All Articles

Does Medicare Pay for Mobility Equipment? What's Covered and How to Qualify

CONTENTS

What Mobility Equipment Does Medicare Cover?
Do You Qualify for Medicare Mobility Equipment?
What Documentation Does Medicare Require?
Why Do People Who Qualify Still Get Denied?
How to Lower Your Out-of-

KEY POINTS

- Medicare Part B covers most mobility equipment, including canes, walkers, rollators, wheelchairs, and scooters, when your doctor certifies the device is medically necessary for getting around inside your home.
- Medicare pays 80% of the approved amount after your Part B deductible. The remaining 20% is yours unless a Medigap plan, Medicaid, or other coverage picks it up.
- The device Medicare covers is on a ladder system, meaning it pays for the least costly device that meets your documented needs, so the paperwork has to show why a simpler aid won't work.
- Most denials trace back to documentation gaps or a mismatch between the device requested and the

Pocket Costs

How to Get Medicare-Covered Mobility Equipment: Step by Step

FAQs

need on file.

- A Solace advocate can coordinate the process end to end. They work with your doctor on documentation, confirm your supplier accepts Medicare, and follow your claim through prior authorization and any appeal.

Short answer — yes, Medicare Part B can cover everything from a basic cane to a power wheelchair, as long as a doctor certifies the device is medically necessary for use inside your home.

Nearly 24% of Medicare beneficiaries over age 65 use some form of mobility device, and the right one can mean fewer falls, fewer hospital visits, and more independence at home.

Medicare's rules change from device to device, and the approval process runs through your doctor, your supplier, and often a prior authorization review. Qualifying for mobility equipment in general doesn't mean you'll get approved for the specific device you asked about. A Solace advocate can carry that process for you, from the first appointment through delivery.

What Mobility Equipment Does Medicare Cover?

Medicare Part B covers mobility equipment as durable medical equipment (DME), the same category as oxygen machines and hospital beds. To count as DME, a device has to hold up under repeated use and serve a medical purpose. It also has to be appropriate for use in the home, and it has to be the kind of equipment that wouldn't be much use to someone who isn't sick or injured.

Within that category, Medicare covers a wide range of devices. Coverage works like a ladder: each device gets approved only after your medical record shows the simpler options below it won't work. The list below runs in that order, from the bottom rung up.

- **Canes and crutches.** The simplest devices with the simplest paperwork. A written order from your doctor is usually enough.
- **Walkers and rollators.** Covered as basic DME, with the most straightforward approval path among wheeled devices. That includes standard walkers, folding walkers, and wheeled rollators with seats.
- **Manual wheelchairs.** Covered when you can't get around safely with a cane or walker, and you can propel the chair yourself or have someone at home who can help. Most manual wheelchairs are capped rentals: Medicare pays monthly, and after 13 months of continuous use, the chair becomes yours.
- **Transport wheelchairs.** Lightweight chairs designed to be pushed by a caregiver. Medicare treats these as their own category, separate from standard manual wheelchairs.

- **Mobility scooters.** Covered when you can't propel a manual chair but can sit upright, steer safely, and transfer on and off (on your own or with a caregiver's help). Scooters require a face-to-face exam and a detailed written order, and many models need prior authorization. We walk through the full process in our guide to Medicare coverage for mobility scooters.
- **Power wheelchairs.** The top of the ladder, with the strictest documentation requirements. These are for people who can't operate a scooter's tiller or need more support than a scooter seat provides.

Medicare generally won't pay for two devices that serve the same purpose at the same time. Reviewers call this the "same or similar" check. If Medicare already paid for a rollator, a power wheelchair request for the same condition needs documentation showing your needs have changed.

Do You Qualify for Medicare Mobility Equipment?

