



Medicare Advocacy Toolkit

Power Wheelchairs

An Advocate’s Guide for Helping Medicare Beneficiaries
Access Durable Medical Equipment

Winter 2025

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About the Medicare Rights Center

Based in New York, the Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Since 1989, Medicare Rights has helped people with Medicare understand their rights and benefits, navigate the Medicare system, and secure the quality health care they deserve. Medicare Rights is committed to:

1. Serving as a **kind and expert** health insurance counselor, educator, and advocate for those who need it most.
2. Providing **independent, timely, and clear** information on Medicare, Medicaid for dual-eligibles, and related topics to communities nationwide.
3. Fostering **diverse** partnerships and points of view.
4. Finding **lasting** solutions to systemic problems that prevent older adults and people with disabilities from accessing needed health coverage and care.

About the Advocacy Toolkits

With 30 years of counseling and advocacy experience, the Medicare Rights Center possesses specialized knowledge about the barriers people with Medicare face in accessing affordable health care, as well as strategies for overcoming these barriers. This series of Medicare Advocacy Toolkits has been developed for any New York advocate who is helping older adults and people with disabilities navigate health insurance benefits. The goal of this project is to empower New York advocates and those they serve to navigate Medicare coverage so that they can access needed care. While intended for a New York audience, the Medicare Advocacy Toolkits may offer lessons to other states and be useful resources as advocates and policymakers think about ways to improve the federal Medicare program, which today serves 60 million Americans. **Advocates with additional questions can contact Medicare Rights' professional email inbox at professional@medicarerights.org. Consumers with questions can call Medicare Rights' national consumer helpline at 1-800-333-4114.**

Acknowledgements

Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, and staff.

The author, Jacob McDonald, would like to thank everyone who makes possible the Medicare Rights Center's counseling and advocacy work, with a particular acknowledgement of the Medicare beneficiaries and caregivers whose experiences have informed the organization's advocacy and these Medicare Advocacy Toolkits. The author specifically thanks Alice Murphy, Emily Whicheloe, and Mitchell Clark, for their writing and editorial support.

The Medicare Rights Center provides these Medicare Advocacy Toolkits as a public service. They are not intended as personalized legal advice, nor is Medicare Rights acting as a private attorney in providing guide content. For the latest information about toolkit topics and customized assistance, contact Medicare Rights, 1-800-MEDICARE, or a local [State Health Insurance Assistance Program](#) (SHIP).

Introduction: Accessing Durable Medical Equipment

Every year, more than 500 clients reach out to the Medicare Rights Center's national helpline with issues relating to accessing durable medical equipment (DME). Medicare's coverage for DME is vital, since the category includes common medically necessary items, such as diabetes testing supplies, mobility aids, and adaptive medical equipment like commode chairs, patient lifts, and hospital beds.¹ Unfortunately, many individuals find it difficult to access these essential items through Medicare.

This Medicare Advocacy Toolkit serves as a step-by-step resource to help advocates and people eligible for Medicare navigate DME access issues. The toolkit first describes the problem and target audience, then explains strategies for accessing power wheelchairs and offers a case example to demonstrate how to evaluate and use these strategies in a complex scenario. Throughout the guide, content is organized in a way that parallels how our counselors evaluate and troubleshoot actual Medicare issues. In addition, the guide contains a wealth of citations to the relevant rules that form the basis for helping people solve their Medicare problems.

The Problem

Over 5 million American adults use a wheelchair to allow them to stay mobile inside and outside of their home.² Access to mobility devices, like electric or power wheelchairs and scooters is vital to ensuring many Medicare beneficiaries can have freedom of movement. Yet, Medicare Rights hears annually from dozens of clients who face barriers to accessing the mobility devices they or their loved ones need. These problems include coverage denials, suppliers who refuse to repair or replace broken DME, providers failing to meet documentation requirements, and individuals struggling to secure appropriate power wheelchairs for their medical condition and body type. Recently, Medicare has imposed a prior authorization requirement on power wheelchairs across the country.³ While designed to reduce fraud and the incidence of incorrectly covered power wheelchairs, the requirements can make it more difficult for beneficiaries to access the power wheelchairs they need.⁴

These access problems often have a cascading, negative effect on the lives of Medicare beneficiaries with mobility issues. Every year, Medicare Rights hears from people who do not get needed health care because they do not have the mobility to get to their doctors' appointments or who injure themselves while trying to move without a fully functioning wheelchair. Especially for individuals who need power wheelchairs—whose health may be particularly vulnerable, delays in care, isolation, unmet medical needs, and worsening health can lead to a downward spiral in health outcomes. Accessing appropriate mobility devices is a key component to maintaining many individuals' health and quality of life.

Target Audience

¹ 42 U.S.C. § 1395m; Medicare.gov, [Durable medical equipment \(DME\) coverage](#).

² Taylor, Danielle, [Americans With Disabilities: 2014](#), U.S. Census Bureau (Nov. 2018), p. 8.

³ Centers for Medicare & Medicaid Services (CMS), [Prior Authorization of Power Mobility Devices \(PMDs\) Demonstration](#).

⁴ CMS, [Medicare Learning Network SE18010](#) (Aug. 17, 2018): "The goal of prior authorization for select DMEPOS items is to reduce unnecessary usage and aberrant billing for these devices." [83 FR 25947](#) at 25947 (June 5, 2018); U.S. Department of Health & Human Services, Office of Inspector General, [Spotlight On... Power Wheelchairs](#).

This Medicare Advocacy Toolkit is designed to help advocates address the needs of New Yorkers who are eligible for Medicare coverage of power wheelchairs (PWCs).⁵

Medicare's coverage rules for PWCs are the same regardless of how someone qualifies for Medicare. Thus, this guide is intended for use with individuals who are eligible for Medicare due to age, disability, or because they have End-Stage Renal Disease (ESRD).

Medicare's Coverage of Power Wheelchairs (PWCs)

Medicare covers a variety of mobility aids, such as canes, walkers, manual wheelchairs, and power mobility devices. Power mobility devices is a general term that includes PWCs, power scooters, and power-assisted manual wheelchairs.

