Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Power Operated Vehicles (POVs)

Effective: December 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

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).

Clinical Guideline Coverage Criteria

The Plan may authorize coverage of a power-operated vehicle for members when **ALL** of the following criteria are met:

1. 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; **and**
2. 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; **and**
3. The Member is not able to walk more than 150 feet; **and**
4. 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; **and**
5. The Member has sufficient strength to safely transfer to and from a POV either independently or with contact guard or minimal assist of 1; **and**
6. The Member has postural stability and cognition to operate a power operated vehicle safely and without support or assistance; **and**
7. The Member has impairments of their upper extremities that prevent them from being able to maneuver a manual

wheelchair for more than 150 feet; **and**

8. 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:

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

Limitations

The 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 Member's primary mobility device (e.g., manual wheelchair, power wheelchair)

The Plan will not cover access ramps, home or vehicle wheelchair lifts or home adaptations.

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

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
K0801	Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds
K0812	Power operated vehicle, not otherwise classified

References:

1. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD) L33789 Power Mobility Devices. Accessed November 8, 2024. LCD - Power Mobility Devices (L33789) (cms.gov)
2. Center for Medicare & Medicaid Services. National Coverage Determination (NCD) 280.3 for Mobility Assistive Equipment. Accessed November 8, 2024. NCD - Mobility Assistive Equipment (MAE) (280.3) (cms.gov)

Approval And Revision History

October 21, 2020: Reviewed by the Medical Policy Approval Committee (MPAC), renewed without changes

Subsequent endorsement date(s) and changes made:

- November 10, 2020: Fax number for Unify updated
- October 20, 2021: Reviewed by IMPAC, renewed without changes
- November 16, 2022: Reviewed by MPAC, renewed without changes for integration between Harvard Pilgrim Health Care and Tufts Health Plan
- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Unify name changed to One Care effective January 1, 2024
- October 17, 2024: Reviewed by MPAC, renewed without changes, effective December 1, 2024
- October 15, 2025: Reviewed by MPAC, renewed without changes effective December 1, 2025
- November 12, 2025: Fax number for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed; Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template

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. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

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.