



Practitioner & DMEPOS Supplier Information on Power Mobility Devices



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What's Changed?

We added information about newly covered power seat elevation equipment for certain power wheelchairs (page 6).

Substantive content changes are in dark red.

Medicare Covers Power Mobility Devices

Medicare Part B covers power mobility devices, including power-operated vehicles (scooters) and power wheelchairs, as [Mobility Assistive Equipment](#).

We cover these devices if the Medicare patient, practitioner, and supplier meet these basic coverage criteria:

- The qualified practitioner (a physician or non-physician practitioner) submits a standard written order (SWO).
- The practitioner sees the patient face-to-face. See [Step 1: See the Patient Face-to-Face](#) for more information.
- The practitioner and DMEPOS supplier both accept Medicare.
- The patient:
 - Has a mobility limitation that:
 - Significantly impairs their ability to perform 1 or more of these mobility-related activities of daily living: using the toilet, eating, getting dressed, grooming, or bathing in a bathroom
 - Can't be sufficiently and safely resolved using a cane or walker
 - Doesn't have the upper extremity function needed to use an optimally configured manual wheelchair in their home to perform activities of daily living. The patient may have a limitation of strength, endurance, range of motion, or coordination; presence of pain; or deformity or absence of 1 or both upper extremities.
 - Can safely operate and get on and off the device, or have someone with them who's available, willing, and able to help them safely use the device.
 - Meets the criteria listed in [Local Coverage Determination \(LCD\): Power Mobility Devices \(L33789\)](#).
 - Meets the conditions for the specific device. See [Types of Devices](#) for more information.

Types of Devices

Practitioners can help determine which type of device best meets their patients' needs. We cover the following items if the patient, practitioner, and supplier meet the basic coverage criteria above AND ALL these conditions apply.

Power-operated vehicle (scooter)

The patient:

- Can get in and out of the vehicle safely
- Can operate the vehicle's tiller steering system
- Can maintain postural stability and position while operating the vehicle in their home
- Is mentally and physically able (including having the cognitive function, judgment, and vision) to safely operate the vehicle in their home
- Lives in a home that allows the vehicle adequate access between rooms, maneuvering space, and surfaces
- Can use the vehicle at home to significantly improve their ability to participate in mobility-related activities of daily living at home, like using the bathroom or eating
- Hasn't expressed that they're unwilling to use the device at home
- Meets both of these weight requirements:
 - They weigh less than or equal to the maximum weight capacity of the power-operated vehicle
 - They weigh greater than or equal to 95% of the weight capacity of the next lower power-operated vehicle weight class
- Meets all [Local Coverage Determination: Power Mobility Devices \(L33789\) criteria](#)



Power wheelchair

The patient:

- Is mentally and physically able to operate the device, or they have a caregiver who's available and willing, but can't push an optimally configured manual wheelchair in a safe or effective way
- Lives in a home that allows the device adequate access between rooms, space within rooms, and surfaces
- Can use the device to significantly improve their ability to participate in mobility-related activities of daily living at home
- Hasn't expressed that they're unwilling to use the device at home
- Meets both of these weight requirements:
 - They weigh less than or equal to the maximum weight capacity of the power wheelchair
 - They weigh greater than or equal to 95% of the weight capacity of the next lower power-operated vehicle weight class
- Doesn't meet all of the criteria for a power-operated vehicle
- Meets all [Local Coverage Determination: Power Mobility Devices \(L33789\) criteria](#)



See the [Master List](#) for the full library of DMEPOS items that may be selected for inclusion on the [Required Face-to-Face Encounter and Written Order Prior to Delivery List](#) or the [Required Prior Authorization List](#).

Medicare Covers Options & Accessories

We cover options and accessories if both of these apply:

- The patient has a power mobility device that meets our coverage criteria
- Medical necessity is supported in the medical record

Options and accessories include, but aren't limited to:

- Arm of chair
- Foot or leg rests
- Back cushions
- Seat cushions
- Non-standard seat frames
- Batteries and chargers
- Power tilt and recline seating systems
- Power wheelchair drive control systems
- **Power [seat elevation equipment](#) for certain power wheelchairs**

We don't cover all options and accessories.

Medicare Covers Repairs & Replacements

We cover repairs (including parts and labor) of patient-owned power mobility devices if necessary and reasonable.

View [42 CFR 414.210](#) for more information.

Practitioners: What You Need to Do

Step 1: See the Patient Face-to-Face

A face-to-face visit is an in-person visit or telehealth visit between you and the patient. If you use telehealth for the visit, you must meet [telehealth services requirements](#) to get [paid](#).