Before an individual can begin the process of getting a PWC, they must meet Medicare's coverage criteria. In general, Medicare's criteria are designed to ensure that beneficiaries receive only the least expensive mobility option that fits their needs. For instance, Medicare would cover a manual wheelchair only if an individual can show that they are unable to use a cane or walker. Likewise, Medicare would only cover a PWC, power scooter, or a push-rim activated power assist system (which attaches to a manual wheelchair to provide mechanical support in moving the wheels) if an individual can show they are unable to propel themselves in a manual wheelchair. In addition, Medicare has a hierarchy of mobility devices that categorizes PWCs into different sub-types and then divides those types into five groups. Furthermore, each group has sub-groups for different seat type, portability, weight capacity, and power features. In short, Medicare beneficiaries must have documented medical evidence that they cannot use more inexpensive mobility options before receiving coverage for more expensive options.

There is a huge variety of PWCs. Each one is intended to address a particular set of patient needs. As a result, Medicare's coverage criteria consider not only the amount and kind of mobility assistance a beneficiary needs, but also their medical condition and its expected duration, their living situation (including "the physical layout, surfaces, and obstacles that exist..."), their cognitive abilities, and the availability of a caregiver.⁶ In other words, Medicare's coverage criteria are designed to match a person's needs to the most appropriate and least costly PWC, based on how the beneficiary will need to use the PWC in their actual home.

For these reasons, Medicare's coverage criteria for PWCs are specific, detailed, and complex. To help providers and PWC suppliers evaluate patients for Medicare coverage of PWCs, Medicare has created a flowchart⁷ and list of questions to walk through.⁸ By following this algorithm, providers are supposed to be able to accurately match a patient with the appropriate Medicare-covered power mobility device.

Coverage Criteria for PWCs

⁵ For the definition of "home," see CMS, Medicare Benefit Policy Manual, [Ch. 15](#), § 110.1(D).

⁶ CMS, National Coverage Determination (NCD) [280.3\(A\)](#), Mobility Assistive Equipment (MAE).

⁷ CMS, [Clinical Criteria Algorithm for Wheelchair Prescribing](#).

⁸ CMS, NCD [280.3\(B\)](#), Mobility Assistive Equipment (MAE).

The basic criteria for Medicare PWCs (and other power mobility devices) require that the individual:⁹

1. Has a mobility limitation that prevents them from completing within a reasonable time frame, or places them at a “reasonably determined heightened risk of death” for attempting, at least one mobility-related activity of daily living (e.g., toileting, feeding, dressing, grooming, and bathing in customary locations in the home);
2. Cannot “sufficiently and safely resolve” the limitation through using another mobility device (e.g., a cane or walker);
3. Cannot physically use “an optimally-configured manual wheelchair” to perform their mobility-related activities of daily living in their home on a typical day; and
4. Needs the device for more than three months.¹⁰

Once an individual meets the basic criteria, Medicare would still prefer to cover a power scooter rather than a PWC. For that reason, an individual first needs to show that they could not use a power scooter. If they can show that, then Medicare will cover a PWC for an individual if:¹¹

1. They have the mental and physical abilities to safely use the PWC, or have a caregiver who can and will operate the PWC but would not be able to move the person in a manual wheelchair;
2. They have a home that provides adequate space and surfaces in which to use the PWC;
3. Their weight is appropriate for the class of PWC; and
4. They have expressed a willingness to use the PWC in their home.

At this point, the coverage criteria for Medicare becomes even more specific. As previously mentioned, PWCs are divided into five different groups based on their features and, within these groups, there are sub-groups for different seat types, portability, weight capacity, and power features.¹² Providers should consult the additional criteria found in the Local Coverage Determination for Power Mobility Devices when ordering a specific type of PWC, but, for advocacy purposes, understanding the criteria above is almost always sufficient: if an individual can show they meet the above criteria, then Medicare should cover some type of PWC for them.¹³

Other Power Mobility Devices

Medicare covers other mobility devices (e.g., canes, walkers, manual wheelchairs) and other power mobility devices (e.g., power-assisted manual wheelchairs, power scooters, and pediatric, or Group 5, PWCs).¹⁴ However, unlike PWCs, these other mobility devices do not require prior authorization.¹⁵ To identify whether an individual needs a PWC (and will need to pursue prior authorization) or another power mobility device, it is helpful to understand how to identify these DME.

- **Power-assisted manual wheelchairs:** these are accessories added to a manual wheelchair that, essentially, convert the chair into a PWC. Medicare covers the push-rim activated power assist system, which attaches to a manual wheelchair and mechanically

⁹ CMS, LCD [L33789](#), General Coverage Criteria.

¹⁰ CMS, LCD [L33789](#), Miscellaneous.

¹¹ Ibid., Power Wheelchairs (K0013, K0813-K0891, K0898).

¹² Ibid., CPT/HCPCS Codes.

¹³ Ibid., Additional Criteria for Specific Types of Power Wheelchairs.

¹⁴ Ibid.

¹⁵ CMS, [Required Prior Authorization List](#) (Updated February 7, 2020).

assists the user in moving the chair.¹⁶ Medicare does not cover add-ons to convert a manual wheelchair to a joy-stick- or tiller-controlled power mobility device.¹⁷

- Power scooters (also called Power Operated Vehicles (POVs)): these are similar to PWCs but have tiller steering, rather than electronic (usually joystick) steering.¹⁸ POVs are generally less expensive, have easier coverage criteria to meet, and are covered by Medicare without prior authorization.¹⁹

Advocacy Tip: Replacements and Back-Ups

Medicare will only cover one type of power mobility device at a time.²⁰ If someone already has a PWC (or other mobility device), it is vital that the provider and supplier document why a new one is needed. If they do not, Medicare will deny the second device as not reasonable and medically necessary because it is duplicative of a device the person already owns. Reasons sufficient for Medicare to cover a new PWC include a change in medical condition necessitating a different type of device or if the previous device was lost, stolen, or irreparably damaged from a specific accident.²¹ This also means that Medicare will not cover a back-up chair.²²

Medicare covers DME for use in the home, not outside the home.

