

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

NAVIGATING MEDICARE

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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 through Medicare. 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 rather than bill Medicare. They will tell you Medicare won't pay for your equipment, because the company doesn't want to go through the complex process of billing Medicare. 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 would be doing. You have to go through several steps to get your insurance or government to pay for your chair, but these steps can help you choose the chair you need. Below are tips to help you navigate the Medicare approval process.

General Tips

1. Wheelchairs Approved Once Every 5 Years: Government programs and Insurance only pay for 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. If you have a change in your medical condition (including weight gain) that requires a different wheelchair configuration

¹ Medicare (generally the same for Medi-Cal and 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

or a power chair if you have a manual chair, Medicare and insurance may cover a replacement chair sooner than five years. ⁱ

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.

Medicare Coverage For Mobility Assistive Equipment

Medicare is one important source of funding for wheelchairs. First, it is important to understand your basic Medicare benefits. Medicare Part A covers hospital services, while you are in the hospital or getting skilled nursing care. If you need a wheelchair in those kinds of health care facilities, you will use what they provide for you to use. Medicare Part B covers health care services you don't get in a hospital like care from your doctor and medical equipment including wheelchairs and scooters. You can get your Part B coverage through either original Medicare or by joining a Medicare Advantage Plan or other Medicare plan.

Through either, they pay for what they call Mobility Assistive Equipment including, Manual Wheelchairs, Power Mobility Devices (Power wheelchairs and Scooters also called Power Operated Vehicles) if you have limited mobility and meet **all** of these conditions: ⁱⁱ

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." ⁱⁱⁱ 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.^{iv} 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.^v

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.
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 and your supplier are both enrolled in Medicare.
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.)

Types of Equipment Medicare Pays For ^{vi}

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.

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.

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.

Rent Before You Buy

If you don't need a custom wheelchair you may be required to rent it first, even if you eventually plan to buy it. Medicare pays to rent the chair for up to 13 months. At the end of this period, if the wheelchair is still needed, Medicare will go ahead and purchase the wheelchair if the user wishes it to be purchased. Medicare will send out what is called a "rent/purchase" option letter, which allows the individual using the chair to determine if it will be purchased or will continue in a rental status. Medicare will then pay the rental fee for another three or five months (depending on the option selected). The person using the chair will be able to use it for as long as they need it. In the case of the purchased chair, the individual owns it and in the case of the rental chair the vendor owns it. Regardless, the individual using it can keep the chair for as long as they qualify for this chair under Medicare's rules.

What Medicare Pays

Generally, original Medicare (Medicare not through a health plan) will pay 80% of the Medicare-approved amount, after you've met the Part B deductible. In order to get this 80% paid you must pay your monthly Part B premium and have paid your Part B deductible for the year (\$166 for 2016).^{vii} The deductible can change every year, so make sure you have the most up-to-date information from Medicare, either through official paperwork they send you, or through the website: <https://www.medicare.gov/your-medicare-costs/index.html>

After Medicare pays 80%, you will be responsible for paying the wheelchair supplier a 20% co-payment of the Medicare-approved amount. If you have additional coverage through a second health plan, or you also have Medi-Cal coverage they typically pay this 20% cost. If you don't have additional coverage and are unable to pay that 20%, you may be able to get additional assistance through the [Medicare Savings Program or Medicare Buy-Ins](#). There are four Medi-Cal programs that pay for Medicare premiums, copayments, or deductibles. Each program has specific income limits and pays for different Medicare cost.