You must conduct and document the encounter for us to cover a power mobility device. Be sure to gather all information about diagnosing, treating, or managing the patient's condition that requires the power mobility device. This visit must happen within 6 months prior to ordering a device.

During the visit:

- Evaluate and treat the patient for their medical conditions
- Tailor your evaluation to the patient's conditions
- Determine if a power mobility device is a necessary part of their treatment plan
- Document that a mobility exam was a major reason for the visit
- Perform a mobility exam, including a physical exam and assessment of their mobility-related activities of daily life
- Answer these questions about the patient:
 1. What's their mobility limitation?
 2. Does their mobility interfere with them performing activities of daily living?
 3. Why won't a cane or walker meet their needs at home?
 4. Why won't a manual wheelchair meet their needs at home?
 5. Why won't a power-operated vehicle, if applicable, meet their needs at home?
 6. Are they physically and mentally able to operate a power wheelchair safely in the home?

You don't need to do a new face-to-face visit in these limited cases:

- The power mobility device is replaced during the 5-year useful lifetime of the item, and it's in the same [Medicare Performance Group](#) previously covered.
- You're ordering power mobility device accessories that aren't included in the Required Face-to-Face Encounter and Written Order Prior to Delivery lists. See [Types of Devices](#) for more information.

Step 2: Update their Medical Record

After the face-to-face visit, document the encounter in a detailed narrative note in the patient's chart. Try to paint a picture of the patient's functional abilities and limitations on a typical day. Include as much objective information as possible.

You don't need to include elements if they don't apply (for example, don't include respiratory information if a patient doesn't have a respiratory illness or injury).

Consider including these details about the patient:

- **Present and past medical history of mobility needs**, including:
 - Symptoms and diagnoses that make it difficult for them to move
 - Medications or other treatments
 - Increased difficulty moving over time
 - Other related ambulatory problems
 - Description of their home
 - Confirmation that the patient can perform activities of daily living at home
 - How far and fast they can walk without stopping
 - If they need help standing up from a seat without help
 - What they currently use to help them get around
 - Any changes that now require they use a power mobility device
- **Physical exam**, which focuses on the patient's body systems that are responsible for ambulatory difficulty or impact their ambulatory ability, including:
 - Height
 - Weight
 - Cardiopulmonary exam results
 - Musculoskeletal exam results
 - Neurological exam results, like balance
 - Respiratory, cardiovascular, or neuromusculoskeletal information
 - Other medical conditions

You can include other relevant details, even if they aren't on this list.

Tip: Be sure to submit complete, signed medical records that show a power mobility device is medically necessary.

In addition to the detailed narrative, be sure the patient's medical record supports the medical need of a power mobility device in their home. Include lab tests, X-rays, and any other diagnostic tests that show their mobility needs.

Tip: Some DMEPOS suppliers may provide templates for documentation. While these may be helpful, they aren't a substitute for a comprehensive medical record.

Step 3: Write a Standard Written Order (Prescription)

Write a prescription, known as a standard written order or SWO, that shows the patient's need for a power mobility device. Send this to the DMEPOS supplier within 6 months of the face-to-face visit. When the DMEPOS supplier gets the order, they can submit the claim. For some items, like power wheelchairs, the practitioner must send the order to the DMEPOS supplier before they deliver the item.

Tip: You must do the face-to-face visit and the SWO. You can't write the SWO if another practitioner sees the patient for the face-to-face visit.

The SWO must include:

- The patient's name or MBI
- A general description of the item, like brand name or model number, HCPCS code, or HCPCS code narrative
- Quantity, if applicable
- Order date
- Your name or NPI
- Your signature

Step 4: Make a Prior Authorization Request

[Power wheelchairs](#) require approval before delivery to the patient. A Medicare Administrative Contractor (MAC) will review the prior authorization request, then tell you if the item is approved ("affirmation") or not approved ("non-affirmation"). If you don't get prior authorization before delivery, we'll deny the claim. This request can be completed by either you or the DMEPOS supplier, not both.

[Voluntary prior authorization](#) is available for some options and accessories.

Step 5: Complete a Home Assessment

Perform an on-site patient home assessment and write a report. The report must show the patient can safely use the power mobility device, considering these home details: physical layout, doorway width, doorway threshold, and surfaces.

You or the DMEPOS supplier must complete the on-site visit. This can happen either before or during delivery of the power mobility device.

