

The Department of Vermont Health Access Medical Policy

Subject: Repairs/Replacements/Modifications for Durable Medical Equipment (DME)

Last Review: May 10, 2016

Revision 4: June 3, 2015

Revision 3: January 9, 2014

Revision 2: May 3, 2013

Revision 1: February 15, 2012

Original Effective: 2004

Description of Service or Procedure

Repair: A fix for a damaged part of a DME item.

Replacement: A substitute for a damaged part of a DME item.

Modification: A change to a DME item that no longer meets the beneficiary's medical needs due to change in size, medical condition, living situation, or ability to perform mobility related activities of daily living.

Disclaimer

Coverage is limited to that outlined in Medicaid Rule that pertains to the beneficiary's aid category. Prior Authorization (PA) is only valid if the beneficiary is eligible for the applicable item or service on the date of service.

Medicaid Rule

- [7102.2](#) Prior Authorization Determination
- [7103](#) Medical Necessity
- [7315](#) Hearing Aids
- [7316](#) Vision Care
- [7505](#) Durable Medical Equipment (DME)
- [7506](#) Wheelchairs, Mobility Devices and Seating Systems
- [7507](#) Augmentative Communication Systems
- [7508](#) Prosthetics/orthotics

Medicaid Rules can be found at <http://humanservices.vermont.gov/on-line-rules>



Coverage Position

A repair/replacement/modification may be covered for beneficiaries:

- When the repair/replacement/modification is prescribed by a licensed medical provider, enrolled in the Vermont Medicaid program, operating within their scope of practice in accordance with the Vermont State Practice Act, who is knowledgeable in the use of DME requiring repair/replacement/modification and who provides medical care to the beneficiary AND
- When the clinical guidelines below are met.

Coverage Criteria

A repair/replacement/modification may be covered for beneficiaries who meet the following guidelines:

Repairs are covered when:

- The beneficiary's equipment is no longer functioning properly; AND
- The repair cost is less than 50% the cost of replacing the equipment; AND
- The repair does not result in a change in the nature, structure, or function of the equipment as it was originally intended. Such change would be considered a modification and would require additional documentation from the medical practitioner for the medical necessity of any changes; AND
- The equipment is not under warranty; AND
- The repair is non-routine and must require the skill of a technician.

Replacements are covered when:

- The beneficiary's equipment is no longer functioning properly; AND
- The replacement cost is less than 50% the cost of repairing the equipment; AND
- The replacement does not result in a change in the nature, structure, or function of the equipment as it was originally intended. Such change would be considered a modification and would require additional documentation from the medical practitioner for the medical necessity of any changes; AND
- The equipment is not under warranty; AND
- The replacement is non-routine and must require the skill of a technician.

Modifications are covered when:

- The beneficiary's equipment is no longer fitting properly or meeting the medical need; AND
- The modification requires the skill of a technician; AND
- The modification does not void the warranty; AND
- The modification does not adversely affect the function or the life expectancy of the equipment; AND
- The modification is specifically for the proper fit and/or medically necessary function of the device.
- Modifications require assessment by a medical professional with expertise in the field of rehabilitation, including a physician, a physical therapist, or an occupational therapist.

Notes:

- See [Vermont Medicaid Rule](#) for specific information on DME items.

