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# How to Get Medicare to Pay to Replace a Worn-Out Walker or Rollator

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## KEY POINTS

- Medicare covers walker and rollator replacement after 5 years, but three specific exceptions allow early replacement before that window closes.
- A Standard Written Order (SWO) from your doctor – with precise language about your diagnosis and functional limitations – is required for any replacement claim.
- If Medicare denies your request, you have 120 days to file a Redetermination (the first level of appeal), and most appeals that include complete documentation succeed.
- A Solace advocate can handle the calls, paperwork, and follow-up so you don't have to fight the system alone.

Figuring out how to get Medicare to replace a walker before 5 years have passed isn't intuitive. The system doesn't explain itself. You're expected to know the right exception, gather the right documentation, and submit it to the right place – all while managing the health condition that made the walker necessary in the first place. Most people in this situation feel the same way. The rules around durable medical equipment (DME) – gear like walkers, rollators, wheelchairs, and hospital beds that serve a medical purpose and are built to last – were designed for administrators, not patients. A Solace advocate can step in to handle exactly this kind of situation: making the calls, coordinating with your doctor, and submitting the paperwork so you're not stuck doing it alone. This article breaks down everything you need to know about Medicare walker replacement rules, when early replacement is covered, and what to do if Medicare says no.

It takes just a minute to [see if you're covered](#).

## What Is Medicare's 5-Year Rule for Walkers and Rollators?

Under Medicare Part B, walkers and rollators are covered as durable medical equipment. The key concept here is the **reasonable useful lifetime (RUL)** – the period during which Medicare considers a piece of equipment still serviceable. For walkers and rollators, Medicare sets the RUL at five years, measured from the **delivery date** of the device to you, not the date you purchased it or the date it was manufactured.

During that five-year window, Medicare's general rule is that repairs come before replacement. If your walker develops a problem – a wobbly wheel, worn-down grips, a brake that's sticking – Medicare will cover repairs that are reasonable and necessary, up to the cost of replacement. Only when repair is no longer practical does Medicare consider replacing the device early.

Once the RUL has passed, Medicare can cover a replacement if your device is worn out and you still meet the medical necessity criteria. "Worn out" has a specific meaning here: the device can no longer function safely, and repair is either impossible or costs as much as replacement. Age alone is not enough – a five-year-old walker that still works safely does not automatically qualify.

Walkers and rollators fall under Medicare Local Coverage Determination LCD L33791, which governs coverage criteria and documentation requirements. The HCPCS codes that apply are:

HCPCS Code Device Description  
 E0130 Standard walker, rigid (pickup), adjustable or fixed height  
 E0135 Standard walker, folding (pickup), adjustable or fixed height  
 E0140 Walker with trunk support  
 E0141 Walker, rigid, wheeled, adjustable or fixed height  
 E0143 Walker, folding, wheeled (standard rollator)  
 E0147 Heavy-duty walker, multiple braking system, variable wheel resistance  
 E0148 Heavy-duty walker without wheels  
 E0149 Heavy-duty

variable wheel resistance for heavy-duty walker, without wheels E0147/ heavy-duty walker, wheeled

For most patients, the relevant codes are E0130 or E0135 (basic pickup walkers) and E0143 (a standard four-wheeled rollator). Heavy-duty codes E0148 and E0149 apply only when a patient weighs more than 300 pounds.

## Can You Get a New Walker Before 5 Years? Yes – Here's When

The 5-year RUL is not an absolute barrier. Medicare recognizes three documented exceptions that allow early walker replacement Medicare. Each comes with specific qualifying criteria, required paperwork, and common pitfalls that can trip up a claim.

### If Your Walker Was Lost, Stolen, or Damaged Beyond Repair

**What qualifies:** Medicare covers early replacement when a walker is lost, stolen, or damaged by a specific, identifiable incident — a house fire, a car accident, a flood. This is distinct from ordinary wear and tear. Wear happens gradually over time through daily use; damage from a specific event is what Medicare calls "irreparable damage," and it's treated differently.

#### Required documentation:

- A police report (for theft or loss) or a written incident report describing what happened
- A written assessment from a Medicare-enrolled DME supplier confirming the device cannot be repaired
- A doctor's note — a new Standard Written Order (SWO) — confirming continued medical necessity and that the device is non-functional

**What the doctor's notes must say:** The SWO must include your name and date of birth, the specific HCPCS code for the walker, a description of your mobility limitation, and a statement that the device was rendered non-functional by the described event. Vague language like "patient needs new walker" will be denied.