Medicare Advantage Plans (like an HMO or PPO) must cover the same items and services as traditional Medicare. Your costs will depend on which plan you choose. If you're in a Medicare Advantage Plan, you should call the plan and ask for "Utilization Management." They can tell you if your equipment is covered and how much it will cost. If you decide to drop enrollment in your Medicare health plan and return to traditional Medicare, you should tell your supplier to bill Medicare directly after the date your coverage in the Medicare Advantage Plan ends.^{viii ix}

Original Medicare Process

In order to get your equipment paid for by Medicare, your doctor must follow a series of rules established by The Centers for Medicare & Medicaid Services (CMS). These rules are outlined in the National Coverage Determination Policy (NCD). Under this policy, CMS establishes general coverage guidelines for things like "mobility assistive equipment" (MAE) and includes within that category canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. For more information on the NCD for Mobility Assistive Equipment see:

<https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=219&ncdver=2&bc=AAAAQAAAAAAAAAA%3d%3d&>

The National Coverage Determination Policy (NCD) is used at a regional level to establish the specific medical criteria that you must prove and types of equipment you can receive under Medicare rules. Medicare contracts with a regional organization called a Local Medicare Administrative Contractor (MAC) to develop a Local Coverage Determination (LCD) process and procedures. California is in

Region D and is currently served by a company called Noridian Health Solutions, LLC.

Your doctor and equipment supplier will work with the MAC to follow the Local Coverage Determination (LCD) process, submit the forms and documents required to get your equipment approved. ^x For a list of the Medicare Contractor, Noridian's LCD policies and information on what is covered see.

<https://med.noridianmedicare.com/web/jddme/policies/documentation-checklists>

Below is a list of the various steps your doctor and equipment supplier will work with you, to do, in order to get your equipment paid for. If you have a Medicare health plan your doctor will work with the health plan to follow their process and get your equipment through approved suppliers. Medicare health plans are required to cover, at minimum, the same types of equipment as required by the National Coverage Determination Policy.

1. Find a Wheelchair or Scooter Supplier^{xi} With original Medicare, you have to get your equipment through an approved supplier and from a list of approved equipment. The list is called the Competitive Bidding program. These vendors bid to be a Medicare supplier. Medicare uses these bids to set the amount it will pay for medical equipment. Call 1-800-MEDICARE or go to the [supplier directory](#) to find your local approved supplier enter your zip code into this link.^{xii} If you have a Medicare health plan you will work with them directly to find an approved vendor.

2. Get Evaluated by Your Doctor: Your doctor will do a physical exam called a **The Face-to-Face Mobility Examination**. During The Face-to-Face Mobility Examination, your doctor or another doctor such as a Physical Therapist (PT) or Occupational Therapist (OT), will examine you in person and fill out paperwork that shows your symptoms, diagnosis, history of the condition, if you've tried physical therapy and have you used a manual wheelchair if you are requesting a power wheelchair. They will also ask a series of questions called 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. ^{xiii} To evaluate your MRADLs your doctor will answer a series of questions relating to your abilities.²⁻³

Functional Assessment questions include things like:

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/MAEAlgorithm.pdf> and <http://www.adldata.org/wp-content/uploads/2015/07/Algorithm.pdf>

³ Many manufacturers and suppliers have created forms that have not been approved by Medicare. These forms are sent to the physician with instructions to complete, sign and date. Even if the physician completes this type of form and puts it in his/her chart, the supplier-generated form is not a substitute for the face-to-face exam.

- 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.

3. Specialty Assessments: If you need a power chair with various additions such as alternative power controls you may need to have a specialty assessment conducted by a PT or OT with experience in rehabilitation wheelchair evaluations. They will provide Medicare with detailed information explaining the need for each wheelchair option. This assessment is done in addition to the face-to-face evaluation requirement.^{xiv xv}

****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 demonstrating why it's 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).

