SECTION 2

Medical Supplies

Table of Contents

1 MEDICAL SUPPLIES

A. Authority

The Utah State Department of Health, Division of Medicaid and Health Financing, in compliance with federal law defined in 42 CFR 440.70, provides a program under Home Health Services, to make medical supplies and durable medical equipment available to members who are living at home and for certain circumstances to members living in long term care centers.

B. Purpose

1. Medical supplies, durable medical equipment, and prosthetic equipment are optional programs. In accordance with federal law, medical supplies and durable medical equipment are mandatory services for individuals entitled to nursing home services or residents of an Intermediate Care Facility for the Intellectually Disabled (ICF/ID).

2. The Utah Medicaid Program covers medical supplies and equipment if these conditions are met. The supply/equipment:
   - Has a valid physician order.
   - Meets the requirements on the Coverage and Reimbursement Code Lookup tool on the Medicaid website at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php, and Medicaid Policy.
   - Is medically necessary.

   Changes in either policy or the Coverage and Reimbursement Code Lookup tool are announced in Medicaid Information Bulletins. Medicaid coverage is stated in current policy and limited to items indicated as a covered benefit on the Coverage and Reimbursement Code Lookup tool as amended by Medicaid Information Bulletins.

3. These services do not include use primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort. The physician's order must list each item requested and be signed and dated by the physician or other licensed medical practitioner. An item simply marked on a preprinted multiple item order sheet is not acceptable.

4. The goal and purpose of the Medical Supplies Program is to provide services and/or supplies, ordered by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law, and the scope of service provided within the program.

5. Supplies should be limited to the most appropriate quantity for a one month usage. "Stockpiling" is prohibited.

6. Medical supplies are those items that are disposable or semi-disposable, are used for a member who is residing at home, and are used in conjunction with Home Health Agency nursing if necessary. However, it is not necessary to obtain the services of a Home Health Agency nurse in order to secure the needed supplies. It is necessary to reside at home. Examples of medical supplies are:

   a. elastic stockings
   b. ostomy supplies
   c. disposable or semi-disposable ostomy/urinary incontinency supplies are benefits under the program.

d. first aid supplies are limited to those used for post-surgical need, decubitus treatment, and long term dressing. Routine minor first aid needs are not a benefit of the Medicaid program. Usual household remedies such as Band-Aids, hydrogen peroxide, etc., are not a benefit of the program.
e. miscellaneous disposable supplies such as syringes, test-tape, and catheters are benefits under the program for members who reside at home.

C. Child Health Evaluation and Care (CHEC) or Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Coverage

The CHEC/EPSDT program may approve medical supplies and medical equipment which are medically necessary for children less than 21 years of age. Please refer to the Utah Medicaid Provider Manual for Child Health Evaluation and Care (CHEC) Services for specific information.

D. Members in Long Term Care Facilities and Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID)

Disposable and semi-disposable medical supplies are not a benefit for members residing in long term care facilities and ICFs/ID. These supplies MUST be furnished by the facility. These supplies include:
1. syringes;
2. ostomy supplies;
3. irrigation equipment;
4. dressing;
5. catheters;
6. elastic stockings;
7. test tape;
8. I.V. set up;
9. disposable incontinence products.

The following ICFs/ID are covered under this policy:
Bungalow Care Center, East Side Center, Hidden Hollow Care Center, Hillcrest Care Center, Lindon Care Center, Medallion Manor, Medallion Supported Living (Lehi, Payson and Springville), Mesa Vista, North Side Center, Provo Care Center, Topham's Tiny Tots, Trinity Mission Wide Horizons Residential Care of Ogden, West Jordan Care Center, West Side Center

DME providers may be reimbursed for the following items for members in long term care facilities and ICFs/ID:
1. Oxygen
2. Special beds and overlays and mattresses
3. Customized (Medicaid definition) and motorized wheelchairs
4. Prosthetic devices, such as artificial arms and legs, special braces for leg, arm, back, and neck.

E. Durable Medical Equipment (DME)

1. Durable medical equipment to be used by a member who resides in a long term care facility continues to be the responsibility of the facility. This includes:
   a. standard wheelchairs;
   b. commodes;
   c. canes;
   d. walkers;
   e. traction equipment.

2. Durable medical equipment may not be replaced more often than every five years unless prior approved.

3. Rental of DME: Certain highly specialized equipment is so technical and costly to maintain that it is fiscally more responsible to furnish the equipment to a member on a permanent rental basis. This rental will include maintenance and back-up equipment if needed. This type of rental DME will have an RR modifier associated with the code.