- **Medicare** will cover repair, replacement, and maintenance of medically required DME, including equipment which had been in use before the user enrolled in Part B of the program (see Medicare Benefit Policy Manual Chapter 15, 110.2, revision 10/26/12.) If a beneficiary has Medicare, but Medicare denied the purchase of the original piece of equipment, Medicaid will cover the cost of a repair/replacement/modification with proof of *appropriate* Medicare denial via a Medicare Explanation of Benefits (EOMB) form.
- **Primary Insurance:** If a beneficiary had a primary insurance at the time of service delivery of the original device, but subsequently lost the primary insurance coverage and is now a Medicaid beneficiary, Medicaid will cover the cost of the repair/replacement/modification provided that the original device meets Medicaid's rules and guidelines as demonstrated by clinical documentation provided by a physician/therapist active with Vermont Medicaid AND the device has been fully inspected and documented as safe and medically necessary for the beneficiary. In the case of a modification, medical necessity documentation with specific rationales for each modification must be provided from the prescribing physician/therapist.
- **Privately purchased devices:** If a beneficiary purchased or obtained a device privately, Medicaid will cover the cost of the repair/replacement/modification only if the original device meets Medicaid's rules and guidelines as demonstrated by clinical documentation provided by a physician/therapist active with Vermont Medicaid AND the device has been fully inspected and documented as medically safe and medically necessary for the beneficiary by the physician/therapist, AND as structurally safe by a DME provider active with Vermont Medicaid.
- **Labor Reimbursement:** Regulation 7506.2 states that "reimbursement for labor associated with a custom fabricated seating system (a seat with a back and one other positioning component) will be made to the DME provider up to the limit of 5 hours." Administrative and clerical tasks, even if these tasks are performed by the technician, are not reimbursable.
- **Labor time:** Labor charges include travel time **for those beneficiaries who are not able to travel to the DME vendor's office or therapy department for the repair/replacement/modification needed.** The expectation is that beneficiaries will bring their equipment to their vendor's nearest office if possible. The travel "benefit" is not for convenience but must be for medical necessity. The exception would be if the beneficiary requires travel assistance that is more expensive than the DME provider's travel expenses- for example, an ambulance. It is also expected that the vendor, if billing for travel time, will make every effort to utilize travel time as efficaciously as possible by combining trips and by traveling the most direct route. Medicaid can only be billed for the portion of the travel time that involves Medicaid clients. For example, if the technician has 3 client visits, and the second client is a Medicaid beneficiary, the expectation is that the technician will bill for travel time only between the first and second client's home. It is advised that providers keep technician's travel logs to demonstrate compliance with this guideline in the event of an audit.
- **Safety:** Caution must be used when an item of DME has been involved in a significant incident such as a motor vehicle accident; such a device may need to be replaced rather than repaired. Special needs car seats must never be repaired after a motor vehicle accident. Damaged care seats must be replaced.

Clinical guidelines for repeat service or procedure

Repeat services are covered when the DME equipment requires repair/replacement/modification before the DME restriction time frame.

Note: If a device is requiring frequent repair, consideration must be given to more heavy-duty equipment, and/or a discussion with the beneficiary regarding careful use of Medicaid-provided equipment. Consideration must also be given to having a therapist provide an assessment to determine if there are more appropriate options.

Note: Hearing aids are limited to one repair per aid per year.

Type of service or procedure covered

Repair/replacement/modification of Durable Medical Equipment, prosthetics/orthotics, augmentative communication devices, vision and hearing aids that meet the above guidelines

Type of service or procedure not covered (this list may not be all inclusive)

- Repairs/replacements that cost more than 50% of the cost of a new device.
- Repeat repairs/replacements without a documented careful consideration of the issues causing the need for repeat services.
- Repair/replacement of a device under warranty.
- Repair/adjustment of a device within 60 days of purchase. Note: with complex equipment such as a wheelchair with multiple components, it may be determined at the time of service delivery that additional components or modifications are required to achieve proper fit and functionality. These changes may be covered with prior authorization and with additional documentation from the prescribing therapist, describing the medical necessity rationale for the changes and an explanation of why the original prescription was incorrect. If at all possible the incorrect components should be returned to the manufacturer and recoupment obtained.
- Repairs/replacements that result in a change in the nature, structure, or function of the equipment different than the originally intent of the device.
- Repairs that do not require the skill of a technician.
- Modification of a device without documentation from a physician or therapist describing the rationale for the modification and its medical necessity.
- Modification that may result in a voiding of the warranty.
- Modification that does not require the skill of a technician.
- Modification that adversely affects the function of the equipment or the life expectancy of the equipment.

References

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