One frequent coverage issue stems from the fact that Medicare only covers DME, such as PWCs, when they are appropriate for use in the home.²³ Practically, this rule does not affect most individuals, since as long as they need a PWC in their home, and they show a willingness and ability use the PWC in their home, Medicare will cover their device.²⁴ These individuals can use their Medicare-covered equipment outside of their home; they just cannot use it exclusively outside their home.²⁵

Some types of PWC have specific capabilities that are designed for use outside the home and, as a result, Medicare will not cover them.²⁶ For example, Medicare does not cover Group 4 PWCs, which are those with heavy-duty frames, more powerful motors, and enhanced suspension.²⁷ In other words, Medicare does not cover PWCs designed to be used mainly outside.

Advocacy Tip: Documenting Use in the Home

In order to get Medicare coverage for a PWC, individuals need to show they need the device to get around their home, could use it to get around their home, and that it is

¹⁶ CMS, Local Coverage Article (LCA) [A52498](#), Coding Guidelines, Definitions, Push-rim activated power assist (E0986).

¹⁷ CMS, LCD [L33789](#), Miscellaneous. Non-covered billing codes are E0983 and E0984.

¹⁸ CMS, [Medicare's Wheelchair & Scooter Benefit](#), p. 2.

¹⁹ CMS, LCD [L33789](#), Power Operated Vehicles (K0800-K0808, K0812); CMS, [Power Mobility Devices ICN 905063](#) at p. 4.

²⁰ CMS, LCD [L33789](#), Miscellaneous.

²¹ [42 CFR § 414.229\(g\)\(2\)](#).

²² CMS, LCD [L33789](#), Miscellaneous.

²³ CMS, Medicare Benefit Policy Manual, [Ch. 15](#), §110 and 110.1(D).

²⁴ CMS, LCD [L33789](#), Power Mobility Devices.

²⁵ CMS, LCA [A52498](#), Non-Medical Necessity Coverage and Payment Rules.

²⁶ CMS, LCD [L33789](#), Additional Criteria for Specific Types of Power Wheelchairs.

²⁷ CGS, [Upgrades to Group 2 Power Operated Vehicles \(K0806-K0808\) and Group 4 Power Wheelchairs \(K0868-K0886\)](#) (April 11, 2011).

designed mainly to be used in their home. While suppliers usually understand this rule, in Medicare Rights' experience, the prescribing providers are not always familiar with it. In such cases, it is important to communicate to the provider the need to focus the medical record on PWC needs in the home. For example, a doctor would not want to write a letter explaining why an individual needs a PWC to get to their medical appointments, but rather that they need the PWC to get from their living room to their kitchen. This focus can be unintuitive for medical professionals who are thinking broadly about their patients' medical needs but is key to ensuring the correct information is provided to Medicare.

Custom-Made PWCs

Some individuals need a PWC (and meet the criteria for one) but have "specific configurational needs" that cannot be met using cushions, options, or accessories added to a standard PWC.²⁸ In those cases, the PWC itself needs to be custom-made (i.e., "uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of the beneficiary's treating practitioner.").²⁹ Medicare will cover custom-made PWCs, but not if the need is temporary (i.e., needed for less than three months).³⁰

Medicare does not require prior authorization for custom PWCs.³¹ However, individuals must show that they cannot be accommodated by any standard PWCs, including those with custom accessories and seating arrangements.³² Once approved, Medicare will pay a custom amount for the custom-built PWC based on the cost of labor and material in making the chair.³³

Advocacy Tip: Find the Right Supplier for Custom Devices

While it is always important for individuals to carefully consider their supplier, this is particularly true if they need a custom-built PWC. Individuals should be certain to use a supplier who can custom build a PWC that fits their needs, but who also has experience successfully obtaining Medicare coverage for their work and navigating the additional documentation requirements.³⁴

Medicare will not pay for PWCs with certain features.

As previously mentioned, Medicare will not pay for PWCs in Group 4, since those devices are designed to be used outside of the home.³⁵ Similarly, Medicare does not cover what it considers "upgrades" to standard PWCs that "are beneficiary primarily" in allowing the individual "to perform leisure or recreational activities" rather than in performing mobility-related activities of

²⁸ 42 C.F.R. § 414.224(a); CMS, LCD [L33789](#), Additional Criteria for Specific Types of Power Wheelchairs.

²⁹ CMS, LCA [A52498](#), Non-Medical Necessity Coverage and Payment Rules.

³⁰ CMS, LCD [L33789](#), Additional Criteria for Specific Types of Power Wheelchairs.

³¹ CMS, [Required Prior Authorization List](#) (Updated February 7, 2020).

³² CMS, LCA [A52498](#), Non-Medical Necessity Coverage and Payment Rules.

³³ 42 C.F.R. § 414.224(b).

³⁴ See, CMS, LCA [A52498](#), Policy Specific Documentation: "Documentation must include a description of the beneficiary's unique physical and functional characteristics that require a custom motorized/power wheelchair base. This must include a detailed description of the manufacturing of the wheelchair base, including types of materials used in custom fabricating or substantially modifying it, and the construction process and labor skills required to modify it. The record must document that the needs of the beneficiary cannot be met using another power wheelchair base that incorporates seating modifications or other options or accessories (prefabricated and/or custom). The documentation must demonstrate that the K0013 is so different from another power wheelchair base that the two items cannot be grouped together for pricing purposes."