**Most common denial reason:** A missing supplier assessment. Medicare requires documentation that a qualified supplier evaluated the device and determined it cannot be repaired. Submitting only the police report and the SWO, without the supplier's written assessment, is the single most frequent reason these claims are rejected.

### If Your Medical Condition Has Changed

**What qualifies:** If your health condition has worsened or changed in a way that means your current device no longer meets your mobility needs, Medicare can approve early replacement — including a different device category entirely. This might mean upgrading from a basic pickup walker to a four-wheeled rollator with a seat, or from a standard rollator to a heavy-duty model after significant weight gain.

Common qualifying diagnoses include Parkinson's disease progression, COPD exacerbation, post-stroke changes in balance or strength, and significant weight change. What matters is that the change is documented and specific.

#### Required documentation:

- An updated face-to-face evaluation conducted by your Medicare-enrolled physician, within six months of the order
- A new SWO that names the specific diagnosis and explains why your current device no longer meets your needs
- Medical records documenting the condition change

**What the doctor's notes must say:** The SWO must name the specific condition — "patient's Parkinson's has progressed with significant bilateral tremor, current two-wheeled walker no longer safe for home ambulation." Vague language is denied. The documentation must make clear that the medical change is the direct reason the new device is necessary, not simply that the patient would prefer a different model.

**Most common denial reason:** Non-specific doctor's notes. If the SWO doesn't name the condition and explain the functional impact, Medicare will deny the claim as not medically necessary. Your doctor needs to be explicit.

### If Your Device Is Worn Out Beyond Repair Before 5 Years

This is the narrowest exception, and also the most misunderstood. As noted earlier, Medicare distinguishes between **irreparable damage** (a specific incident) and **wear** (gradual deterioration from daily use). Replacement due to ordinary wear during the RUL is not covered. However, if the cost of repairing your device approaches the cost of replacing it —

even within the five-year window – Medicare may approve early replacement.

**Required documentation:**

- A written repair-vs.-replace cost comparison from a Medicare-enrolled DME supplier, showing that repair costs are not reasonable relative to the cost of a new device
- A new SWO from your doctor confirming continued medical necessity for the same device category

**What the doctor's notes must say:** The physician must confirm that the patient still requires a device in the same category (e.g., a four-wheeled rollator) and that the need is ongoing. The supplier's documentation does the heavier lifting in this exception – the cost comparison is the key piece.

**Most common denial reason:** Submitting this claim without a formal cost comparison from the supplier. Medicare needs to see, in writing, that repair is economically unreasonable. A patient's description of how worn out the device is, without the supplier's assessment, is not sufficient.

## How to Request an Early Replacement: Step by Step

The process is clear once you know it. Here's how to request an early replacement walker or rollator through Medicare:

1. **Call your doctor's office.** Explain that you need an early replacement for your walker and the reason it qualifies (lost/stolen/damaged, condition change, or worn out beyond reasonable repair). Ask for a face-to-face appointment or telehealth evaluation.
2. **Complete the face-to-face evaluation.** Your doctor must examine you and document your current mobility limitations. This evaluation must be conducted by a Medicare-enrolled physician, nurse practitioner, or physician assistant within six months of the equipment order.
3. **Get your Standard Written Order (SWO).** The SWO is a formal prescription. It must include: your full name and date of birth, the date of the order, your physician's name and NPI (National Provider Identifier), the specific HCPCS code for the device, your diagnosis with the specific ICD-10 code, a description of your mobility limitations, a statement of medical necessity, and your physician's signature. For early replacement, it should also include the specific reason the early replacement is warranted.
4. **Find a Medicare-enrolled DME supplier.** The supplier must be enrolled in Medicare and must "accept assignment" – meaning they agree to bill Medicare directly at Medicare-approved rates. You can verify suppliers at [Medicare.gov](https://www.medicare.gov). Using a non-enrolled supplier means Medicare will not pay, and you'll be responsible for the full cost.
5. **Gather your supporting documentation.** Depending on your exception type, this will include a police or incident report, a supplier repair assessment or cost comparison, and your updated medical records. Organize everything before submission.
6. **Submit your claim.** In most cases, your Medicare-enrolled supplier handles the billing directly and submits the claim to the Medicare Administrative Contractor (MAC). Confirm with your supplier that they've submitted the claim and get a confirmation number.
7. **Follow up within two weeks.** Contact your supplier to confirm the claim was received. Medicare typically takes 30 days to process standard DME claims. If you haven't heard anything in two weeks, follow up proactively – delays are often caused by missing documentation that could have been caught early.