4. You Need Your Wheelchair or Scooter in Your Home: As described above, 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. They must show you're unable to do things like bathing, dressing, getting in or out of a bed or chair, or using the bathroom (called Mobility- Related Activities of Daily Living, or MRADLs) in your home, even with the help of a cane, crutch, or walker. 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). 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."^{xvi} 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 paper work you submit to the health plan, must support and explain the need for the wheelchair within the home.^{xvii}

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.^{xviii}

5. *Your Doctor and Wheelchair Supplier will work with a Medicare Administrator Contractor (MAC).* The Medicare Administrative Contractor (MAC) is a company Medicare pays to help figure out who should get equipment like wheelchairs and scooters. This company develops the paperwork and the process your doctor and wheelchair supplier must follow (called Local Coverage Determination) to get approval. In California, as of 2016, our MAC is the company ***Noridian Health Care Solutions***. Your doctor and staff has this information and should know what paperwork to complete and who to send it to.⁴

6. Your doctor submits Prescription for your Wheelchair (7EO forms):

For Your Doctor: Within 45 days of completing the face-to-face assessment your doctor or your PT/OT evaluation team must give to your equipment supplier the 7 Element Order (7EO) forms and documentation. The 7EO is another term used by Medicare for the prescription that your doctor gives to your wheelchair and scooter dealer/vendor. It will describe your diagnosis and your need for wheelchair or scooter, which the dealer can use to submit your claim to the Medicare Contractor (currently Noridian Health Care Solutions, LLC) for approval.

For You: You should follow up with both your doctor and your equipment supplier to make sure the prescription (7 Element Order) was received. It’s a good idea to contact your doctor around 30 days after your face-to-face examination to make sure they submitted the 7 element order/ prescription to your supplier. Then contact your supplier to make sure they actually received it.

7. Schedule Home Assessment: Medicare requires either your equipment supplier or a medical professional to complete an in-person home assessment. This assessment is intended to ensure that the recommended equipment meets your needs “inside the home”. This could be for instance, an opportunity to

⁴ Medicare Administrative Contractor (MAC) is a company Medicare pays to evaluate requests for things like wheelchairs and scooters. With guidelines from Medicare this company develops the rules and process (called Local Coverage Determination) that your doctor uses to get your equipment. Your doctor will submit the paperwork to this company. Medicare pays several different companies to do this work depending on where you live. As of 2016 for California, which is Region D, Medicare works with Noridian Health Care Solutions, LLC. Depending on where you live you may have a different contractor. For more information see: <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/DME-MAC-Jurisdiction-Map-July-2016.pdf> Medicare can change who the use as a Medicare Contractor. If this happens your doctor may send information to a different contractor. As a doctor that works with Medicare they will be made aware of who this is. You don’t need to submit anything to Noridian yourself, your doctor will do it for you. If you want information about all of the current Durable Medical Equipment (DME) MACs see: information see: <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html>

recognize that you need to install a ramp to your front door or that a motorized wheelchair will turn from the hallway to the bedroom, but a scooter will not.

8. Detailed Product Description (DPD) The DPD is a form that lists the wheelchair and all the things you need for it. Your Doctor must sign the form and your supplier must submit this form for approval to the Medicare Contractor, (currently Noridian Health Care Solutions). Your equipment supplier must get you the equipment within 120 days from the date of your face-to-face examination.⁵

9. Beneficiary Authorization Form: You will sign either CMS Form 1500 or a form developed by your medical supplier that asks Medicare to pay for your equipment. It also gives permission for your doctor to send your medical information to the Medicare contractor (currently Noridian Health Care Solutions).

10. Advanced Determination of Medicare Coverage (ADMC)^{xix}

Medicare covers most wheelchairs and scooters. However, for custom power wheelchairs it can be helpful to know if Medicare will pay for it before you order your wheelchair from the supplier. This is called an Advance Coverage Determination for Medicare Coverage (ADMC). ADMC's help prevent you from being charged for equipment that Medicare won't pay for. If you need a power wheelchair with a seat that power lifts, tilts, reclines, or need a wheelchair controller other than a joystick you should ask your supplier to submit an ADMC. The Medicare contractor will let your equipment supplier know within 30 days if you medically qualify for the wheelchair.

11. Advance Beneficiary Notice of Non-Coverage (ABN) ^{xx xxi xxii xxiii xxiv}

If you have Original Medicare and your doctor, other health care provider, or supplier thinks Medicare probably (or certainly) won't pay for items or services, they may give you a written notice called an "Advance Beneficiary Notice of Noncoverage" (ABN). However, an ABN isn't required for items or services that Medicare never covers.