³⁵ CMS, LCD [L33789](#), Additional Criteria for Specific Types of Power Wheelchairs.

daily living.³⁶ While many suppliers offer a tremendous variety of PWCs, it is important to consider what Medicare will cover, thinking always of what is needed to assist a person with completing their mobility-related activities of daily living in their own home. For example, Medicare will generally not cover PWCs with seat elevators, though many other types of insurance do.³⁷

Differences for Individuals in a Medicare Advantage Plan

Coverage rules for PWCs may change depending on whether the individual receives their Medicare benefits through the federal government (Original Medicare) or through a private health insurance plan (Medicare Advantage). In most cases, there are only small differences, as noted throughout this guide. This is because Medicare Advantage (MA) Plans have to cover PWCs whenever Medicare would,³⁸ and the majority of plans follow the same documentation and supplier requirements that Medicare imposes.³⁹ However, it is important for any individual in an MA Plan to make sure they follow any specific rules that their plan has imposed for accessing DME. Individuals can find these rules in the plan's Evidence of Coverage (EOC) or by calling member services at the plan.

What exactly does Medicare cover?

Since Medicare covers a variety of PWCs, it can be helpful to diagnosing and addressing problems to understand what's included in the basic PWC package, besides the chair, motor, and battery: safety belt, battery charger, tires and casters, legrests, footrests, armrests, weight-specific components, and a controller (e.g., joystick).⁴⁰

Advocacy Tip: Extra Features

When an individual needs additional equipment beyond the basic equipment package, it is important for the supplier to determine whether the equipment is covered and can be billed separately. When equipment is not covered, individuals who are able can still choose to purchase the additional equipment through secondary coverage or by paying out of pocket. When equipment is covered but cannot be billed separately, the supplier is expected to provide the equipment without any extra charge to Medicare or the beneficiary.

Accessing Medicare-Covered Power Wheelchairs

1. Working with a Provider

- a. Face-to-face examination and medical record
- b. Written prescription
- c. Detailed product description

³⁶ CMS, LCA [A52498](#), Non-Medical Necessity Coverage and Payment Rules, Miscellaneous.

³⁷ Ibid.

³⁸ [42 C.F.R. § 422.101](#); CMS, Medicare Managed Care Manual, [Ch. 4](#), §10.12.

³⁹ See, e.g., UnitedHealthcare, Coverage Summary, [Mobility Assistive Equipment](#); Aetna, Clinical Policy Bulletin Number: 0271, [Wheelchairs and Power Operated Vehicles \(Scooters\)](#).

⁴⁰ CMS, LCA [A52498](#), Coding Guidelines, Definitions, Basic Equipment Package.

2. Working with a Supplier

- a. Finding a supplier
- b. Submitting a prior authorization request
- c. Choosing a brand
- d. How are suppliers paid?
- e. After five years, consider getting a new PWC

Working with a Provider

The first step for any individual looking to access a Medicare-covered PWC is to see their doctor, often a primary care physician, to secure medical documentation and an order for the equipment after a face-to-face visit.⁴¹ The individual's provider should take these steps:⁴²

1. Conduct a **face-to-face examination** and prepare the **medical record**
2. Complete a **written prescription (or 7-element order)**
3. Sign a **detailed product description**

Advocacy Tip: What to Look for in an Ordering Provider

Obtaining Medicare coverage for a PWC is a long and complicated process even in the best circumstances. It can be vital for individuals to have a cooperative and experienced provider ordering the PWC. Individuals may want to consider asking a few key questions about their provider before they begin this process: Are they informed and current on the requirements for Medicare PWC coverage? Are they supportive and willing to put in the time necessary to ensure the documentation requirements are met? Are they responsive and able to coordinate with the supplier? Individuals can also keep in mind that Medicare does provide additional reimbursement to providers for preparing the required documentation.⁴³ Furthermore, individuals will often not be communicating directly with the prescribing doctor, but, more commonly, with the office staff, a social worker, a nurse, or physician's assistant. Thus, individuals should consider the responsiveness of the doctor's office and not just of the doctor themselves.

Face-To-Face Examination and Medical Record

First, the provider⁴⁴ must prepare a medical record that shows the patient meets Medicare's coverage criteria for a PWC.⁴⁵ This preparation begins with a face-to-face mobility examination where the provider documents the individual's medical history related to mobility, evaluates the individual's medical condition, and determines the medical necessity of a PWC as part of an

⁴¹ Noridian Healthcare Solutions, [Medical Records](#).

⁴² CMS, Medicare Learning Network, [Power Mobility Devices](#), ICN 905063 p. 5.

⁴³ Noridian Healthcare Solutions, [Documentation Requirements for Power Wheelchairs and Power Operated Vehicles](#) (Oct. 2018).

⁴⁴ Qualifying providers include Medical Doctors, Doctors of Osteopathic Medicine, Doctors of Podiatric Medicine, physician assistants, nurse practitioners, and clinical nurse specialists. CMS, Medicare Claims Processing Manual, [Ch. 12](#) § 30.6.15.4; Noridian Healthcare Solutions, [Face-to-Face and Written Order Requirements for Certain Types of DME](#) (Oct. 2018).

⁴⁵ CMS, Medicare Program Integrity Manual, [Ch. 5](#) § 5.9.2.

overall treatment plan.⁴⁶ This mobility examination may not be a single visit with a doctor—it may also include a visit to other providers, often physical therapists, who perform specific parts of the evaluation. In addition, when an individual also needs specific accessories or customizations for their PWC, Medicare requires a separate specialty evaluation by a provider who can explain why each option is needed.⁴⁷

In all cases, the provider must establish a medical record showing:⁴⁸

1. The individual's mobility limitation and how it interferes with activities of daily living;
2. Why a cane, walker, manual wheelchair, or scooter would not meet the individual's mobility needs in their home; and
3. That the individual has the physical and mental abilities to operate a PWC in their home.

In some cases, the supplier will provide the doctor with a documentation template to help ensure the medical record is complete.⁴⁹ In addition to any template, the doctor should also provide current and historical notes, consultations with other doctors, lab and test reports, and any other information on the severity of the individual's mobility issues.⁵⁰ Medicare does not provide a specific template or form, but it does provide a checklist for the face-to-face evaluation and medical records requirement and an example of the required level of detail and support.⁵¹

Advocacy Tip: When the Provider Needs Help

Some providers have difficulty putting together the correct medical documentation or understanding the requirements. Fortunately, there are several resources to assist providers.