Qualifying comes down to three factors:

1. **Your condition.** You need a documented diagnosis that limits your ability to handle daily activities inside your home, such as bathing, dressing, or getting to the bathroom. Conditions that commonly qualify include:
    - Severe arthritis that makes walking painful
    - Cardiopulmonary conditions like COPD or heart failure that cause shortness of breath with exertion
    - Neurological conditions, including:
        - Multiple sclerosis (MS)
        - Parkinson's disease

- Stroke after-effects
- Spinal cord injuries

2. **Your doctor.** The prescribing physician must be enrolled in Medicare, and for power devices, must complete a face-to-face exam focused on your mobility. Their notes have to describe your limitations in the specific terms Medicare reviewers look for.
3. **Your device match.** The device has to fit both your needs and your home. Medicare requires that you (or a caregiver) can operate it safely, and that it works in your home's layout. Narrow hallways and tight doorways can rule out certain models.

What Documentation Does Medicare Require?

The required paperwork scales with the device.

For canes, crutches, and walkers, a written order from your Medicare-enrolled doctor is usually all it takes.

For manual wheelchairs, the medical record needs to show why a walker isn't enough, along with confirmation that you can propel the chair or have help at home.

For scooters and power wheelchairs, the requirements tighten considerably:

- A face-to-face exam focused on your mobility, completed within 45 days before the written order
- A detailed written order stating the diagnosis, the device, and why less costly options won't meet your needs

- Documentation that you can operate the device safely, or that a caregiver is available to help
- Prior authorization for many models, submitted by your supplier before delivery

Documentation gaps are one of the top reasons mobility equipment claims get denied. A Solace advocate coordinates with your doctor's office to gather the records Medicare wants to see, and confirms the file is complete before anything gets submitted.

Why Do People Who Qualify Still Get Denied?

A denial usually means the paperwork didn't line up with the device requested, but don’t worry — denials are commonly overturned and are not the end of the road.

- **The device didn't match the documentation.** This is the most common reason for a denial. If you’ve never even tried a walker and ask for a power wheelchair, Medicare denies the claim.
- **The need wasn't framed around your home.** Notes that describe trouble walking to the mailbox or through the grocery store miss Medicare's standard. Reviewers want evidence that you can't manage daily activities inside your home without aid.
- **The exam was outdated.** For power devices, a face-to-face exam must be within 45 days of the equipment request submission.
- **The supplier wasn’t in-network.** Equipment from a supplier who isn't Medicare-approved isn't covered.

Your provider's wording can determine the outcome. A note that says you "have difficulty walking" can sink a claim that would have sailed through with "cannot perform mobility-related activities of daily living even with a cane or walker."

If Medicare says no, you have **five levels of appeal**, and most successful appeals happen at the first two levels once the documentation gets corrected. A Solace advocate can coordinate the appeals, work with your doctor on a stronger file, and track every deadline along the way.

How Much Does Medicare Pay for Mobility Equipment?

Once a device is approved, Medicare pays 80% of the approved amount after you meet your Part B deductible ($283 in 2026). You're responsible for the remaining 20% unless supplemental coverage picks it up.

The phrase "approved amount" refers to the price Medicare sets, which is often lower than what the equipment sells for. If your supplier accepts Medicare assignment, they agree to the approved amount and you only owe your 20% share. If they don't, you can be billed the difference on top of your coinsurance.

How to Lower Your Out-of-Pocket Costs

The 20% cost is standard, but several programs exist that can reduce or cover it.

- **Medigap plans** can cover your full coinsurance on any covered mobility device. Plan G covers the 20% share (you still pay the Part B deductible). Plan F covers the deductible too, but it's only open to people who were eligible for Medicare before 2020.
- **Medicare Advantage** plans often require a copay for DME, and rules vary widely by plan, so check your plan documents before you start the process.
- **Medicaid** can cover the 20% if you qualify for both programs. Many people are dual-eligible, but a **Medicare Savings Program** can help even if full Medicaid isn't an option.
- **VA benefits** may cover the full cost for enrolled veterans. The VA uses its own criteria and often provides higher-end models.
- Local disability organizations and civic groups sometimes help with equipment costs, some suppliers offer zero-interest payment plans, and mobility equipment may count as a tax-deductible medical expense.

