

Get Rolling: Tips on Paying For the Mobility Equipment You Need

Navigating Employer and Private Insurance

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Introduction

Have you seen those ads on TV that show how much better life is with a power chair or scooter? You know, the ones that show smiling happy people using their power chair at the park. They tell you to call their 800 numbers and trust them, it will be easy to get your chair and they will bill your insurance. Well the process isn't so simple. Wheelchairs, power chairs and scooters are expensive. Most people can't afford the cost on their own. Most people need help from insurance, or if eligible from government programs like Medicare or Medicaid (called Medi-Cal in California) to help pay. Don't be tricked by those TV ads. If you call them they may encourage you to pay for your equipment yourself. They will say your insurance company won't pay for your equipment. Or they may only offer you one choice in a power chair or scooter. Would you choose to buy a chair without researching what you need or without driving it? If you choose a chair through a TV ad, that is what you will be doing. You have to go through several steps to get your insurance to pay for your chair, but these steps can help you choose the chair you need. Below are tips to help you navigate the insurance approval process.

General Tips

- 1. Wheelchairs Approved Once Every 5 Years:** Insurance and government programs only pay for a wheelchair, power chair or scooter (mobility equipment) once every five years.¹ It's important for you to choose a chair that is easy to use, fits you well and meets your needs. Generally, private insurance companies follow similar rules as Medicare. If you have a change in your medical condition (including weight gain) that requires a different wheelchair configuration or a power chair if you have a manual chair, your insurance may cover a replacement chair sooner than five years. ⁱ

¹ Similar to Medicare, private insurance will provide you with a new wheelchair, power wheelchair or scooter but only after it has reached its Reasonable Useful Lifetime (RUL). Reasonable Useful Lifetime (RUL) is estimated at, but no fewer than, five years. RUL begins on the day you receive your equipment

2. **Once you get your chair or scooter it can't be returned.** Like a new car, once you get your equipment in most cases it cannot be returned, so it's important to pick the right equipment for you. However, you have rights that protect you against defective equipment. If you purchase a power chair or scooter and it is defective you may have rights through the [California's Lemon Law, The Song-Beverly Consumer Warranty Act. CA Civil Code Section 1790-1795.8](#) that requires the wheelchair supplier to repair or the manufacturer to replace the equipment.

Private Health Insurance

You may have private insurance through work, through a family member, or because you purchased insurance on your own through the Covered California program (sometimes people call this Obama Care). <http://www.coveredca.com>

While each health plan has slightly different rules about what equipment is covered, how to get your equipment and from whom you can get your equipment, most follow similar guidelines to Medicare. When considering health insurance there are several things to research before choosing a plan.ⁱⁱ

1. **Benefits:** Your benefit package includes all the benefits, or services, your health plan covers. Each year your health plans will send you a document called Evidence of Coverage (EOC). The Evidence of Coverage (EOC) is a document that describes in detail the health care benefits covered by the health plan. It provides documentation of what that plan will cover and how it works, including how much you pay. The EOC can also refer to a certificate or contract provided to a health plan member that contains information about coverage and other rights. Before you join a health plan and choose your coverage level, you have the right to review the EOC to see what will be covered and how much you will pay.^{iii iv} If you think you will need a wheelchair or scooter it's especially important you review your EOC. Included in the EOC is a specific list of types of wheelchairs, the related accessories and scooters that they will and will not cover.^{v vi}
2. **Costs:** Premium costs and out of pocket costs differ from plan to plan. As you compare costs, look at the benefits as well as the costs. Plans with lower premium costs may end up costing you more if the plan does not cover what you need.
3. **Quality:** The quality of care differs from plan to plan. Providers are typically rated in the areas of clinical performance and patient experience. You should check to see if your providers are contracted with the health plan you are considering. In California, and nationally, health plans are accessed and ranked on various quality criteria. You can view an example issued by the Office of the Patient Advocate, [California Health Plan Quality Report](#). Health plans currently don't have any quality scores

based on the process they use to approve wheelchairs/scooters or for the vendors that supply the equipment. If you have a specific wheelchair supplier you have used in the past and like the services you were provided, you should contact the health plan to see if they work with that vendor. In most cases they may not use the same vendor but this will give you an opportunity to find out who they work with to supply wheelchairs.

