State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
www.dvha.vermont.gov

Agency of Human Services
[Phone] 802-879-5903
[Fax] 802-879-5963

The Department of Vermont Health Access Clinical Criteria

Subject: Repairs/Replacements/Modifications/Labor for Durable Medical Equipment (DME)
Last Review: January 20, 2022*
Past Revisions: July 22, 2020, April 4, 2017, May 10, 2016, January 9, 2014, May 3, 2013, February 15, 2012, and 2004

***Please note: Most current content changes will be highlighted in yellow.**

Description of Service or Procedure

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

Replacement: A direct 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 or Health Care Administrative Rules 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

Medicaid and Health Care Administrative Rules can be found at https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar/adopted-rules

- 7102.2 Prior Authorization Determination
- 7508 Prosthetics/orthotics

Health Care Administrative Rules

- 4.101 Medical Necessity for Covered Services
- 4.104 Medicaid Non-Covered Services
- 4.209 Durable Medical Equipment (DME)
- 4.210 Wheelchairs, Mobility Devices and Seating Systems
- 4.211 Augmentative Communication Devices/Systems
- 4.213 Audiology Services
- 4.214 Eyewear and Vision Care Services

Coverage Position

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

- When the device is prescribed by a licensed medical provider, enrolled in the Vermont Medicaid program, operating within their scope of practice as described on the Vermont's Office of Professional Regulation's website*, Statute, or Rule who is knowledgeable regarding durable medical equipment, and who provides medical care to the beneficiary AND
- When the clinical criteria below are met.

* Vermont's Office of Professional Regulation's website: https://sos.vermont.gov/opr/

Coverage Criteria

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; AND
- The repair has been ordered by a physician or other licensed provider who is enrolled in Vermont Medicaid and is working within the scope of their practice; AND
- The repairs are necessary to make the item useful.

Replacements are covered when:

- The beneficiary's equipment is no longer functioning properly; AND
- The repair cost is more than 50% the cost of replacing 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 existing device or system no longer effectively addresses the beneficiary's needs;
- When changing circumstances or conditions are sufficient to justify replacement
- The useful lifetime has been reached; OR
- When convincing evidence shows that replacement is medically necessary and appropriate.

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; AND

- The modification cost is less than 50% of the cost of replacing the equipment; AND
- Modifications require assessment by a medical professional with expertise in the field specific to the type of device, for example a physician, an audiologist, a speech language pathologist, a physical therapist, or an occupational therapist.

When substantial modifications are required to a device and it appears that the original prescription was in error, the medical practitioner for the modifications must document collaboration with the original practitioner to ensure seamless care and education.

Notes:

- See Vermont Medicaid Rule and/or Health Care Administrative Rules for specific information on DME items.
- Payment will not be made for repairs/replacement/modifications to equipment for use in skilled nursing homes, ICFs, ICF-MRs, mental or general hospitals or psychiatric facilities except: when a beneficiary resides in a long term care facility and the repair/replacement/modification is to a wheelchair or wheelchair component that is not owned by the facility and is so uniquely constructed or substantially modified to the individual that it would not be useful to other residents.
- **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, revision10/13/16). 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, a National Coverage Determination, a Local Coverage Determination for Jurisdiction A or the presence of the item on the Medicare Non-Covered List.
- **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, nurse practitioner or clinical nurse specialist, a physician assistant, or a 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 above listed practitioner or 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, nurse practitioner or clinical nurse specialist, a physician assistant, or a 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 above listed practitioner, AND as structurally safe by a DME supplying provider active with Vermont Medicaid.
- **Labor Reimbursement:** Per HCAR 4.210, "reimbursement for up to five hours of labor associated with custom fabrication of a seating system or customizing a seating system will be made to the DME provider." Administrative and clerical tasks, even if these tasks are performed by the technician, are not reimbursable. Prior authorization is required for the labor cost of DME repairs where parts are under warranty.
- **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 car seats must be replaced.
- **Maintenance:** Regular maintenance is recommended and covered to prevent injury and functional limitations resulting from broken devices.
- **Eyewear** repair and replacements are provided by the DVHA's contracted vendor.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Vermont Medicaid will provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions for Medicaid members under age 21.

Clinical criteria for repeat service or procedure

Repeat services are covered when the DME equipment requires repair/replacement/modification before the DME restriction list time frame. The DME restriction list can be found at: https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment

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.

Type of service or procedure covered

Repair/replacement/modification of Durable Medical Equipment that meet the above guidelines, and labor to repair, replace, or modify DME.

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

DME that is under warranty.

References

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