Priority Health	BILLING POLICY No. 108
DURABLE MEDICAL EQUIPMENT (DME) REPAIR AND REPLACEMENT	
Date of origin: July 11, 2025	**Review dates: June 2026**

DEFINITION

This policy identifies the payment and documentation requirements associated with various durable medical equipment (DME) supplies.

"Repair" is defined as the act of restoring an item to good working condition by fixing or mending damage or wear.

“Replacement” is generally defined as the provision of an identical or nearly identical item when the original has been lost, stolen, or rendered irreparably damaged.

For the purposes of determining reasonable useful lifetime (RUL) and calculating continuous use, the start date is defined as the first day of the initial rental month for payment (i.e., the Date of Service). In such cases, Proof of Delivery (POD) documentation confirms that the beneficiary is already in possession of the item.

MEDICAL POLICY

- Durable Medical Equipment (#91110) – reference for coverage details

FOR MEDICARE

For indications that don’t meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Repairs to member owned items are covered when they are necessary to restore the items to a serviceable condition.

Repairs are not separately reimbursed for the following:

- Items classified under the frequent and substantial servicing payment category
- Oxygen equipment
- Items in the capped rental payment category during the rental period
- Items that are covered under a manufacturer’s or supplier’s warranty
- Items that have been previously denied for coverage

Replacement of member owned items, including capped rental items and oxygen equipment, may be replaced if they are lost or irreparably damaged. Irreparable damage may result from specific incidents such as accidents or natural disasters (e.g., fire, flood). In such cases, Priority Health may request supporting documentation, such as a police report or insurance claim.

Replacement due to wear

Replacement due to irreparable wear is evaluated based on the item’s Reasonable Useful Lifetime (RUL). The RUL is typically defined as no less than five years. If the item has been in continuous use for its full RUL, the member may choose to obtain a replacement.

Non-covered replacements
Items in the frequent and substantial servicing payment category
Inexpensive or routinely purchased rental items

Medical necessity and documentation

A treating practitioner's order is required, when applicable, to confirm the medical necessity of the replacement.

Special rules for prosthetic devices

General Coverage
Adjustments and repairs to prostheses and prosthetic components are covered under the original order. Coverage of the replacement of prosthetic devices (e.g., artificial limbs) or their components without regard to continuous use or RUL, if a treating practitioner determines the replacement is medically necessary.

Documentation requirements
Claims for replacement of a prosthesis or major component (e.g., foot, ankle, knee, socket) must include:

- A new order from the treating practitioner
- Supporting documentation outlining the reason for replacement, which must fall under one of the following:
    - A change in the patient's physiological condition (e.g., weight change, residual limb changes, altered functional needs)
    - An irreparable change in the condition of the device or its components
    - The cost of repairs exceeds 60% of the cost of a replacement

The prosthetist must retain records detailing:

- The device or component replaced
- The reason for replacement
- A description of the labor involved

This documentation must be available upon request. Replacements may be necessary due to factors such as excessive wear, changes in residual limb, or increased activity levels in very active amputees.

Reimbursement specifics

For reimbursement purposes, repairs and replacements are treated differently.

- Repairs refer to the servicing of the base item, including labor and the replacement of parts or components that are integral to that item. These are considered part of the repair process.
- In contrast, the replacement of accessories or components that are separately payable and were not part of the original base item is classified as a replacement, not a repair. This is addressed under separate guidelines.

When a member-owned DMEPOS item is replaced, it typically involves furnishing an identical or nearly identical item to the one originally provided

Modifiers

The RA modifier indicates replacement of a previously purchased item that has been lost or damaged. The RB modifier applies when replacing individual components during a repair.

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Get more information on modifier use in our Provider Manual.

Place of service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

REFERENCES

- Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426) (CMS)

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
06/26	Reviewed, no revisions made