Types of Equipment Your Health Plan May Pay For ^{vii}

The types of equipment your health plan may pay for and how much you will be required to pay (your co-payment) can vary based on the type of coverage. Most health plans follow similar criteria of coverage as Medicare. Your plan's Evidence of Coverage (EOC) will have specific information on what is covered.

1. **Manual wheelchair** If you can't use a cane or walker safely, but you have enough upper body strength or have a caregiver who's available to help, you may qualify for a manual wheelchair.
2. **Power-operated vehicle/scooter** If you can't use a cane or walker, or can't operate a manual wheelchair, you may qualify for a power-operated scooter, if you can safely get in and out of it and are strong enough to sit up and safely operate the controls.
3. **Power wheelchair** If you can't use a manual wheelchair in your home, or if you don't qualify for a power-operated scooter because you aren't strong enough to sit up or to work the scooter controls safely, you may qualify for a power wheelchair. *If you can't operate a standard joystick you maybe eligible for alternative control devices

Medical Criteria Health Plans May Require

The medical criteria your health plans will require to approve Mobility Assistive Equipment including, Manual Wheelchairs, Power Mobility Devices (Power wheelchairs and Scooters also called Power Operated Vehicles) generally follow similar criteria used by Medicare. In general, if you have limited mobility and meet all of these conditions you may qualify for equipment: ^{viii}

1. You have a health condition that causes significant difficulty moving around in your **home**. You must have a medical need for your health plan to cover a manual wheelchair, power wheelchair or scooter. The wheelchair or scooter must be required "in order to provide a safe and functional means to get around inside the house." You may be confused by the use of the term "in the home," believing it means that your scooter or wheelchair can't be used outside of the home. This isn't the case, you can use it outside the house. The goal is to demonstrate that if you didn't have the manual wheelchair, power wheelchair or scooter it would be difficult for you to move around your home, let alone go outside. In other words, Medicare won't cover this

equipment if it'll be used mainly for leisure or recreational activities, or if it's only needed to move around outside your home. Therefore all your medical records and paperwork you submit to the health plan, must support and explain the need for the wheelchair within the home.^{ix} Medicare use to have a rule that said you had to be "bed bound," you could only get equipment if you couldn't get out of bed. This is no longer the case.^x

2. You're unable to do Mobility- Related Activities of Daily Living, called MRADLs (like bathing, dressing, getting in or out of a bed or chair, or using the bathroom) in your home, even with the help of a cane, crutch, or walker. Your doctor, or a physical therapist, will work with you to complete a report, to show what you cannot do now and what you could do if you had a wheelchair or scooter. The report must describe what kind of danger you may be in if you don't get a wheelchair or scooter (such as risk for falls, etc). If your needs for a wheelchair or scooter are for recreation / sports only then your insurance company will likely deny the claim.
3. You're able to safely operate and get on and off the wheelchair or scooter, or have someone with you who is available to help you safely use the device.
4. Your doctor who's treating you for the condition that requires a wheelchair or scooter is a doctor approved by the health plan. You get your equipment through a supplier approved by your health plan.
5. The equipment must be usable within your home (for example, it's not too big to fit through doorways in your home or blocked by floor surfaces or things in its path.)

Health Plan's Process to Get Your Equipment

If you have a health plan like an HMO or PPO, you must follow the plan's rules for getting your equipment. If you think you need a wheelchair or scooter, contact your health plan's customer services department to understand the process. Typically this process will include:

1. **Face-to-Face Exam:** You will meet with your doctor or sometimes a team of doctors (Wheelchair Seating specialists made up of physical therapist, occupational therapists and others) who specialize in evaluating and determining what types of equipment people need. During the face-to-face examination you can expect they will gather information like:
 - Your symptoms
 - Related Diagnosis
 - History
 - How long you have had the condition

- How has it progressed
- Have you tried other interventions like physical therapy
- Have you tried other types of equipment (such as a manual wheelchair if you need a power chair)
- Physical Exam
 - Weight
 - Impairments of strength, range of motion, sensation, coordination
 - Presence of abnormal tone or deformity
 - Neck, trunk, and pelvic posture and flexibility
 - Sitting and standing balance

2. Functional Assessment: During your face-to-face exam your doctor will perform a functional assessment. This assessment is designed to determine if you have difficulty with Mobility-Related Activities of Daily Living (MRADLs). Your MRADLs is your ability to do daily activities like eating, bathing, dressing and going to the bathroom, in your home. Your doctor must show that you have difficulty with your MRADLs in order for the health plan to approve getting the equipment you need. ^{xi} To evaluate your MRADLs your doctor will answer a series of questions relating to your abilities.² Functional Assessment questions include things like

- a. Your ability to transfer assisted and unassisted between bed, chair, and mobility equipment (wheelchair, or scooter)
- b. Your Ability, if any, to walk around your home to bathroom, kitchen, living room.