4. Other rental DME may be capped and no more rental fees paid after 12 months. These codes should be billed with an LL modifier will indicate it is a capped rental in the lookup tool notes. New equipment must be placed at the beginning, during, or at the end of the 12 month conversion to a purchase. DME that is capped and require maintenance and service may use the "ms" modifier once every six months, beginning six months after the rental has converted to a purchase and all rental charges have been billed for reimbursement for maintenance and service required to maintain the device. This may be billed using the HCPCs code and adding the "ms" modifier on the CMS-1500 (08/05) form. The reimbursement for the "ms" modifier will be equal to one monthly rental fee. Prior authorization is required for maintenance and service.

   A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions must exceed 60 consecutive days plus the days remaining in the rental month in which the use ceases in order for a new 12-month rental period to begin.

   The maintenance and service fee is for maintenance and service on the DME as needed to keep the equipment operating properly and includes service and maintenance which are routinely supplied when the item was being provided as a monthly rental. Supplies, masks, tubing, etc. may be billed separately for CPAP and BIPAPs.

5. Durable medical equipment such as wheelchairs, commodes, oxygen concentrators, and beds, are benefits of the program for members residing at home. Canes and crutches are considered to be durable medical equipment and are supplied to assist the member with ambulation.

6. Limitations on DME: While the Division recognizes the desirability of many products and the sophistication of many modifications to durable medical equipment, it remains fiscally necessary to adhere to the guidelines established concerning these modifications. These guidelines stipulate that no item is reimbursable whose use is primarily for:
   a. hygiene;
   b. education;
   c. exercise;
   d. convenience;
   e. cosmetic purposes;
   f. comfort.

F. Prosthetic Devices

1. Prosthetic devices such as hearing aids and special appliances such as braces are a benefit of the Medicaid program. These devices comprise a group of items and are separate and distinct from the "Home Health Services" program and are available to members residing in a long term care facility as well as for members in their own home and are limited to the services described in the Coverage and Reimbursement Code Lookup tool.

2. Artificial limbs are provided to address the medical condition of the member. Prior authorization not required for these codes; utilization is controlled by quantity limits as posted on the Coverage and Reimbursement Code Look-up Tool. If a replacement prosthetic with the same or different codes is being provided, that would exceed the quantity limits for the current prosthetic a prior authorization must be obtained. Prudent buying and continued effectiveness are essential. Duplicative appliances, such as an artificial leg plus a wheelchair, will be reviewed carefully to determine necessity and/or duplication.

   Miscellaneous codes and manually priced codes require prior authorization. Documentation must be retained by the provider to support and justify the level of the prosthetic provided.

3. Although artificial eyes have been classified in some cases as cosmetic, the Division of Medicaid and Health Financing has adopted the guidelines promulgated by Medicare and will furnish the artificial eye to Medicaid members via prior approval. Replacement will be made at five year intervals when medical need is verified.

4. Hearing aids are addressed in the Speech-Language Pathology and Audiology Services Provider Manual. Refer to that manual for criteria and coverage.

5. Augmentative Speech Devices are addressed in the Speech-Language Pathology and Audiology Services Provider Manual. Refer to that manual for criteria and coverage.

1 - 1 Credentials

To become a Medicaid provider for medical supplies and be eligible for reimbursement for medical supplies and equipment, providers must have a current business license, a tax I.D. number, a place of business and an inventory. Individuals providing services and supplies from an automobile or van with no home base may not become Medicaid providers.

1 - 2 Definitions

The following definitions apply to medical supplies and equipment covered by Medicaid.

Cassettes are prepackaged containers or envelopes of semi-disposable needles and tubing which provide a pathway for the total parenteral nutrition or intravenous medication to pass from container to vein.

Disposable means a medical supply or equipment that is intended for one-time use and not for re-use.

Durable medical equipment is medical equipment that can withstand use; is primarily used to serve a medical purpose; is appropriate for use in the home; and is generally not useful to a person in the absence of an illness or injury.

EN means enteral nutrition.

Enteral nutrition (EN) is nutrition by nasogastric, jejunostomy or gastrostomy tube into the stomach or intestines to supply total nutrition when a non-functioning gastrointestinal tract, temporary or permanent, is present due to pathology or structure.

Failure to Thrive includes:

- Underweight – weight for age is below the 3rd percentile (z score < -2). This may be due to wasting or stunting, or both.
- Wasted – weight for length below the 3rd percentile (z score < -2). The child looks thin, as their weight is low compared to their height. Wasting is due to malnutrition over a shorter time, and may be reversible with appropriate care.
- Stunted – length for age is below the 3rd percentile (z score < -2). The child is short for their age, but if their weight and height match, they may not look thin. Stunting is more often due to chronic malnutrition and may not be reversible.

High Flow Oxygen Concentrator is an oxygen concentrator with a flow of greater than or equal to 10 liters.

I.V. means intravenous.

I.V. Medication is a sterile solution or a drug or an infusion injected into a vein for infection, pain, hydration, blood factor replacement, or chemical or electrolyte replacement.

