial claim must include a copy of the CMN.

For claims received by the DMERC on or after 10/1/05, the initial claim for a POV must include a CMN completed by the supplier as instructed by the DMERC. The physician does not need to complete, review, or sign the CMN.

#### CLAIMS WITH DATES OF SERVICE ON OR AFTER 10/25/05:

##### Orders:

The order that the supplier must receive within 30 days after the completion of the face-to-face examination (see Policy Article) must contain all of the following elements:

- 1) Beneficiary's name
- 2) Description of the item that is ordered. This may be general – e.g., "POV" or "power mobility device" – or may be more specific.
- 3) Date of the face-to-face examination
- 4) Pertinent diagnoses/conditions that relate to the need for the POV
- 5) Length of need
- 6) Physician's signature
- 7) Date of physician signature

If this order says "power mobility device" and if it is determined that a POV meets the patient's needs, the supplier must clarify this by obtaining another written order which specifies "POV". The item on this order may be entered by the supplier. This order must be signed and dated by the treating physician and must be received by the supplier prior to dispensing the POV – but it does not have to be received within 30 days following the face-to face examination.

If a written order containing all the required elements specified above is not received by the supplier within 30 days after the face-to-face examination or if the POV is dispensed before the supplier receives a written order for the specific device that is provided, an EY modifier must be added to the HCPCS codes for the POV. The order(s) must be available to the DMERC on request.

##### Face-to-face examination:

The report of the face-to-face examination (see Policy Article) should provide information relating to the following questions:

What is this patient's mobility limitation and how does it interfere with the performance of activities of daily living?
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Why can't a cane or walker meet this patient's mobility needs in the home?
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Why can't a manual wheelchair meet this patient's mobility needs in the home?
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Does this patient have the physical and mental abilities to operate a POV (scooter) safely in the home?
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The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

- Symptoms
- Related diagnoses
- History
  - How long the condition has been present
  - Clinical progression
  - Interventions that have been tried and the results
  - Past use of walker, manual wheelchair, POV, or power wheelchair and the results
- Physical exam

- Weight Impairment of strength, range of motion, sensation, or coordination of arms and legs
- Presence of abnormal tone or deformity of arms, legs, or trunk
- Neck, trunk, and pelvic posture and flexibility
- Sitting and standing balance
- Functional assessment – any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person
  - Transferring between a bed, chair, and PMD
  - Walking around the home – to bathroom, kitchen, living room, etc. – provide information on distance walked, speed, and balance

The written report of this evaluation must be available to the DMERC on request.

Although patients who qualify for coverage of a POV may use that device outside the home, because Medicare's coverage of a wheelchair is determined solely by the patient's mobility needs within the home, the examination must clearly distinguish the patient's abilities and needs within the home from any additional needs for use outside the home.

Miscellaneous:

The initial claim for a POV must include a CMN completed by the supplier as instructed by the DMERC. The physician does not need to complete, review, or sign the CMN.

If the POV that is provided is only to be used for mobility outside the home, the GY modifier must be added to the code.

Information about whether the patient's home can accommodate a POV (Criteria E) may be documented by the supplier.

Refer to the Supplier Manual for more information on documentation requirements

## **Appendices**

### **Utilization Guidelines**

Refer to Indications and Limitations of Coverage and/or Medical Necessity.

### **Sources of Information and Basis for Decision**

Reserved for future use.

### **Advisory Committee Meeting Notes**

This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from.

### **Start Date of Comment Period**

04/16/1993

### **End Date of Comment Period**

05/31/1993

**Start Date of Notice Period**

08/01/1993

**Revision History Number**

POV005

**Revision History Explanation**

Revision effective date: 05/05/2005

LMP converted to LCD and Policy Article

INDICATIONS AND LIMITATIONS OF COVERAGE:

Incorporated coverage criteria from new NCD.

HCPCS CODES AND MODIFIERS:

Added: GY Modifier

DOCUMENTATION REQUIREMENTS:

Revised instructions for CMNs.

Added instructions for use of GY modifier.

Added information about orders and the face-to-face examination for dates of service on or after 10/25/05.

Added statement specifying what information must be in the patient's record and what may be documented by the supplier.

Revision effective date: 04/01/2004

HCPCS CODES AND MODIFIERS:

Added: E0984

Deleted: K0461

CODING GUIDELINES:

Substitutes code E0984 for K0461

DOCUMENTATION REQUIREMENTS:

Substitutes code E0984 for K0461

Revision effective date: 04/01/2003

HCPCS CODES AND MODIFIERS:

Added: EY

INDICATIONS AND LIMITATIONS OF COVERAGE:

Adds standard language concerning coverage of items without an order.

