Medical Necessity Guidelines:

Power Operated Vehicles (POVs) for Tufts Health Together, Tufts Health RITogether, and Tufts Health One Care

Effective: December 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	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

A power operated vehicle (POV), also known as a motorized/electric scooter, is a three- or four-wheeled mobility device for use by individuals with impaired ambulatory mobility. A POV is powered by a rechargeable battery.

Clinical Guideline Coverage Criteria

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations where available. For **Tufts Health One Care and RITogether** plan members the following criteria is used: Power Mobility Devices LCD L33789 and related Policy Article A52498

The Plan may authorize coverage of a Group 1 or Group 2 POV when General Coverage Criteria and Power Operated Vehicle Coverage Criteria are met.

The following Clinical Coverage Criteria applies to **Tufts Health Together:**

1. Durable medical equipment (DME) is defined as equipment that:

a. is fabricated primarily and customarily to fulfill a medical purpose;
b. is generally not useful in the absence of illness or injury;
c. can withstand repeated use over an extended period; and
d. is appropriate for use in any setting in which normal life activities take place, including, but not limited to, the member's home. [4,6,7]

2. Documentation of a trial/evaluation in setting where power mobility device is to be used primarily (e.g. home, school) must attest to the power mobility device fit in the setting, including secure storage and charging, adequate access between rooms, adequate maneuvering space, and ability to safely maneuver as needed on setting terrains, surfaces

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, member meets the above criteria for a power operated vehicle, and **ONE** of the following criteria is met:

1. A decline in 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:

1. When used for convenience
2. When used primarily for recreation or leisure
3. In addition to a power wheelchair

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
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
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds
K0807	Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds
K0808	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds

References:

1. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD) L33789 Power Mobility Devices. Accessed August 20, 2025. LCD - Power Mobility Devices (L33789) (cms.gov)
2. Center for Medicare & Medicaid Services. National Coverage Determination (NCD) 280.3 for Mobility Assistive Equipment. Accessed August 20, 2025. NCD - Mobility Assistive Equipment (MAE) (280.3) (cms.gov)
3. Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment: Subchapter 6; Service Codes. Accessed August 20, 2025. Transmittal Letter DME-41 (mass.gov)
4. Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment, 130 CMR 409.420 last accessed August 20, 2025. Durable Medical Equipment Manual for MassHealth Providers | Mass.gov
5. Executive Office of Health and Human Services, State of Rhode Island. Coverage Guidelines for Durable Medical Equipment Wheelchairs/Stroller. Accessed August 20, 2025. Coverage Guidelines For Durable Medical Equipment | Executive Office of Health and Human Services
6. Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. Durable Medical Equipment Bulletin 21. Accessed August 20, 2025. download (mass.gov)
7. Commonwealth of Massachusetts Executive Office of Health and Human Services of Medicaid. Transmittal Letter DME-37. Accessed August 20, 2025. Microsoft Word - DME-37.docx (mass.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
- August 18, 2021: Reviewed at IMPAC. For effective date August 18, 2021: Removed Group 2 POV's and "community use only" from limitations section, clarified definition of DME and interpretation of this DME definition. For effective date November 1, 2021: Added coverage criteria for home evaluation documentation requirements.
- October 20, 2021: Reviewed by IMPAC, renewed without changes
- November 17, 2021: Tufts Health Unify added to MNG title
- February 2, 2022: LCD link updated
- April 7, 2022: Template updated
- November 16, 2022: Reviewed by MPAC, renewed without changes
- September 20, 2023:Reviewed at MPAC. Effective January 1, 2024, LCD L33789 applies to RITogether. HCPCS E1230 and K0812 removed from guideline. Home modification RITogether limitation removed from guideline
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- October 17, 2024: Reviewed by MPAC, updated links effective December 1, 2024
- October 15, 2025: Reviewed by MPAC, updated links 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.