The ABN lists the items or services that Medicare isn't expected to pay for, an estimate of the costs for the items and services, and the reasons why Medicare may not pay. The ABN gives you information to make an informed choice about whether or not to get items or services, understanding that you may have to accept responsibility for payment.

⁵ It can be helpful to review Detailed Product Description (DPD) to make sure it lists everything that you need. To get Medicare approval and to make sure you get the chair you need, especially if your chair needs any upgrades, such as positioning belts, calf straps, or custom footrests, then the DPD needs to list them. On the DPD The supplier must list how much they will charge, Medicare fee schedule allowance, billing codes for medical equipment, narrative description, manufacturer name and model name/number for each separately billed item. If the information is not listed correctly or medical billing codes aren't correct Medicare may not approve your equipment.

You'll be asked to choose an option box and sign the notice to say that you read and understood it. You must choose one of these options:

Option 1: You want the items or services that may not be paid for by Medicare. Your provider or supplier may ask you to pay for them now, but you also want them to submit a claim to Medicare for the items or services. If Medicare denies payment, you're responsible for paying, but, since a claim was submitted, you can appeal to Medicare.

Option 2: You want the items or services that may not be paid for by Medicare, but you don't want your provider or supplier to bill Medicare. You may be asked to pay for the items or services now, but because you request your provider or supplier to not submit a claim to Medicare, you can't file an appeal.

Option 3: You don't want the items or services that may not be paid for by Medicare, and you aren't responsible for any payments. A claim isn't submitted to Medicare, and you can't file an appeal.

An ABN isn't an official denial of coverage by Medicare. You have the right to file an appeal if payment is denied when a claim is submitted.

12. Delivery of Your Equipment: Many equipment suppliers will deliver your equipment to your home. In order to make adjustments to the chair and make sure it's properly fit they may request that you come to the supplier's shop. If you do not have access to transportation, and the shop is not near public transportation you can request that they deliver it to your home. Beware that depending on the adjustments that need to be made to the chair they may have some difficulty doing it in your home. Also depending on what they need to do to your chair, they may need to make more than one appointment. This may be because they need to order additional parts, make parts themselves, or do research on things that can be added to your chair to better meet your needs. When you receive your chair you will be asked to sign a Proof of Delivery form (POD) so Medicare can pay the supplier. Make sure you are happy with your chair. You have a right to get a properly fitted chair. If you are not happy ask to make changes to your chair and or possibly a different cushion. Be aware that it can take time to get use to your chair and so you may need to go back several weeks later to your supplier to ask for changes to your chair. Make sure you are happy before you signed the form. Your wheelchair supplier will help you because they need this form signed.

Medicare Coverage For Wheelchair Cushions xxv xxvi

Cushions come in a huge variety of options. The right cushion prevents injury, including pressure sores, and helps determine how stable you feel in the chair and the ability to move it. Cushions are designed to be adjustable, non-adjustable and custom fit or molded. Shaping different types and various layers

of foam based on your buttock makes the custom fit design. The adjustable design generally uses fluid medium (air, gas, liquid or gel) that can be altered by addition or removal of the fluid (such as removing air from a cushion or adding or removing packets of gel). Medicare does provide coverage for seat cushions including adjustable, non-adjustable, positioning and customized cushions as long as in general:

1. If you have a wheelchair that meets Medicare's coverage criteria and
2. Have a history of pressure ulcers, or currently have a pressure ulcer or have impaired or no sensation on your butt, or can't shift your weight in your chair because of a medical condition including, but not limited to, spinal cord injury, MS, ALS, CP, muscular dystrophy, Parkinson's, Alzheimer's, Brain Injury, Polio, Stroke or other medically proven condition that qualified you for your wheelchair.