- **Supplier:** PWC suppliers are trained by Medicare to understand the coverage criteria and make assessments to determine when someone qualifies for PWCs.⁵² Providers can reach out to the supplier for help in understanding what documentation they need and how to complete it correctly.
- **Centers for Medicare & Medicaid Service (CMS) materials:** CMS has created educational materials for providers,⁵³ and extensively laid out the coverage criteria and documentation requirements for PWCs.⁵⁴
- **DME Medicare Administrative Contractor (MAC):** DME MACs process Original Medicare claims for PWCs and publish the coverage criteria. Providers can reach out to the DME MAC directly⁵⁵ or use their online training materials.⁵⁶

⁴⁶ CMS, Medicare Learning Network, [Power Mobility Devices](#) (ICN 905063) p. 6.

⁴⁷ CMS, LCD [L33789](#), Policy Specific Documentation Requirements, Specialty Evaluation: "The specialty evaluation that is required for beneficiary's who receive a Group 2 Single Power Option or Multiple Power Options PWC, any Group 3 PWC, or a push-rim activated power assist device is in addition to the requirement for the face-to-face encounter. The specialty evaluation provides detailed information explaining why each specific option or accessory – i.e., power seating system, alternate drive control interface, or push-rim activated power assist – is needed to address the beneficiary's mobility limitation. There must be a written report of this evaluation available on request."

⁴⁸ CMS, Medicare Learning Network, [Power Mobility Devices](#) (ICN 905063) p. 6.

⁴⁹ Ibid. at p. 7.

⁵⁰ Noridian Healthcare Solutions, [Medicare Prior Authorization Condition of Payment for Certain Power Mobility Devices](#) (July 2019).

⁵¹ CMS, MLN Matters [Power Mobility Device Face-to-Face Examination Checklist](#) (SE1112).

⁵² Noridian Healthcare Solutions, [Durable Medical Equipment, Prosthetics, Orthotics and Supplies \(DMEPOS\)](#).

⁵³ CMS, Medicare Learning Network, [Power Mobility Devices](#) (ICN 905063).

⁵⁴ CMS, National Coverage Determination (NCD) [280.3](#); LCD [L33789](#); LCA [A52498](#).

⁵⁵ In New York, this is [Noridian Healthcare Solutions](#), which providers can reach online at the [Noridian Medicare Portal](#) or by calling (866) 419-9458.

⁵⁶ E.g., Noridian Healthcare Solutions, [Clinician DME on Demand Tutorials](#).

- **Medicare Advantage Plan:** MA Plans process claims for PWCs for their plan members. Providers can reach out to the plan to discuss coverage criteria, documentation requirements, and any other coverage-related questions. In addition, providers, suppliers, and plan members can all request pre-service organization determinations from the plan.⁵⁷ An organization determination is the plan's decision about whether it will cover the PWC.⁵⁸ An individual or their provider can appeal an unfavorable organization determination.⁵⁹

Written Prescription (or 7-Element Order)

Next, the medical record must be supported by matching information on a timely and accurate written prescription.⁶⁰ The prescription must include seven items:⁶¹

1. Patient's name;
2. Date of the face-to-face examination;
3. Pertinent diagnoses/conditions that create the needs for a PWC;
4. Description of the PWC being ordered;
5. Length of time the individual will need the PWC;
6. Provider's signature; and
7. Date of provider's signature.

Advocacy Tip: Details Matter

It is crucial for providers to follow all directions and accurately report the required information in a timely fashion. Medicare Rights hears from many clients who are denied coverage for PWCs or are unable to get a supplier to provide a PWC to them because of incomplete, inaccurate, or untimely documentation.

Detailed Product Description (DPD)

When the medical record and prescription are complete, the provider should then sign and date a DPD the suppliers sends to them.⁶² While the provider already sent to the supplier a written order for the PWC, the DPD is the final, itemized order that furnishes specific instructions to the supplier about the type of chair, options, and accessories needed.⁶³ Individuals should double-check that the DPD accurately reflects the kind of chair and accessories they need, since this is what will be sent to Medicare.

⁵⁷ CMS, Medicare Managed Care Manual, [Ch. 4](#), § 160; [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#), § 40.6.

⁵⁸ CMS, Medicare Managed Care Manual, [Ch. 4](#), § 160.

⁵⁹ CMS, Medicare Managed Care Manual, [Ch. 4](#), § 160; [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#), § 50.1.

⁶⁰ CMS, Medicare Learning Network, [Power Mobility Devices](#) (ICN 905063) p. 8.

⁶¹ CMS, Medicare Program Integrity Manual, [Ch. 5](#) § 5.2.4(B); CMS, Medicare Learning Network, [Power Mobility Devices](#) (ICN 905063) p. 8.

⁶² CMS, Medicare Learning Network, [Power Mobility Devices](#) (ICN 905063) p. 9.

⁶³ Noridian Healthcare Solutions, [Medicare Prior Authorization Condition of Payment for Certain Power Mobility Devices](#) (July 2019).

Advocacy Tip: Order Matters

To ensure Medicare coverage, it is crucial for providers and suppliers to complete the required paperwork in the correct order. For example, if the supplier delivers the PWC prior to the receipt of the DPD, Medicare should deny the equipment for being statutorily non-covered, meaning the equipment fails to meet the Medicare law's definition of DME since it was not properly ordered by a doctor.⁶⁴

Remember to Follow Any Additional Rules Required by the MA Plan

MA Plans sometimes impose additional DME coverage requirements. For example, a plan, like Medicare, might also require prior authorization before approving a PWC for one of their plan members. To avoid problems, individuals with an MA Plan should ensure they understand the plan's rules, follow them, and communicate with their in-network provider and supplier to ensure the rules are followed. Individuals can find these rules in their plan's Explanation of Coverage or by calling member services at the plan (being careful to note the name of the person they speak with, the date and time of the call, and any information that was obtained).