## What to Do If Medicare Denies Your Replacement Request

A denial is not the end of the road. Medicare denials are frequently overturned – research from Premier Inc. found that 54% of denied insurance claims are reversed on appeal. You have rights, and using them is worth it.

**Common denial reasons for walker replacement claims:**

- Missing or incomplete SWO (most common)
- Supplier not enrolled in Medicare or doesn't accept assignment
- Documentation doesn't support medical necessity
- Walker claimed as needed only for outdoor use (Medicare covers home use only)
- Claim submitted within the RUL without a qualifying exception

**The appeals process for Original Medicare:**

Original Medicare offers five levels of appeal. For most patients, the first level – the **Redetermination** – resolves the issue.

- 1. Level 1 — Redetermination:** You have **120 days** from receiving your Medicare Summary Notice (MSN) to file. Complete Form CMS-20027 and send it to the MAC listed on your denial notice. The MAC has 60 days to issue a decision. Include all missing documentation — this is your best chance to fix whatever caused the initial denial.
- 2. Level 2 — Reconsideration:** If denied again, you have 180 days to request review by a Qualified Independent Contractor (QIC), which is independent of the MAC.
- 3. Level 3 — Administrative Law Judge (ALJ) Hearing:** Available if the amount in dispute meets the minimum threshold (\$200 for 2026). Most walker replacement claims qualify.
- 4. Level 4 — Medicare Appeals Council:** Review by the HHS Departmental Appeals Board.
- 5. Level 5 — Federal District Court:** The final level, rarely needed for DME claims.

For a full walkthrough of the process, see our guide on [how to appeal a denied Medicare claim](#).

This is exactly where a Solace advocate earns their place. Advocates — nurses, social workers, and clinical researchers who know how Medicare works from the inside — write the appeal letters, gather the missing documentation, and follow up with the MAC until the problem is resolved. They don't hand you a to-do list. They do it. According to the CHCAO (Coalition of Health Care Advocacy Organizations), 98% of patients who work with an advocate feel more in control of their care — and 92% see better health outcomes overall.

[See if you're covered and find your advocate.](#)

## Medicare Advantage: The Rules Are Different

If you're enrolled in a Medicare Advantage (Part C) plan — a private insurance plan that covers Medicare benefits — the rules around early walker replacement can be stricter than Original Medicare.

**Prior authorization:** Many Medicare Advantage plans require prior authorization (pre-approval) before you can receive DME, including walker replacement. Your supplier or physician typically submits this request. Under 2024 CMS rules, plans must respond to standard prior authorization requests within 7 calendar days, and urgent requests within 72 hours. If your plan denies the prior authorization, you have the right to appeal.

**In-network supplier restrictions:** Most Medicare Advantage plans require you to use suppliers within their network. Using an out-of-network supplier — even one enrolled in Medicare — may result in your claim being denied or you paying the full cost. Always confirm your supplier is in your plan's network before proceeding.

**Appeal window:** For Medicare Advantage, you have **65 days** from the date of the initial denial notice to file a Level 1 appeal with your plan. This is shorter than Original Medicare's 120-day window, so don't wait.

**How to check your plan's coverage:** Log into your plan's member portal, call the member services number on your insurance card, or request a copy of your Evidence of Coverage document. The Evidence of Coverage spells out your plan's specific DME rules, including any prior authorization requirements and which suppliers are in-network.

**Open Enrollment consideration:** If your Medicare Advantage plan consistently denies DME coverage or has a limited supplier network in your area, Medicare Open Enrollment (October 15 – December 7 each year) is the right time to compare plans and switch.

For more on Medicare Advantage appeals, see our guide on [Medicare Advantage appeals](#).

## When Does Medicare Cover Repairs Instead of Replacement?

During the five-year reasonable useful lifetime, Medicare's default is to cover repairs rather than replacement. Understanding what repairs Medicare covers — and when it switches to replacement — can save you time and confusion.

**Parts Medicare commonly covers for walker repair:**

- Wheels and casters
- Hand brakes and brake cables
- Hand grips and handle covers
- Seat cushions and backrests (on rollators)
- Frame welds and structural components

Medicare pays 80% of the Medicare-approved repair cost after you've met your Part B deductible (\$257 in 2025). You're responsible for the remaining 20%. You can use any Medicare-approved DME supplier to make repairs — it doesn't have to be the original supplier.