Your vendor will consult with your local Medical Administrator Contractor (MAC), currently Noridian Health Solutions, LLC for the specific billing criteria for the specific cushion you need. Cushions no matter what the type do wear out over time. In general, insurance companies and Medicare have been approving a cushion once every five years. For a variety of reasons your cushion may not last five years. Anytime the cushion you are using shows signs it isn't doing an effective job of protecting your skin, for example you notice your skin remaining red after a day of sitting, please see your doctor right away and get a seating evaluation. While a non-adjustable cushion may be cheaper, your needs from your cushion may change over time. To get a new cushion you will need a seating evaluation and approval of the new cushion. Having a cushion that does not fit you well can cause pressure ulcers. With an adjustable cushion you can quickly adjust the cushion to adapt to your needs. As always, when it comes to ordering a new cushion, it is vital to make sure the exact make, model, and size cushion are on all therapists' and physicians' prescriptions.^{xxvii xxviii}

If Medicare Doesn't approve your Prescription

Sometimes Medicare 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 part

If you are denied first check with your supplier, and doctor to determine why, then ask them to file an appeal. If you are in Original Medicare your doctor will file your appeal [Medicare Administrator Contractor \(currently Noridian\)](#). If you are a member of the Medicare Health Plan your doctor will work with the health plan to navigate the [appeals process](#).

If you need help with the appeal you can contact the [California Health Insurance Counseling Advocacy Program \(HICAP\)](#). HICAP offers local, personalized counseling and assistance to people with Medicare and their families. HICAPs serve each local county and provide free information and counseling to help you with Medicare questions, complaints, appeals and how to change Medicare health plans. For help call HICAP 1-800-434-0222. If you are dual eligible, have Medicare and Medi-Cal, you can also get help from [Disability Rights California \(DRC\)](#). DRC may provide advice on your rights and the appeals process. You can contact them at (800) 952-5544 / TTY 1-800-719-5798.

Medicare Health Plan (Also called Medicare Advantage)

If you have a Medicare Advantage Plan (like an HMO or PPO), you must follow the plan's rules for getting a wheelchair. You will work with your plan to get equipment. Generally they follow the same rules as original Medicare and are required at minimum to approve the same items that Medicare would. 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. Call your plan to find out what you must do to get your wheelchair or scooter covered. In general, if you have limited mobility and meet all of these conditions, you may qualify for equipment: ^{xxix}

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.^{xxx} 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.^{xxxi}

1. 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).

2. 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.
3. Your doctor who's treating you for the condition that requires a wheelchair or scooter is a doctor approved by your Medicare health plan.
4. You get your equipment through a supplier approved by your Medicare 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

3.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. ^{xxxii} To evaluate your MRADLs your doctor will answer a series of questions relating to your abilities.⁶ Functional Assessment questions include things like:

- c. Your ability to transfer assisted and unassisted between bed, chair, and mobility equipment (wheelchair, or scooter)
- d. 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 demonstrating why it's 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).

2.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.

3.Getting an Approved 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, since these brands maybe the least costly to you. You can

⁶ 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/MAEAlgorithm.pdf> and <http://www.adldata.org/wp-content/uploads/2015/07/Algorithm.pdf>

get this information by talking to your health plan, your supplier and reviewing your Evidence of Coverage (EOC)

4.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. ^{xxxiii}

5.Right to an Appeal: If you have a problem, 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 or a grievance against the supplier, and/or your health plan. To do so, first contact your health plan to file a complaint. You can file a complaint with your health plan over the phone or in writing. Or you can call the Health Services Advisory Group (HSAG) at 1-818-409-9229. HSAG is an organization that has a contract with Medicare to help members with appeals. ^{xxxiv}

Medicare and Medi-Cal (Dual Eligible) also called Coordinated Care Initiative, or Cal MediConnect

If you are Dual Eligible (have Medicare and Medi-Cal), both programs help cover the costs of your medical equipment. Being Dual eligible means Medicare pays the 80% cost of the equipment and Medi-Cal is required to pay for whatever Medicare doesn't pay for. Under California State Law, your equipment supplier can't bill you for the Medicare 20% co-payment or for any part of the equipment Medicare does not pay for. ^{xxxv} In order to get Medi-Cal to cover these costs you have to join a Cal MediConnect Health Plan for more information:
<http://www.calduals.org>