Working with a Supplier

The second step for accessing a Medicare-covered PWC is to find a supplier that is knowledgeable and communicative. Finding the right PWC supplier can help an individual avoid access problems immediately and in the future, as individuals normally rely on the same supplier for the five-year lifespan of their PWC. Suppliers are expected to:

- Evaluate individuals for coverage, including acquiring the required medical documentation and assisting with appeals for coverage denials from Medicare or their MA Plan.⁶⁵
- Communicate with the individual's provider at the time of the initial order to secure the required medical documentation, order, and DPD.
- Perform (or have the provider perform) and document an on-site evaluation of the individual's home to ensure they will be able to maneuver the PWC in it.⁶⁶
- Communicate with the individual's provider after the initial order to acquire any needed recertifications and document continued need and use.
- Deliver, set-up, and educate the individual about the use of their PWC.⁶⁷

Advocacy Tip: What to Look for in a Supplier

Obtaining Medicare coverage for a PWC is a long and complicated process even in the best circumstances. It can be vital for individuals to have a cooperative and experienced supplier providing the PWC. Individuals may want to consider asking a few key

⁶⁴ CMS, LCA [A52498](#), Non-Medical Necessity Coverage and Payment Rules.

⁶⁵ Suppliers have a variety of resources available through the DME MACs, e.g. Noridian Healthcare Solutions, [Power Mobility Devices](#) (PMDs) and CGS, [DME MAC Jurisdiction C Power Mobility Devices Denial Help Aid](#).

⁶⁶ CMS, LCD [L33789](#), Policy Specific Documentation Requirements.

⁶⁷ CMS, LCA [A52514](#), Miscellaneous. Suppliers must also maintain documentation in the form of proof of delivery. LCD [L33789](#), General.

questions about their supplier: Are they informed and current on the requirements for Medicare PWC coverage? Are they supportive and willing to put in the time necessary to ensure the documentation requirements are met? Are they responsive and able to coordinate with the provider? Are they organized enough to properly document medical necessity and submit the claim with everything that is needed? Will they make sure the individual can actually use the PWC in their home, that it correctly fits, and that it is comfortable? Will they respond to maintenance requests in a timely fashion? If needed, will they help with a denial?

Finding a Supplier

To ensure their PWC is covered and to protect themselves from higher costs, individuals should carefully choose their PWC supplier. How to find an appropriate supplier depends on whether the individual receives their Medicare benefits through Original Medicare or an MA Plan.

Those with Original Medicare should use a Medicare-approved supplier that takes assignment. Individuals can call 1-800-MEDICARE or visit www.medicare.gov/supplier to find DME suppliers who take assignment.

- **If the supplier takes assignment for PWCs:**⁶⁸ Once an individual meets their Part B deductible, Original Medicare normally pays 80% of the Medicare-approved amount for the PWC leaving individuals (or their secondary insurance) responsible for 20% of the Medicare-approved amount. The supplier must accept Medicare's approved amount as payment in full.
- **If the supplier does not take assignment for PWCs:**⁶⁹ The supplier may charge the individual more than Medicare's approved amount for a PWC. Medicare may still pay the same 80% of the Medicare-approved amount, which leaves the individual responsible for the additional costs. There is no limiting charge for DME as there is with most health care services, meaning a supplier who does not accept assignment can charge any amount over the Medicare-approved cost for a service or item.

Finding a Supplier for Those in an MA Plan

Follow the plan's rules for getting DME, including which providers and suppliers to use. Individuals can find these rules in the plan's Explanation of Coverage or by calling member services at the plan. In most MA Plans, it is important to find a supplier that contracts with that plan (an in-network supplier). In most cases, individuals who use an out-of-network supplier will face higher costs and may lose some billing protections. Plans are required to keep up-to-date lists of their in-network suppliers.⁷⁰

Advocacy Tip: Provider-Supplier Miscommunications

⁶⁸ Medicare.gov, [Lower costs with assignment](#); CGS, [DME Supplier Participation and Assignment Reminders](#).

⁶⁹ Ibid.

⁷⁰ CMS, Medicare Managed Care Manual, [Ch. 4](#), §10.12.1.

Some of the most difficult PWC access cases Medicare Rights encounters are where there is a breakdown in communication between the ordering provider and the PWC supplier. When encountering this situation, individuals can:

- **Advocate:** The individual or their advocate can educate themselves on the coverage criteria and prior authorization process in order to reach out to the provider and suppliers to make specific, actionable requests.
- **Complain:** Suppliers should have grievance processes that individuals can use to try to escalate a problem internally.
- **Escalate:** Individuals in Original Medicare can contact the CMS Regional Office to get assistance from a caseworker.⁷¹ Both the Regional Office and 1-800-MEDICARE can also forward a complaint to the Medicare Ombudsman or Competitive Acquisition Ombudsman. Individuals in an MA Plan can call member services at the plan, file a grievance with their plan, or file a complaint against their plan with 1-800-MEDICARE.
- **Choose a provider and supplier who have a working relationship:** Some individuals have had good experiences when using wheelchair clinics connected to their preferred hospital. While certainly not foolproof, the idea is an individual can reduce the chance of miscommunication issues if the provider and supplier know each other and have successfully worked together in the past to get PWCs covered by Medicare.

Submitting a Prior Authorization Request

Once suppliers collect the necessary documentation, they are expected to submit a prior authorization request (called a “PAR”) to the local DME Medicare Administrative Contractor (DME MAC).⁷² This is always preferred, since suppliers have access to the documentation and already regularly communicate with the DME MAC. That being said, in a pinch, individuals are able to send their prior authorization request directly to the DME MAC, assuming they have access to the required documentation.⁷³ The request includes the relevant billing codes and evidence the PWC and the individual meet the coverage and payment rules (such as the order from the doctor, the individual’s medical record, and DPD).⁷⁴

Once the DME MAC has reviewed the prior authorization request, it has ten business days to send a decision letter to the supplier.⁷⁵ This ten-day response time is shortened to two days when the supplier requests it be expedited and documents “evidence that applying the standard timeframe for making a decision could seriously jeopardize the life or health of the beneficiary.”⁷⁶ When prior authorization is denied, a non-affirmative decision is sent and the supplier has an opportunity to correct any errors (such as by providing missing documentation).⁷⁷ When the supplier receives a prior authorization approval, they are given a unique tracking number which they include in their claim for the PWC to prove the prior

⁷¹ CMS, [New York Regional Office](#).