DOCUMENTATION REQUIREMENTS:

Adds standard language concerning use of EY modifier for items without an order.

Revises standard language concerning use of CMNs.

The revision date listed below is the date the revision was published and not necessarily the effective date for the revision.

01/01/2002 - The revisions include changes in codes, coverage and payment rules, coding guidelines, and documentation requirements, which have occurred since the policy was last published.

**Last Reviewed On Date****Related Documents****Article(s)**

A35675 - Power Operated Vehicles - Policy Article - Effective May 2005

**LCD Attachments**

There are no attachments for this LCD

### Contractor Information

**Contractor Name**

[Tricenturion](#)

**Contractor Number**

77011

**Contractor Type**

DMERC

### Article Information

**Article ID Number**

A35675

**Article Type**

Article

**Key Article**

Yes

**Article Title**

Power Operated Vehicles - Policy Article - Effective May 2005

**Primary Geographic Jurisdiction**

Connecticut

Delaware

Massachusetts

Maine

New Hampshire

New Jersey

New York - Entire State

Pennsylvania

Rhode Island

Vermont

**DMERC Region Article Covers**

Region A

**Original Article Effective Date**

05/05/2005

**Article Revision Effective Date****Article Text**

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES**

#### CLAIMS WITH DATES OF SERVICE PRIOR TO 10/25/05:

See Documentation Requirements section of the LCD concerning requirements for orders. There is no requirement for a face-to-face examination for these dates of service.

#### CLAIMS WITH DATES OF SERVICE ON OR AFTER 10/25/05:

##### Orders:

For a POV to be covered, the supplier must receive from the treating physician a written order containing all the elements specified in the Documentation Requirements section of the Local Coverage Determination (LCD) within 30 days after the physician's face-to-face examination and prior to delivery of the device. (Exception: If the examination is performed during a hospital or nursing home stay, the supplier must receive the order within 30 days after discharge.) If these requirements are not met, the claim will be denied as noncovered.

If the written order for the specific device is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

##### Face-to-face examination:

For a power operated vehicle (POV) to be covered, the treating physician must conduct a face-to-face examination of the patient before writing the order and the supplier must receive a written report of this examination within 30 days after the face-to-face examination and prior to delivery of the device. If this requirement is not met, the claim will be denied as noncovered. (Exceptions: If this examination is performed during a hospital or nursing home stay, the supplier must receive the report of the examination within 30 days after discharge. If the POV is a replacement of a similar item that was previously covered by Medicare, a face-to-face examination is not required.)

The physician may refer the patient to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the supplier or have any financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination.)

If the patient was referred to the PT/OT before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the patient and perform any additional examination that is needed. The report of the physician's visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician must provide the supplier with a copy of both examinations within 30 days after the face-to-face examination with the physician.

If the physician saw the patient to begin the examination before referring the patient to a PT/OT, then if the physician sees the patient again in person after receiving the report of the PT/OT examination, the 30-day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the note from his/her initial visit to evaluate the patient plus the annotated, signed, and dated copy of the PT/OT examination to the supplier. The 30-day period begins when the physician signs and dates the PT/OT examination.

##### ALL DATES OF SERVICE:

If a POV is only for use outside the home, it will be denied as noncovered.

Vehicles that because of their size and/or other features are generally intended for use outdoors will be denied as noncovered.

The Medicare allowance for a POV includes all options and accessories that are provided at the time

of initial issue, including but not limited to batteries, battery chargers, seating systems, etc.

## **CODING GUIDELINES**

Code E1230 should be used only for POVs that can be operated inside the home. Code A9270 (noncovered item or service) should be used for vehicles that cannot be operated inside the home.

Code E1230 is not used for a manual wheelchair with an add-on tiller control power pack. Use the appropriate code for the manual wheelchair base provided (K0001-K0009) and code E0984.

If an option or accessory provided at the time of initial issue is billed separately, it must be coded A9900 (miscellaneous DME supply, accessory, and/or service component of another HCPCS code).

A replacement item, including but not limited to replacement batteries, should be billed using the specific wheelchair option or accessory code if one exists. (Refer to the Wheelchairs Options & Accessories medical policy.) If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified).

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

### **Coverage Topic**

Durable Medical Equipment  
Wheelchairs

## **Coding Information**

**No Coding Information has been entered in this section of the article.**

## **Other Information**

### **Revision History Explanation**

Effective Date: 05/05/2005

LMRP converted to LCD and Policy Article

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added requirements for a face-to-face examination and the order for a POV.

Added noncoverage statement for use outside the home.

### **Related Documents**

#### **LCD(s)**

[L11469 - Power Operated Vehicles](#)