Your doctor may also send medical records [such as physician’s office records; hospital records; skilled nursing facility records; home health agency records; PT/OT records; other healthcare professional’s records; and test results x-rays, labs etc.] showing your abilities to your health plan to prove you have a medical need for your equipment. Depending on what equipment (manual wheelchair, specific power wheelchairs, Scooters/ Power Operated Vehicle) your doctor will go through a slightly different process to get approval for your equipment.

****Tip**** If you need a power chair or scooter your doctor must prove why. In the report by your doctor, or a physical therapist, they must medically explain why you cannot do these daily living activities with the assistance of a cane, crutches, a walker or a manual wheelchair. If you are asking for a power wheelchair or scooter, the report must also show measurements of the strength and range of motion in your arms to demonstrate why it’s

² This criteria is for Medicare but generally health plans adopt a similar criteria and in many cases the same process. Medicare’s 9 step algorithm is a series of questions and steps to figure out if you qualify for Medicare to pay for your mobility equipment. For more information see: <https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/downloads/MAEAAlgorithm.pdf> and <http://www.adldata.org/wp-content/uploads/2015/07/Algorithm.pdf>

difficult for you to use a manual chair. The report must state that you can safely use a power wheelchair or scooter and that you are motivated to get one. If the request is for a power wheelchair, the report must discuss why you cannot use an electric scooter (they cost less than a power wheelchair, so you must show why you medically require a higher priced electric wheelchair).

- 3. Using In Network Suppliers:** They may also ask you to use suppliers in the plan's network. You may get little or no coverage if you use suppliers outside of the plan's network. If you have a supplier you prefer, and the supplier is an approved Medicare vendor you can ask your Medicare health plan if you can use them instead. You will have to justify why you need to work with this supplier. For example, they have customized a power chair for you in the past and due to the complexity of your needs they are a better vendor to design your chair.
- 4. Getting an Approve Wheelchair:** Your plan may also have a list of preferred brands of wheelchairs. If these chairs work for you, then you may want to choose one of these chairs. These brands maybe the least costly to you. You can get this information by talking to your health plan, your supplier and reviewing your Evidence of Coverage (EOC)
- 5. Problems with your Equipment Supplier:** If you have problems with your equipment supplier complain to your health plan. For example, Kaiser uses the supplier National Seating and Mobility (NSM). Several individuals have had difficulty working with NSM and disability advocates complained about problems with the vendor. Kaiser has been working with the advocates requiring NSM to setup a consumer advisory board to ensure the company makes changes^{xii}.

Know Your Rights to Appeal: When your Health Plan Says they Won't Pay

Sometimes your health plan says they won't pay for your equipment. Don't give up the first time! Several mistakes could have been made either by your doctor or equipment supplier including:

- Filling out the paperwork wrong,
- Missing paperwork,
- Errors in documenting your condition or needs
- Ordering the wrong wheelchair or parts

If you are denied, first check with your supplier and doctor to determine why, and then ask them to file an appeal (also called a grievance).

Problems with your Health Plan or Supplier

If you have a problem with your health plan, such as coverage of your equipment is denied, you feel that the co-payment amount isn't correct, or your equipment vendor is not treating you well. You have a right to file an appeal also called a grievance, or complaint, against your wheelchair supplier, and/or your health plan. To do so, first contact your health plan to file the complaint. You can file a complaint with your health plan over the phone or in writing. You may also be able to file a complaint on your health plan's website.

If your health problem is urgent, if you already filed a complaint with your health plan and are not satisfied with the decision, or it has been more than 30 days since you filed a complaint with your health plan you may submit an Independent Medical Review Application/Complaint Form with the California Department of Managed Health Care (DMHC).