⁷² In New York, the DME MAC is [Noridian Healthcare Solutions](#).

⁷³ CMS, [Medicare’s Wheelchair & Scooter Benefit](#), p. 2.

⁷⁴ CMS, [Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Items — Operational Guide](#), § 3.1.

⁷⁵ CMS, [Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Items Frequently Asked Questions](#), p. 3, #10.

⁷⁶ CMS, [Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Items Frequently Asked Questions](#), p. 3, #11; CMS, [Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Items — Operational Guide](#), § 4.1.

⁷⁷ CMS, [Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Items Frequently Asked Questions](#), p. 6, #12.

authorization requirement was met.⁷⁸ Without a unique tracking number, claims for power wheelchairs are auto-denied.⁷⁹

Advocacy Tip: Timing Matters

Unfortunately, Medicare Rights sees many individuals who have to restart the process of getting a PWC because a deadline was missed. For example, the supplier must receive the medical records and order within 45 days of the completion of the face-to-face examination,⁸⁰ while the PWC must be delivered within 120 days of the face-to-face examination or the individual will have to get a new examination.⁸¹ Likewise, once prior authorization is granted, that decision is only good for six months.⁸² In other words, if the PWC is not delivered within six months of prior authorization being granted, then the individual has to start over and seek prior authorization again. In Medicare Rights' experience, it is important for individuals to stay in close contact with their provider and supplier to ensure that both are taking timely action so that all deadlines are met.

Choosing a Brand

Individuals can face pressure in choosing which brand of PWC to select. The ordering provider, friends and family, suppliers, the insurance plan, and advertising all often offer different reasons for different brands. From an advocate's perspective, there are a few reasons to choose one brand over another:

- **Many MA Plans have preferred and non-preferred brands of DME.**⁸³ This is important to consider because non-preferred brands will almost always be more expensive for the individual because they pay a greater share of the cost. If the individual needs a particular brand and that brand is non-preferred by their MA Plan, they may want to consider switching plans.⁸⁴ MA Plans are required to disclose information about any brand limitations in the Explanation of Coverage and Annual Notice of Change.⁸⁵
- **Suppliers may not carry all brands of PWCs.** Before choosing a supplier, the individual should consider whether the supplier carries their brand preference by contacting the supplier or their plan. In addition, they have to ensure in-network suppliers provide access to all of the plan's preferred brands and that preferred brands are not removed from coverage mid-year.⁸⁶
- **Different brands sell substantively different products.** For example, there can be significant seating and control differences between different brands of PWCs. For individuals who have specific body types or disabilities, making sure they use a brand that offers the equipment they need should be a chief consideration.

⁷⁸ Ibid. p. 7, #13.

⁷⁹ CMS, [Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Items — Operational Guide](#), § 4.1; Noridian Healthcare Solutions, [Medicare Prior Authorization Condition of Payment for Certain Power Mobility Devices](#) (July 2019).

⁸⁰ CMS, Medicare Learning Network, [Power Mobility Devices](#) (ICN 905063) p. 8.

⁸¹ CMS, Medicare Learning Network, [Power Mobility Devices](#) (ICN 905063) p. 9.

⁸² CMS, LCD [L33789](#), Miscellaneous.

⁸³ CMS, Medicare Managed Care Manual, [Ch. 4](#), §10.12.2.

⁸⁴ For a list of special enrollment periods MA Plan members can use to switch mid-year, see Medicare Rights, [Special Enrollment Periods for Medicare Advantage Plans and Medicare Part D Drug Plans](#).

⁸⁵ CMS, Medicare Managed Care Manual, [Ch. 4](#), §10.12.1.

⁸⁶ [42 C.F.R. § 422.100](#)(l)(2); CMS, Medicare Managed Care Manual, [Ch. 4](#), §10.12.2.

How are suppliers paid?

In most cases, Medicare pays for PWCs through a monthly rental fee for 13 months.⁸⁷ After the 13th month, the PWC's title should be automatically transferred by the supplier to the individual (unless the individual requested to continue renting during the 10th month, in which case, Medicare will continue to make rental payments until the 15th month and the title will stay with the supplier).⁸⁸ The exception is for Group 2 and 3 PWCs, called "complex rehabilitative" PWCs.⁸⁹ If the individual chooses, Medicare will purchase those chairs in the first month in a lump sum rather than renting.⁹⁰ Otherwise, they will be rented like other PWCs.⁹¹ Both the rental and purchase fee include allotments for all labor charges in the assembly of the chair, delivery, set-up, training on using the PWC, and other "support services."⁹² Whether renting or purchasing, Medicare covers 80% of the Medicare-approved amount for DME.⁹³

After five years, consider getting a new PWC.

Medicare considers the reasonable useful lifetime of a PWC to be five years, so this period is what the rental and purchase cycles are linked to.⁹⁴ At the end of the five-year cycle, individuals—in almost all cases—should request a new PWC and begin another five-year cycle. This is because Medicare will no longer cover repairs to the current equipment and, if the chair does break down, it may take weeks or months to go through another prior authorization process to get a new chair.

Addressing Problems with a Supplier

Medicare imposes specific requirements on DME suppliers and MA Plans regarding DME coverage, delivery, maintenance, and replacement. Relevant to individuals with PWCs, suppliers must:⁹⁵

- Document compliance with medical device safety standards.
- Employ appropriately credentialed personnel to deliver, set-up, and train the patient on how to use the equipment.
- Inform patients about the equipment's use and maintenance in a way that is tailored to the patient's particular needs and abilities.
- Ensure patients can use the equipment safely in the setting in which the patient plans to use it.
- Repair and maintain equipment.
- "Whenever the beneficiary needs assistance," answer "all" questions, go to the individual's home, provide additional equipment, or otherwise troubleshoot the issue.

Advocacy Tip: Escalating Supplier Issues

⁸⁷ [42 CFR § 414.229\(f\)](#).