NDC means the National Drug Code.

National Drug Code means the unique eleven-digit number which identifies each approved drug product, dose, formation and strength.

Orthotic device is a brace for neck, arm, leg, or foot which is not a part of another system.

Parenteral means any route used for infusing medication or nutrients other than the gastrointestinal tract.

Prosthetic device is a replacement, corrective, or supportive device prescribed to artificially replace a missing portion of the body; prevent or correct physical deformities or malfunction; or support a weak or deformed portion of the body.

TPN means total parenteral nutrition. **Total Parenteral Nutrition (TPN)** is nutrition supplied directly into the blood stream by intravenous, subcutaneous, or mucosal infusion.

WIC Formula Database identifies those products that are on the Exempt Infant Formula and Medical Food lists. The database is available at: https://wicworks.fns.usda.gov/wic-formula.

1 - 3 Members Enrolled in a Managed Care Organization (MCO)

A Medicaid member enrolled in an MCO must receive all health care services, including medical supplies, through that MCO. Refer to SECTION 1, Chapter 5, Verifying Eligibility, for information about how to verify a member's enrollment in a plan. For more information about MCO, refer to SECTION 1, Chapter 4, Health Plans. Each MCO may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits. Each MCO specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization. All questions concerning services covered by or payment from an MCO must be directed to the appropriate MCO. A list of MCOs with which Medicaid has a contract to provide health care services is available.

Specialized Medical Equipment for MCO Enrollees

When specialized medical equipment is ordered for a member enrolled in a MCO, and the member changes to another MCO before receiving the equipment, the MCO that ordered the equipment is responsible for payment.

Home Health Services

When a member is enrolled in a MCO, the MCO is responsible to authorize home health services and reimburse the home health agency. Providers need to check with the MCO to determine whether any medical supplies ordered as part of a member's home health services are reimburseable.

1 - 4 Members NOT Enrolled in a Managed Care Organization (MCO) (Fee-for-Service Members)

Medicaid members who are *not* enrolled in an MCO and *not* in the Restricted Program may receive services from any provider who accepts Medicaid. Refer to SECTION 1, Medicaid Restriction Program, for more information. Coverage and the Medicaid prior authorization requirements apply **ONLY** to medical supplies and equipment to be provided to a Medicaid member assigned to a Primary Care Provider (instead of being enrolled in a MCO) or when the supplies/equipment are not included in the Medicaid contract with the MCO. Medicaid does NOT process prior authorization requests for supplies/equipment to be provided to a Medicaid member who is enrolled in an MCO, and the supplies/equipment are included in a contract with a MCO. Providers requesting prior authorization for supplies/equipment for a member enrolled in a MCO will be referred to that MCO.

Note: Medicaid staff makes every effort to provide complete and accurate information on all inquiries. Because eligibility information as to what MCO the member must use is available to providers, a "fee for service" claim will not be paid even when information was given in error by Medicaid staff.

1 - 5 Legal References

42 Code of Federal Regulations, Part 440.70(b)(3), 440.120(C), 441.15.

Utah Department of Health Rule R414-70.

2 SCOPE OF SERVICE

The Coverage and Reimbursement Code Lookup tool contains the medical supplies and equipment covered by Medicaid, subject to the conditions stated and subject to changes adopted by state law, changes in policy or procedures, or changes announced in Medicaid Information Bulletins. The Coverage and Reimbursement Code Lookup tool includes the HCPCS code and descriptor, criteria, instructions, comments and limits.

Information is available for each code to verify if the code is open, provider types allowed, age limits, criteria for approval, whether prior authorization is required, whether the item is covered when the member resides in a long term care facility, and any limits on quantity. See the Coverage and Reimbursement Code Look-up tool at:
http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

This chapter and subsequent chapters provide additional information on the scope of service for medical supplies and equipment covered for Medicaid members.

Medical Supply Refills

Effective July 1, 2013, disposable medical supplies that are filled monthly may be refilled between day 25 and 30 to assure the member has the needed product in time for the next 30-day period.

Quantity Limitations

Exceeding quantities and limitations as stated in this manual or in the Coverage and Reimbursement Look-up Tool requires prior authorization. Certain medical supply codes are open only to members who are on one of the waivered programs, such as the technology dependent waiver (the Travis C Waiver is one of these). Other codes will have different limits allowed for those under a waiver. To determine if a member is on a waiver please call Medicaid Customer Service, 801-538-6155 or 1-800- 662-9651. NOTE: If it is medically necessary to exceed the limits listed in the Manual, including waivered members, a prior authorization must be obtained.

All members who are not receiving services through the EPSDT program will be limited to services and quantities listed in the Coverage and Reimbursement Code Lookup tool. Categories of medical supplies and equipment in the Coverage and Reimbursement Code Lookup tool include the following:

1. **First Aid Supplies**

   First aid supplies are limited to those used for postsurgical need, accidents, decubitus treatment, and long term dressings. Individual supplies must be billed as separate items. First aid supply kits are not covered.