**When repair crosses into replacement territory:** If a supplier determines that the cost of repairing the device would equal or exceed the cost of a new device, early replacement may be approved. This threshold triggers the "worn out beyond repair" exception discussed earlier — and the supplier must provide the cost comparison in writing.

**What's not covered as a repair:** Parts that represent an upgrade beyond the original device, or accessories that weren't part of the original covered item. For more detail, see our guide on [walker accessories and parts coverage](#).

## Frequently Asked Questions

### Can Medicare replace my walker before the 5-year mark?

Yes. Medicare can replace a walker or rollator before the five-year reasonable useful lifetime ends if the device was lost, stolen, or damaged by a specific incident — or if your medical condition has changed in a way that means the current device no longer meets your mobility needs. Each exception requires specific documentation, including a new Standard Written Order from your doctor and supporting records from a Medicare-enrolled supplier.

### What counts as "worn out" by Medicare's definition?

Under Medicare's rules, a device is considered worn out when it can no longer function safely and repair is either impossible or costs as much as replacement. Ordinary wear from daily use during the five-year reasonable useful lifetime does not qualify for early replacement on its own. The device must be functionally non-serviceable, and a Medicare-enrolled supplier must document that in writing.

### What documentation do I need for an early replacement?

The specific documents depend on your reason for early replacement. All situations require a new Standard Written Order (SWO) from your Medicare-enrolled physician. Lost, stolen, or damaged claims also need a police or incident report and a supplier's written assessment confirming the device is non-functional. Condition-change claims need an updated face-to-face evaluation and medical records documenting the change. Worn-out claims need a supplier's repair-vs.-replace cost comparison.

### Does Medicare cover a replacement if my walker was stolen?

Yes. Medicare covers replacement for lost or stolen walkers, provided you can supply reasonable proof — typically a police report — and a written supplier assessment confirming the device is no longer available and cannot be used. Your physician must also issue a new Standard Written Order confirming continued medical necessity.

### What if my medical condition changed — can I get a different device?

Yes. If your diagnosis or functional status has changed, you may be eligible for early replacement with a different device — for example, switching from a basic pickup walker to a four-wheeled rollator. Your doctor must conduct an updated face-to-face evaluation and write a new SWO that names the specific condition and explains why the current device no longer meets your needs. Vague documentation is the most common reason these claims are denied.

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Yes. During the five-year reasonable useful lifetime, Medicare defaults to covering repairs rather than replacement. Medicare pays 80% of the approved repair cost (after your Part B deductible), and you pay 20%. Only when repair is no longer reasonable — because it would cost as much as replacement — does Medicare consider early replacement during the RUL. The supplier must provide a written cost comparison to support that determination.

How long does Medicare walker replacement take?

Standard DME claims are typically processed within 30 days. If your supplier submits a complete, well-documented claim, you can expect a decision within that window. Delays are almost always caused by missing documentation — an incomplete SWO, a missing supplier assessment, or a mismatched HCPCS code. Following up with your supplier two weeks after submission helps catch these issues early. If Medicare Advantage requires prior authorization, the plan has 7 calendar days to respond to a standard request.

## How A Solace Advocate Can Help

Knowing the rules is one thing. Getting Medicare to follow them is another. The paperwork is real. The documentation requirements are specific. And if one piece is missing — a supplier's cost comparison, a vague phrase in the SWO — the claim gets denied, and you're back at the beginning.

A Solace advocate knows this system because they've worked inside it — as nurses, social workers, and clinical researchers who have spent years solving exactly these kinds of problems. They make the calls, coordinate with your doctor, and submit everything correctly the first time. If a denial comes back, they write the appeal. Patients pay \$0 or very little per month for Solace advocacy. You don't have to manage this alone — and you shouldn't have to. Learn more about [Medicare rollator walker coverage](#) or find out what [Medicare's 5-year DME replacement rule](#) means for your other equipment. When you're ready to get help, Solace is here.

Check at [find.solace.health](#). It only takes a minute.

REFERENCES



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Solace puts an advocate in your corner—someone who's spent years in healthcare, knows the system, and takes on the toughest parts of your care. Don't do this alone.



Eligibility varies by plan. Advocates do not provide medical or legal advice or services.

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