Repairs and Replacement Workshop Q&A

Q: Can we provide a replacement product for a change in the beneficiary’s condition and bill that item with the RA modifier?
A: If there is a change in condition that warrants a different item Medicare does not consider that a replacement. The RA modifier would not be used in that case. A new order is required and the beneficiary’s medical record must justify the new item.

Q: My understanding is that repairs and replacement cannot exceed the total purchase price. What do we do with patients who "live" in their power wheelchairs and may need several major repairs during the five year lifetime?
A: Medicare will only pay for a repair up to the purchase price of the equipment. If the expense for repairs exceeds the estimated expense of purchasing or renting another item for the remaining period of medical need, no payment can be made for the amount of the excess and suppliers cannot charge the beneficiary for the amount in excess. Under the regulations at 42 CFR 414.210(e)(4), a supplier that transfers title to a capped rental DME item to the beneficiary is responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program if it is determined that the item will not last until the end of its 5 year reasonable useful lifetime. In making this determination, contractors may consider whether the accumulated costs of repairing the item exceed 60 percent of the purchase fee schedule amount for the item.

Q: We have received several denials for replacement parts (tires, armrest pads, upholstery) for the reasonable useful lifetime of the wheelchair has not expired. Can you tell me why we would be getting denied in these instances?
A: Suppliers should call the Supplier Contact Center for claim-specific questions. Parts associated with repairs should be submitted with the RB modifier. If the initial claim denies, the supplier may need to go through the appeal process with supporting documentation.

Q: Every time I submit a claim for repair labor code (K0739) with the RB modifier my claim denies. What am I doing wrong?
A: The RB modifier is not used with K0739. Suppliers should contact the Supplier Contact Center for claim-specific questions.

Q: Why does Medicare require DME suppliers to take a contractual discount on repair "parts"? Example: a replacement blower for a Positive Airway Pressure (PAP) device is billed as E1399 for $105.00 (the manufacturer cost). Medicare does not allow the whole $105.
A: If the item you are replacing as part of the repair does not have a HCPCS code, suppliers may use a not otherwise classified (NOC) code. The supplier must provide a detailed explanation of why the item is necessary for the beneficiary's medical condition.
description of the item and the manufacturer suggested retail price (MSRP). All NOC codes are processed at a percentage of the claimed amount. Suppliers accepting assignment must accept what Medicare allows. Nonparticipating suppliers have the choice to not accept assignment.

**Q:** What if our service tech needs to troubleshoot to determine what the problem is? Sometimes it is the batteries, sometimes battery charger and sometimes something else all together. Can we bill for time accordingly?

**A:** Suppliers must follow the Repair Labor Billing and Payment Policy which includes troubleshooting in the allowance for commonly repaired items.

**Q:** Now that most power wheelchairs are rentals, how do we calculate the allowable dollar amount that can be billed for major repairs?

**A:** Medicare does not pay for repairs to capped rental items during the rental period.

**Q:** Are there any guidelines for upper extremity prosthetic repairs/replacements and if so, where are those located?

**A:** Currently there is no Local Coverage Determination (LCD) for upper limb prostheses. Suppliers should follow general Medicare guidelines regarding repairs and replacements.

**Q:** We sometimes loan an Ankle-Foot Orthosis (AFO) to see if it will help the patient before we go to the time and expense of making them a permanent one. Does loaner equipment apply in this circumstance?

**A:** No. Medicare allows a one month loaner when necessary to repair beneficiary owned equipment.

**Q:** If after five years, a patient's power wheelchair needs extensive repair and the patient does not want a new power wheelchair but wants theirs repaired. Can we do this as long as it does not exceed total purchase price?

**A:** Yes

**Q:** Do I need a new prescription for the repair of a hospital bed, motor and pendent that was purchased by Medicare?

**A:** A new prescription is not required for the repair of patient owned items that meet Medicare coverage criteria.

**Q:** What needs to be included in a PAP repair narrative in order to process a labor claim for a machine that is out of warranty?

**A:** Claims for repairs must include narrative information itemizing each repair and the time taken for each repair. Commonly repaired items must follow the Repair Labor Billing and Payment Policy.
Q: Can items be replaced before five years if patient has grown or has changes in weight?
A: Weight is one aspect of the patient’s medical condition. If the overall medical condition changes such that it can be demonstrated a current device is no longer safe and effective, that can be grounds for replacement with a device that is safe and effective.

Q: We have a patient that wants the brakes on his walker repaired. What if we find that we cannot repair them that they need replaced? Do we need the physician to send a script for the replacement of the brakes?
A: No. Replacement of components to the base piece of equipment to make it function properly is considered a repair. This would not require a new order as long as the base piece of equipment met Medicare coverage criteria initially.

Q: We have a patient who owns a power chair. Repairs are over 60%. Does the patient need a new face-to-face mobility examination for replacement within five years for the same code/chair?
A: If the Power Operated Vehicle (POV) or Power Wheelchair (PWC) is a replacement during the five year useful lifetime of an item in the same performance group that was previously covered by Medicare, a face-to-face examination is not required. Note: Replacement during an item's useful lifetime is limited to situations involving loss or irreparable damage from a specific accident or natural disaster [e.g., fire, flood, etc.].

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Q: If a capped rental item needs a repair from normal wear and tear after reaching the capped rental date, for example the front casters on a patient owned manual wheelchair, does the supplier bill the necessary repairs to Medicare?
A: Yes

Q: Chapter 5 of the Supplier Manual states routine maintenance is not covered by Medicare and is expected to be completed by the beneficiary. If we dispatch a technician to do such things as tightening a bolt, why would we not be able to bill a beneficiary?
A: If a technician was thought to be required and does perform a diagnostic (evaluative) service, even if the finding turns out to be relatively minor, this does not make the service non-covered. The service should be claimed for the medically necessary evaluation. In this scenario,
the beneficiary may clearly have been unclear what the problem was and thus some technical evaluation to address the issue is logical and appropriate.

Q: We are providing a PAP unit to a patient for one month while patient unit is being repaired by the manufacturer. What modifier should be used for the one month rental and does an estimate of repair need to be attached as part of documentation submitted?
A: A modifier is not needed on the E0462 loaner code but a description of what is being repaired on what equipment and the equipment being loaned out is needed.

Q: Since Medicare will not pay for repairs in excess of the purchase cost, how can a new supplier confirm whether or not repairs from the old supplier, who is now out of business, have already exceeded the purchase price?
A: Suppliers may ask the beneficiary to join the call with Medicare to check for any repair codes.

Q: Are replacements allowed on upper extremity prostheses for patients who have gained or lost weight or have other significant changes in the limb?
A: With most DMEPOS items, if the doctor decides the existing item is not medically necessary and prescribes a new item, then a replacement can be covered by Medicare (assuming all proper supporting documentation is obtained).

Q: Is there a maximum number of labor units that are allowed on one claim for one date of service?
A: It depends on what is being repaired and whether or not documentation to support the units being charged is available. Here is a helpful article:

Q: If a repair requires more units of labor than Medicare will allow, is it appropriate to execute an Advance Beneficiary Notice of Noncoverage (ABN), bill non-assigned, and collect from the beneficiary?
A: An ABN is not appropriate but the claim may be billed unassigned if the supplier is not participating.