You can apply for an Independent Medical Review (IMR) with the DMHC when a health care service or treatment has been denied, modified or delayed. An IMR is a review of your case by independent doctors who are not part of your health plan. You have a good chance of receiving the service or treatment you need by requesting an IMR.

If the IMR is decided in your favor, your plan must authorize the service or treatment you requested. IMR's are free to enrollees. For more information contact's DMHC'S Help Center at 1-888-466-2219. Also see the DMHC's website:

<https://www.dmhc.ca.gov/FileaComplaint/SubmitanIndependentMedicalReviewComplaint/HowtoFileaComplaintwithYourHealthPlan.aspx#.VxfNUVKfYYY>

Secondary Insurance May Help Pay Costs

Secondary insurance gives you more insurance coverage on top of your main or 'primary' coverage. This secondary insurance is usually through a different company than your primary insurance coverage. Secondary insurance coverage supplements your existing policies and can cover gaps in your main insurance. In some cases the secondary insurance will pay for your primary insurance company's deductible or co-payment. For example, you may have Health Net coverage through your job and Blue Cross as a secondary insurance from your partner. If you have secondary insurance, don't forget to check with that company regarding their policies as a secondary insurer as well as your primary insurer.

Repair and Replacement of Your Wheelchair or Scooter

- Most health plans require your supplier to guarantee that your wheelchair or scooter will last five years, called the Reasonable Lifetime Period (RUL). ^{xiii}
- If you have any problems within these five years your health plan will generally require the supplier to fix your equipment. Contact your health plan to figure out how to do this.
- Sometimes the vendor that does repairs is different than the one where you got the chair. If your supplier is out of business, your health plan should find a supplier to fix your chair. It's in the plan's best interest to do this, otherwise they will need to buy you a new chair.
- If you are having problems getting your wheelchair repaired or are experiencing delays you can complain to your health plan that you are having problems with the wheelchair supplier. Tell the customer services representatives that you want to file a grievance about the delay. The plan wants to avoid a grievance so this may also help get your chair repaired more quickly.
- If you have a change in your medical condition (including weight gain) that requires a different wheelchair configuration or a power chair if you have a manual chair, your health plan may cover a replacement chair sooner than five years. You will need to go through another face-to-face examination and document your needs in order to get your chair approved. ^{xiv}
- Always keep all your paperwork related to the purchase of your chair including the warranty. It is always easier to repair or replace a chair or scooter while it is covered by warranty.
- Sometimes it takes a long time to get a technician to assess the problem. Speak up, be persistent, and explain why your chair or scooter must get repaired or replaced as soon as possible.
- Make sure you ask to receive a loaner chair while your waiting for your equipment to be fixed. If you are told that your insurance company does not cover loaner equipment ask to file an appeal. Tell your supplier and your health plan that you can't leave the house and access medical care without access to a chair.
- Tell your health plan about the rules under the California Lemon law as a way to pressure the vendor. They may not be aware of these rules. [California's Lemon Law, The Song-Beverly Consumer Warranty Act. CA Civil Code Section 1790-1795.8](#) that requires the wheelchair supplier to repair or the manufacturer to replace the equipment.

Challenging Process But Don't Give Up

The process can seem complicated and sometimes you may have trouble getting approval for the equipment the first time. Many people give up too soon. Just

because your insurance said they wouldn't pay for a chair the first time doesn't mean with a well written appeal they may not approve it. Persistence, patience and understanding the process and your available resources will be your best strategies for a successful outcome.

Disclaimer:

This article is a general summary of third-party payer guidelines including Medi-Cal and Medicare benefit determination criteria for wheeled mobility devices," including manual wheelchairs, power wheelchairs and scooters (also called power operated vehicles, POV) and is not intended to be an exhaustive representation of Medicare, Medi-Cal and private insurance's official guidelines. This article makes no promises of, nor guarantees, Medicare, Medi-Cal's or private insurance approval for mobility devices based solely on the contents contained herein. Readers are encouraged to review their insurance company's Evidence of Coverage (EOC) information, Centers for Medicare & Medicaid Services' guidelines for Medicare, or the California Department of Health Care Services' website for Medi-Cal for more detailed and specific information. This article is for informational and educational purposes only and is not intended to replace professional medical advice.