Step 6: Review All Information to Avoid Improper Payments

It's important to work together with DMEPOS suppliers to avoid improper payments. Be sure to:

- **Complete steps 1–5 above**
- **Double check each patient's medical record and all necessary documents**
- **Know the common causes of improper payments** to avoid spending time and money to correct and resubmit information

Power mobility devices, related options, accessories, and repairs have a high improper payment rate. To avoid improper payments for power mobility devices, be sure:

- Medical records are complete
- Medical records show the devices are medically necessary
- No information or documents are missing, including your signature on the SWO

To avoid improper payments on accessories, repairs, and replacements, be sure to:

- Show a device replacement is necessary
- Show repairs are reasonable, necessary, or meet the requirements
- Show that suppliers document labor time adequately
- Show that DMEPOS suppliers must provide repair warranties
- Specify that wheelchair repair costs can't exceed a certain amount over a device's 5-year lifetime



DMEPOS Suppliers: What You Need to Do

Step 1: Check the Standard Written Order

Ensure there is a written, signed, and dated SWO for all items, including options, accessories, and seating.

Step 2: Make a Prior Authorization Request

[Power wheelchairs](#) require approval before delivery to the patient. A MAC will review the prior authorization request, then tell you if the item is approved (“affirmation”) or not approved (“non-affirmation”). This request can be completed by either you or the practitioner, not both.

Voluntary prior authorization is available for some options and accessories.

Step 3: Complete a Home Assessment

Perform an on-site patient home assessment and write a report. The report must show the patient can safely use the power mobility device, considering these home details: physical layout, doorway width, doorway threshold, and surfaces.

You or the ordering practitioner must complete the on-site visit. This can happen either before or during delivery of the power mobility device.

Step 4: Keep Documents

Keep these documents and be able to provide them, if requested:

- SWO
- Face-to-face visit supporting documents
- Written home assessment report
- Proof of delivery
- Records describing repairs, including a detailed explanation that justifies components or parts replaced and labor time to fix the item
- Licensed/certified professional (LCMP) specialty evaluation or assistive technology professional (ATP), if required

Tip: View the [Complying with Medicare Signature Requirements](#) fact sheet to learn more about proper documentation.

Step 5: Review All Information to Avoid Improper Payments

It's important to work together with practitioners to avoid improper payments. Be sure to:

- **Complete steps 1–4 above**
- **Double check each patient's medical record and all necessary documents** before you submit a claim
- **Know the common causes of improper payments** to avoid spending time and money to correct and resubmit information

Power mobility devices, related options, accessories, and repairs have a high improper payment rate. To avoid improper payments for power mobility devices, be sure:

- Medical records are complete
- Medical records show the devices are medically necessary
- No information or documents are missing, including the practitioner's signature on the SWO

To avoid improper payments on accessories, repairs, and replacements, be sure to:

- Show a device replacement is necessary
- Show repairs are reasonable, necessary, or meet the requirements
- Document labor time adequately
- Show that DMEPOS suppliers must provide repair warranties
- Specify that wheelchair repair costs can't exceed a certain amount over a device's 5-year lifetime



Resources

- [2019 Final Rule Affecting Power Mobility Devices](#)
- [42 CFR 410.38](#)
- [42 CFR 410.78](#)
- [42 CFR 414.210](#)
- [42 CFR 414.65](#)
- [Article: Standard Documentation Requirements for All Claims Submitted to DME MACs \(A55426\)](#) for information on how to properly document and bill repairs
- [Article: Power Mobility Devices \(A52498\)](#)
- [Durable Medical Equipment, Prosthetics, Orthotics and Supplies \(DMEPOS\) Order Requirements](#)
- [Local Coverage Determination: Power Mobility Devices \(L33789\)](#)
- [Local Coverage Determination: Wheelchair Options/Accessories \(L33792\)](#)
- [Medicare Benefit Policy Manual, Chapter 15](#): Section 110.2 for information on repairs, maintenance, replacement, and delivery
- [Medicare Claims Processing Manual, Chapter 20](#)
- [Medicare Program Integrity Manual, Chapter 5](#): Section 5.10.1 for information on DMEPOS supplier documentation for repair claims
- [Medicare Program Integrity Manual, Chapter 5](#): Section 5.2.2 for information on required elements of a standard written order
- [Medicare Provider Compliance Tips: Wheelchair Options & Accessories](#) for information on preventing improper payments for accessories
- [MLN Matters® Article: Standard Elements for DMEPOS Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements \(SE20007\)](#)
- [National Coverage Determination: Mobility Assistive Equipment \(MAE\) \(280.3\)](#)
- [National Coverage Determination: Seat Elevation Equipment \(Power Operated\) on Power Wheelchairs \(280.16\)](#)
- [Provider Compliance](#) for information on how to avoid common coverage, coding, and billing errors

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