

Power Operated Vehicles

TriCenturion

Contractor Information	
Contractor Name	TriCenturion
Contractor Number	77011
Contractor Type	DME PSC
DME MAC this DME PSC is affiliated with	AdminaStar Federal, Inc., HealthNow New York, Inc.
LCD Information	
LCD Database ID Number	L11469
LCD Version Number	18
LCD Title	Power Operated Vehicles
Contractor's Determination Number	POV20060601
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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	CT DC DE IL IN MA MD ME MI MN NH NJ NY OH PA RI VA VT WI WV
Oversight Region	Central Office
DME Region LCD Covers	Jurisdiction A/B
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 06/05/2006
Revision Ending Date	
Indications and Limitations of Coverage and/or Medical Necessity	<p>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.</p> <p>Refer to the related Policy Article for information concerning orders and a face-to-face examination.</p> <p>A power operated vehicle is covered if all of the following criteria (A-G) have been met:</p> <p>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.</p> <p>- A mobility limitation is one that:</p> <ol style="list-style-type: none"> 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. <p>B) The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.</p> <p>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.</p> <p>- 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.</p> <p>- An optimally configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.</p> <p>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.</p> <p>E) The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.</p> <p>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.</p> <p>G) The patient has not expressed an unwillingness to use the POV that is</p>

	<p>provided in the home.</p> <p>If the POV will be used inside the home and the coverage criteria are not met, it will be denied as not medically necessary.</p> <p>If the POV will only be used outside the home, see related Policy Article for information concerning coverage.</p> <p>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.</p> <p>If a patient-owned POV meets coverage criteria, medically necessary replacement items, including but not limited to batteries, are covered.</p>
Coverage Topic	Durable Medical Equipment Wheelchairs
Coding Information	
CPT/HCPCS Codes	<p>The appearance of a code in this section does not necessarily indicate coverage.</p> <p>HCPCS MODIFIERS:</p> <p>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</p> <p>HCPCS Codes:</p> <p>E0984 MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL</p> <p>E1230 POWER OPERATED VEHICLE (THREE OR FOUR WHEEL NONHIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER</p>
Does the CPT 30% Coding Rule Apply?	No
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.
Non-Medical Necessity ICD-9 Codes 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 13951(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.

Orders:

The order that the supplier must receive within 45 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 45 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 45 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?

Why can't a cane or walker meet this patient's mobility needs in the home?

Why can't a manual wheelchair meet this patient's mobility needs in the home?

Does this patient have the physical and mental abilities to operate a POV (scooter) safely in the home?

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

	<ul style="list-style-type: none"> • History <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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 <p>The written report of this evaluation must be available to the DMERC on request.</p> <p>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.</p> <p>Miscellaneous:</p> <p>In order to document that the order and the report of the face-to-face examination was received by the supplier within 45 days after the date of the face-to-face examination, the supplier must use a date stamp or equivalent on the documents.</p> <p>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.</p> <p>Information about whether the patient’s home can accommodate a POV (Criteria E) may be documented by the supplier.</p> <p>Refer to the Supplier Manual for more information on documentation requirements</p>
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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	
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	POV006
Revision History Explanation	<p>Revision Effective Date: 06/05/2006 DOCUMENTATION REQUIREMENTS: Deleted criteria for dates of service prior to 10/25/05. Revised the time frame for the supplier to obtain the dispensing order and report of the face-to-face exam from the physician from 30 days to 45 days. Added requirement for the supplier to date stamp the order and the report of the face-to-face examination.</p> <p>03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).</p> <p>Revision effective date: 05/05/2005 (published October 2005) LMRP 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.</p> <p>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</p> <p>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.</p> <p>The revision date listed below is the date the revision was published and not necessarily the effective date for the revision.</p> <p>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.</p>
Last Reviewed on Date	
Notes	

Does this LCD contain a "Least Costly Alternative" provision?	No
Related Documents	Article(s) A35675 - Power Operated Vehicles - Policy Article - Effective June 2006
LCD Attachments	There are no attachments for this LCD

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Power Operated Vehicles - Policy Article - Effective June 2006

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Contractor Information	
Contractor Name	TriCenturion
Contractor Number	77011
Contractor Type	DME PSC
DME MAC this DME PSC is affiliated with	AdminaStar Federal, Inc., HealthNow New York, Inc.
Article Information	
Article Database ID Number	A35675
Article Type	Article
Key Article	Yes
Article Version Number	7
Article Title	Power Operated Vehicles - Policy Article - Effective June 2006
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Primary Geographic Jurisdiction	CT DC DE IL IN MA MD ME MI MN NH NJ NY OH PA RI VA VT WI WV
DME Region Article Covers	Jurisdiction A/B
Original Article Effective Date	05/05/2005

Article Revision Effective Date	06/05/2006
Article Ending Effective Date	
Article Text	<p>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES</p> <p>CLAIMS WITH DATES OF SERVICE PRIOR TO 10/25/05: Orders:</p> <p>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 45 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 45 days after discharge.) If these requirements are not met, the claim will be denied as noncovered.</p> <p>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.</p> <p>Face-to-face examination:</p> <p>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 45 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 45 days after discharge. If the POV is a replacement of a POV that was previously covered by Medicare, a face-to-face examination is not required.)</p> <p>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.)</p> <p>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 45 days after the face-to-face examination with the physician.</p> <p>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 45-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 45-day period begins when</p>

	<p>the physician signs and dates the PT/OT examination.</p> <p>Miscellaneous:</p> <p>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.</p> <p>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.</p> <p>CODING GUIDELINES</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>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).</p> <p>Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.</p>
Coverage Topic	Durable Medical Equipment Wheelchairs

Coding Information	
CPT/HCPCS Codes	
ICD-9 Codes that are Covered	
ICD-9 Codes that are Not Covered	

Other Information	
Other Comments	
Does this Article contain a "Least Costly Alternative" provision?	No
Approval Notes	
Revision History Explanation	<p>Revision Effective Date: 06/05/2006 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Deleted criteria for dates of service prior to 10/25/05. Revised the time frame for the supplier to obtain the dispensing order and report of the face-to-face exam from the physician from 30 days to 45 days.</p> <p>03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this article was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).</p> <p>Effective Date: 05/05/2005 (published October 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.</p>
Related Documents	LCD(s) L11469 - Power Operated Vehicles
Article Attachments	There are no attachments for this Article

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