⁸⁸ [42 CFR § 414.229\(d\)\(2\)\(ii\)](#).

⁸⁹ [42 CFR § 414.229\(d\)\(1\)](#). These PWCs can be identified by HCPCS codes K0835-K0843 and K0848-K0864.

⁹⁰ [42 CFR § 414.229\(h\)](#).

⁹¹ [42 CFR § 414.229\(h\)](#).

⁹² CMS, LCA [A52498](#), Non-Medical Necessity Coverage and Payment Rules.

⁹³ CMS, Medicare Claims Processing Manual, [Ch. 20](#), § 30.5.3.

⁹⁴ CMS, LCA [A52498](#), Non-Medical Necessity Coverage and Payment Rules.

⁹⁵ CMS, [Supplier Quality Standards and Beneficiary Protections](#).

When suppliers fail to meet these requirements, individuals can escalate the issue in different ways, depending on whether they have Original Medicare or Medicare Advantage.

For those in Original Medicare:

- File a complaint with the supplier, as all suppliers are required to have an internal grievance process.
- Contact the CMS Regional office to request a caseworker.⁹⁶
- Call 1-800-MEDICARE to file a complaint against the supplier and ask for the complaint to be sent to the Medicare Ombudsman or Competitive Acquisition Ombudsman.

For those in an MA Plan:

- File a complaint with the supplier.
- Call member services at the plan asking for help with the in-network supplier.
- If the plan is not helping, file a grievance with the plan for failing to assist with the supplier issue. Forward a copy of the grievance to the CMS Regional Office.⁹⁷
- If the plan does not resolve the supplier issue, call 1-800-MEDICARE to file a complaint against the plan.

Repairs and Replacement

Medicare or, if available, a PWC's warranty, will pay for repairs and replacement of a PWC.⁹⁸ This is true even if an individual has a PWC they purchased before they enrolled in Medicare.⁹⁹ Payment for repairs is already factored into the monthly rental fee or purchase price, so the supplier should not charge the individual any extra amount for repairs.¹⁰⁰ Medicare will also pay for one month's rental of a temporary replacement PWC while a supplier is making repairs.¹⁰¹

The supplier is responsible for replacing equipment that is beyond repair, lost, or stolen.¹⁰² In addition to defective equipment, the supplier may also have to replace equipment with a different type when a doctor orders a different type of equipment, the individual chooses an upgrade and agrees to pay for it, or if CMS or the DME MAC determines that a change is warranted.¹⁰³

Advocacy Tip: Double-Checking the PWC Upon Delivery

As mentioned, suppliers are required to ensure that individuals can use the PWC in their home once it is delivered to them. Despite this, Medicare Rights hears from individuals

⁹⁶ CMS, [New York Regional Office](#).

⁹⁷ CMS, [New York Regional Office](#).

⁹⁸ CMS, Medicare Benefit Policy Manual, [Ch. 15](#), § 110.2.

⁹⁹ Ibid.

¹⁰⁰ Ibid. § 110.2(a).

¹⁰¹ CMS, LCD [L33789](#), Miscellaneous.

¹⁰² CMS, Medicare Benefit Policy Manual, [Ch. 15](#), § 110.2(c).

¹⁰³ [42 CFR § 414.229](#)(g)(2).

who accepted a PWC that doesn't fit or work correctly for them. Yet, after delivery has been accepted, it can be incredibly difficult to switch to a different supplier, return the chair, or get Medicare to cover a new chair. For that reason, individuals should, as much as possible, ensure the chair they receive upon delivery is the correct one and that it comfortably works for them in their home. Individuals have a right to working, well-fitted chairs, but this right becomes harder and more time-consuming to enforce after the delivery is accepted.

Case Example

Eleanor is enrolled in Original Medicare, which covered a manual wheelchair for her two years ago. Unfortunately, Eleanor's medical condition has deteriorated such that she is having difficulty maneuvering her wheelchair to get to her medical appointments. Her doctor has suggested that she switch to a PWC, but Eleanor does not know how she could afford one and her doctor is not familiar with the process. Eleanor saw a commercial for a PWC supplier saying they can get people like her a PWC covered through Medicare. Eleanor called them to set up an appointment. How do you help Eleanor?

- ☐ **Does Eleanor meet the basic PWC requirements?** A red flag here is that Eleanor is looking for a PWC to help her get to medical appointments rather than to use inside her home. It will be important to help Eleanor determine whether she, in fact, needs the PWC for use in her home and, if she does, to ensure her provider documents this fact.
- ☐ **Should Eleanor switch providers?** Providers are incredibly important to getting a PWC. Ideally, Eleanor will have a provider experienced in the process who is willing to take the time to ensure all her documentation is in order and sent to the supplier. In this case, you can talk to Eleanor about whether she can easily switch providers to one who is more experienced or, if she wants to stay with her current provider, ask them if they are willing to learn and follow the Medicare requirements.
- ☐ **Should Eleanor switch suppliers?** Like the prescribing doctor, a supplier can have a huge effect on whether an individual quickly gets Medicare coverage for a PWC or whether they get caught in the hurdles of the prior authorization process. Eleanor will likely want to research suppliers in her area and ensure she finds a supplier she trusts, who is experienced in getting Medicare to cover PWCs, and accepts assignment for PWCs.
- ☐ **Advise Eleanor on the prior authorization process.** Assuming Eleanor meets the coverage criteria, it is important to give Eleanor an idea of the documentation requirements that Medicare puts on her supplier and prescribing doctor. If at all possible, Eleanor will want to stay in touch with both parties to ensure they are timely processing her paperwork and providing all of the necessary information. This is always important but can be particularly difficult if Eleanor has high needs that require more complex PWCs, or custom parts, which can require additional documentation and coverage criteria.

What if Eleanor had an MA Plan?

- ☐ Eleanor should check with her plan to see how and when it covers PWCs. Likely, the MA Plan will have a prior authorization requirement like Original Medicare does. In addition,

she should use an in-network provider, in-network suppliers, and one of her plan's preferred PWC brands.