Repair and Replacement of Your Wheelchair or Scooter

Reasonable Lifetime Period

Medicare requires your supplier to guarantee that your wheelchair or scooter will last five years, called the Reasonable Lifetime Period (RUL). Medicare will pay for a repair up to the purchase price of the equipment. If the expense for repairs exceeds the estimated expense of purchasing or renting another item within the 5 year RUL time period then Medicare will not pay to repair it. If this happens, the equipment supplier that gave you the wheelchair or scooter is responsible for giving you replacement equipment at no cost to you or to Medicare. ^{xxxvi} If your supplier is refusing to give you a new chair then contact 1-800-Medicare. If you are a member of a Medicare health plan contact your health plan. Medicare requires equipment to have a Reasonable Useful Lifetime to pay the supplier for the equipment, so it is in their best interest to make sure your equipment gets replaced. If the supplier doesn't replace your chair they risk losing additional business with 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, Medicare 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. ^{xxxvii}

Loaner Equipment

Medicare will pay for one month of loaner equipment per repair incident. If at a later time you need your equipment repaired again, Medicare will pay for another loaner. Make sure you ask to receive a loaner chair while your waiting for your equipment to be fixed. If you are a member of a Medicare Health Plan and are told by your supply company that your plan does not cover loaner equipment, contact your health plan. Your Medicare health plan is required to pay for, at minimum, what Medicare pays for. Contact your health plan and tell your supplier, that you can't leave the house and access medical care without a loaner chair.

Repairs and Replacements Under Original Medicare and Medicare Health Plan

If you have **Original Medicare** and you have any problems within this five years Medicare will require you to get it repaired from the supplier you got your equipment from. If your supplier is out of business contact 1-800-Medicare to find a supplier to fix your chair. If you are having problems getting your wheelchair repaired or experiencing delays you can complain to 1-800 Medicare, tell the customer services representatives that you want your complaint to go to the Competitive Bidding Ombudsman.

If you have a **Medicare health plan**, call your insurance company's customer service line and ask what to do if you need to repair or replace the chair. Sometimes the vendor that does repairs is different than the one you got the chair from.

Additional Repair and Replacement Tips

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.

Tell your Medicare 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.

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV§ionNum=1793.025.)

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 Medicare said they wouldn't pay for your 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 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 official guidelines. This article makes no promises of, nor guarantees, Medicare, or supplemental 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 for more detailed and specific information. This article is for informational and educational purposes only and is not intended to replace professional medical advice.

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

^v 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/

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<https://med.noridianmedicare.com/web/jddme/policies/documentation-checklists>

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It should be noted, however, that state law limits Medi-Cal's reimbursement on Medicare claims to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal's maximum allowed for similar services, (W&I Code, Section 14109.5). This means that if the Medi-Cal rate is 80 percent or less of the Medicare rate for the service rendered, Medi-Cal will

not reimburse anything on these crossover claims. This has been state law for over 30 years. Since Medi-Cal reimbursements are generally lower than Medicare reimbursements, Medi-Cal will owe reimbursement for only a few services on Medicare claims. Welfare and Institution Code on 14109.5: “Not with standing the provisions of Section on 14109, effective January 1, 1982, the reimbursement rate for costs specified in Sec14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter. For purposes of this sec effective on October 1, 1992, the reimbursement rates established under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services.” This would only impact the DME supplier and not the beneficiary since per Welfare and Institution Code, Sec on 14019.4. (a) the beneficiary cannot be billed for an difference in reimbursement. See CalDuals website related to the Cal MediConnect Program (duals) for a provider bulletin citing this statute. http://www.calduals.org/wp-content/uploads/2014/07/FFS-Medicare-Services_7.18.14.pdf Accessed 4/11/16. <https://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/dme201501.asp>

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