KAISER PERMANENTE® Mid-Atlantic States	**Knee Scooter** **Medical Coverage Policy**

Utilization *ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- For Medicare members, please refer to CMS guidelines through Medicare Coverage Database requirements.

I. **DME Item:**
Knee scooter (Kneeling Walker/Knee Walker/Rolling Knee Walker/ Kneeling Crutch/ Crutch Substitute)
HCPCS code: E0118

II. **Coverage Policy**

A. **Standard mobility item**, i.e., Crutches, Canes, Walkers and Wheelchairs are covered under the DME benefit if a patient meets the MCG criteria for the item.

B. A **knee scooter** is considered a crutch substitute and is not covered (HCPCS code E0118). Devices that are covered include crutches, standard walkers, rolling walkers, hemi-walkers or other standard ambulatory assist devices such as a standard manual wheelchair, or a hemi-wheelchair. The least restrictive device that will meet the patient's need for mobility will be provided under the DME benefit.

C. If it is determined that a **Standard Wheelchair** meets criteria and the patient is unable to mobilize the wheelchair independently, coverage will still be met with a caregiver who is available, willing, and able to provide assistance with the wheelchair.

D. If a wheelchair meets criteria, the patient may choose a transport chair as an alternative to a manual wheelchair.

E. The correct mobility device will be determined by evaluation and documentation that the patient can use the device safely and meets MCG guidelines. The least restrictive device will be supplied i.e., A wheelchair will meet criteria if the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane, crutch or walker.

F. A **custom manual wheelchair** is not reasonable and necessary if the expected duration of need is less than three to six months (e.g., post-operative recovery).

G. A **knee scooter** is not covered and will be denied as not reasonable and necessary as there are other DME mobility devices that meet criteria and can be used for mobility.

References

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Approval History

Effective June 01, 2016, state filing no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

Date approved by RUMC	Date of Implementation
06/07/2017	06/07/2017
05/29/2018	05/29/2018
05/28/2019	05/28/2019
05/14/2020	05/14/2020
05/04/2021	05/04/2021
05/25/2022	05/25/2022
05/29/2023	05/29/2023
05/23/2024	05/23/2024

*The Regional Utilization Management Committee received **delegated authority** to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee in 2011.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Whenever possible, Medical Coverage Policies are evidence-based and may also include expert opinion. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.