References

ⁱ Medicare Benefits Policy Manual, Ch 15, Sec.110.2 Repairs, Maintenance, Replacements and delivery. (Rev 212, 11/5/05) <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf> Accessed 4/11/16.

ⁱⁱ California Department of Managed Health Care. (DMHC) website. <https://www.dmhc.ca.gov/HealthCareinCalifornia/ChoosetheRightPlan.aspx#.VxfLWVKfYYY>. Accessed 4/21/16

ⁱⁱⁱ National Disability Navigator Resource Collaborative, Fact Sheet #2

Getting and Using Health Plan Evidence of Coverage.

<http://www.nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets/fact-sheet-2/> Accessed 7/29/16.

^{iv} Section (6)(A)(i) of California's 1975 Knox-Keene Health Care Service Plan Act as amended requires that managed care health plans' disclosure form state that the Evidence of Coverage discloses the terms and conditions of coverage, and Section (6)(A)(ii) requires that the disclosure form state that the applicant has a right to view the Evidence of Coverage prior to enrollment and also specifies where the Evidence of Coverage can be obtained prior to enrollment.

^v Below is an example of an Evidence of Coverage for Mobility Equipment. This example is for a Medicare health plan but similar types of mobility equipment and medical approval criteria may would apply to employer and private insurance.

United Health Care, Mobility Assistive Equipment, Product: United Healthcare Medicare Advantage Plans, Policy Coverage Guidelines, Policy Number: M-001, Last Reviewed: 4/11/16 <https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20a>

[nd% 20Protocols/UnitedHealthcare% 20Medicare% 20Coverage/Mobility_Assist_Equipment_UH_CMA_CS.pdf](#) Accessed 7/29/16

^{vi} Below is an example of one health plan’s policy for Mobility Equipment and Related Accessories to create custom design wheelchairs. This example is for a Medicare health plan but similar types of mobility equipment /accessories and medical approval criteria may apply to employer and private insurance.

United Health Care, Mobility Devices (Non-Ambulatory) And Accessories, Product: United Healthcare Medicare Advantage Plans, Policy Guidelines, Guideline Number: MPG209.02, Approval Date 7/13/2016,
https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Main% 20Menu/Tools% 20&% 20Resources/Policies% 20and% 20Protocols/Medicare% 20Advantage% 20Policy% 20Guidelines/Mobility_Devices_NonAmbulatory.pdf Accessed 7/29/16

^{vii} Centers for Medicare and Medicaid (CMS), Medicare’s Wheelchair & Scooter Benefit, April 2014. <https://www.medicare.gov/Pubs/pdf/11046.pdf> 4/11/16

^{ix} <http://www.medicareadvocacy.org/medicare-coverage-of-power-mobility-devices-tips-and-reminders/>

^x CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 574 June 3, 2005. “Effective for claims with services performed on or after May 5, 2005, contractors shall disregard the “bed- or chair- confined” criterion which has been historically used to determine if a wheelchair is reasonable and necessary as defined at section 1862(A)(1)(a) of the Social Security Act. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R574CP.pdf> Accessed. 4/12/16/

^{xi} An example of an insurance company’s doctor form to request a wheelchair and the related medical questions is below. This is an example only. Your health plan will use different forms and criteria.

Aetna, Wheelchairs and Power Operated Vehicles (Scooters) Precertification Information Request Form. Effective November 20th, 2015.

<http://www.aetna.com/pharmacy-insurance/healthcare-professional/documents/wheelchairs-power-operated-vehicles-precert-form.pdf> Accessed 7/29/16.

^{xii} Interview with disability Advocate regarding experience getting a wheelchair through insurance, Name omitted for confidentiality, conducted 2/19/16.

^{xiii} The following is the Medicare Policy but generally health plans follow similar requirements as Medicare: Medicare Administrator Contractor, Jurisdiction D, Noridian, Repair and Replacements Workshop Questions and Answers, citing regulations at 42 CFR 414.210(e)(4), <https://med.noridianmedicare.com/web/jddme/education/event-materials/repair-qa>. Accessed 4/11/16.

^{xiv} The following is the Medicare Policy but generally health plans follow similar requirements as Medicare: Medicare Benefits Policy Manual, Ch 15, Sec.110.2 Repairs, Maintenance, Replacements and delivery. (Rev 212, 11/5/05) <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf> Accessed 4/11/16.