Solace advocates can find programs that fit your state and situation, help you apply to several at once, and confirm your supplier accepts assignment before you commit.

How to Get Medicare-Covered Mobility Equipment: Step

by Step

1. Start with your doctor. Schedule a visit to talk through your mobility at home. Come with concrete examples: "I can't get from my bedroom to the bathroom without stopping to rest, even with my walker." Your doctor documents your history, your limitations, and which aids you've already tried.

2. Get the written order. The order must name the specific device requested, the diagnosed condition(s) requiring it, and the medical need for use in your home. For scooters and power wheelchairs, a face-to-face exam has to happen within 45 days before this order.

3. Choose the right supplier. Use Medicare's supplier directory to search by ZIP code, and confirm two things before moving forward: the supplier is enrolled in Medicare, and they accept Medicare assignment.

4. Complete prior authorization if required. For many scooters and power wheelchairs, your supplier submits the documentation to Medicare before delivery. If the request comes back denied, you'll get a notice explaining why, and you have the right to appeal.

How Long Does It Take To Get Mobility Equipment?

The clock starts when Medicare receives complete, correct documentation. For simple equipment like a walker, it shouldn't take more than a few days once your doctor's order reaches the supplier. However, power devices could take several weeks from the required appointment to delivery.

- Prior authorization decisions, when required, come back within 7 calendar days for standard requests, or 2 business days if expedited.
- A denial or documentation gap adds weeks, because a correction restarts the review instead of picking up where things left off.

You can't control Medicare's review, but you can protect yourself from the avoidable delays. A Solace advocate confirms documentation is complete before submission, catches device mismatches that would trigger a denial, and keeps the claim moving when it stalls.

FAQs

1. Does Medicare cover walkers and rollators?
Yes. Walkers and rollators are covered as basic DME, with the simplest approval path of any wheeled device. You'll need a written order from a Medicare-enrolled doctor and a Medicare-approved supplier.

2. Does Medicare pay for wheelchairs?
Yes. Manual wheelchairs are covered when a walker isn't enough, and power wheelchairs are covered when you can't safely operate a manual chair or scooter. Most wheelchairs start as capped rentals, with ownership transferring to you after 13 months.

3. Can I get both a scooter and a wheelchair?
In most cases, no. Medicare's "same or similar" rule blocks payment for two devices that serve the same purpose for the same condition. A second device usually requires documentation that your needs have changed.

4. How often will Medicare replace mobility equipment?
Medicare typically covers a replacement after the device reaches its "reasonable useful lifetime," which is generally five years. Loss, theft, or a documented change in your condition can qualify you sooner.

5. Does Medicare cover stairlifts or wheelchair ramps?
No. Medicare classifies these as home modifications rather than DME, so they're excluded regardless of medical need. Some Medicare Advantage plans, Medicaid HCBS waivers, and VA HISA grants can help instead.

6. Do I need prior authorization for mobility equipment?
Often, yes, especially for scooters and power wheelchairs. Your supplier submits the paperwork to Medicare before delivery. Canes, walkers, and most manual wheelchairs usually don't require it.

7. What happens if Medicare denies my claim?
Denials aren't final. You have five levels of appeal, and most successful appeals happen at the first two levels once the documentation is corrected. A detailed letter from your doctor explaining how you meet Medicare's criteria can turn a denial into an approval.

8. Does Medicare Advantage cover the same equipment?
Medicare Advantage plans must cover at least the same DME as Original Medicare. Prior authorization rules,

supplier networks, and referral requirements can differ by plan, so check your plan's rules before starting.

9. Can I get mobility equipment at no cost?
Sometimes. Your share can drop to $0 if you have a Medigap plan that covers coinsurance, qualify for Medicaid alongside Medicare, or get help through a Medicare Savings Program.

10. Where do I find a Medicare-approved supplier?
Use the supplier directory on Medicare.gov to search by ZIP code. Always confirm the supplier accepts Medicare assignment, which means they agree to Medicare's approved amount and can't bill you beyond your share.

REFERENCES

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