   A. **Disposable Incontinence Products**

   Disposable incontinence products are covered for disabled children and disabled adults only. They are not covered for normal infant use or for adult incontinence not related to a disability. They are not covered for residents of a long term care facility or ICF/ID, as they are furnished by the facility.

   The unit limit for disabled members on traditional Medicaid programs is 156 per month. The unit limit for members on a HCBS waiver program is 312 per month. In both cases, the limit applies to any combination of the open incontinent codes for a one-month supply. If need exceeds these limits, a prior authorization must be obtained.

   The reimbursement rate is based on the appropriate HCPCS code.

   B. **Disposable Supplies**

   Disposable supplies are non-reusable items. Disposable supplies include but are not limited to syringes, ostomy supplies, catheters, under pads and disposable dressings for treatment of decubitus ulcers and burns.

2. **Surgical Stockings**

3. **Urinary Catheters**
   A. Indwelling Catheters
   B. Intermittent Urinary Catheterization:
   Intermittent urinary catheterization is covered when medically necessary and the member or care giver can perform the procedure. Up to **180** catheters are allowed per month.

   Use of Coude (curved) tip catheters is rarely medically necessary. A Coude tip catheter is considered medically necessary for either male or female members only when a straight tip cannot be used.

4. **Ostomy Supplies**

5. **Syringes**

6. **Miscellaneous Supplies**

7. **Donor Human Milk** Refer to Chapter 2 -1.

8. **Enteral, Parenteral Nutrition**. (Refer to Chapter 2 - 2, Nutrition - General.

9. **Nutrients**. Refer to Chapter 2 - 1, Nutritional Products.

10. **I. V. Supplies**. Refer to Chapter 2 - 3, I.V. Therapy.

11. **Pumps**. Refer to Chapter 2 - 4, Enteral, Parenteral and I.V. Therapy Pumps.

12. **Ambulation Devices**

13. **Bathroom Equipment**

14. **Decubitus Care**. Refer to Chapter 2 - 5, Decubitus Care: Water or Air Fluidation Beds.

15. **Hospital Beds and Accessories**. Refer to Chapter 2 - 6, Hospital Beds.

16. **Oxygen and Related Respiratory Equipment**. Refer to Chapter 2 - 7, Oxygen and Related Respiratory Equipment.

17. **Additional Oxygen Related Supplies**. Refer to Chapter 2 - 7, Oxygen and Related Respiratory Equipment.

18. **Humidifiers and Nebulizers**

19. **Suction Pumps and Room Vaporizers**

20. **Monitoring Equipment**. Refer to Chapter 2 - 8, Monitoring Equipment.

21. **Patient Lifts and Traction Equipment**

22. **Wheelchairs and Wheelchair Accessories**. Refer to Chapter 2 - 9, Wheelchairs.

23 **Wheelchair Replacement Supplies**. Refer to Chapter 2 - 9, Wheelchairs.

24. **Repair or non-routine service**. Refer to Chapter 7, Repairs and Replacement.

25. **Durable Medical Equipment, Not Classified**

26. **Pneumatic Compressor and Appliances**

27. **Cervical collar**

28. **Spinal, Thoracic Lumbar Sacral Braces and Orthoses**

29. **Spinal, Lumbar Sacral Braces and Orthoses**

30. **Spinal, Sacroiliac Braces and Orthoses**

31. **Scoliosis, Cervical Thoracic Lumbar Braces and Orthoses**

32. **Lower Limb: Hip, Knee, Ankle Braces and Orthoses**

33. **Additions to Lower Extremity: Orthoses**

34. **Foot Orthopedics: Shoes and Modifications**. Shoes and shoe modifications and repairs are NOT covered, with the following exceptions:
    A. Shoes may be allowed with prior authorization for three circumstances:
        1. When shoe is attached to and part of a brace;
        2. When shoe is especially constructed to provide for a totally or partially missing foot; or
        3. When shoe is attached to and specially fitted to a prosthesis.
    B. Shoe modifications may be made externally to a shoe owned by the member. Modification may be made to elevate a total shoe or provide elevation to part of a shoe.

35. **Upper Limb Orthosis**

36. **Orthotic Repairs**

37. **Prosthetics, Lower Limb**

38. **Prosthetics, Upper Limb**

39. **Repair Prosthetic Device**

40. **Breast Prosthetics**

41. **Prosthetic Sock**

42. **Eye Prosthesis**

43. **Hearing Aids and Repairs**. For complete information about coverage of hearing aids and assistive listening devices, refer to the Speech-Language Pathology and Audiology Services Utah Medicaid Provider Manual.

2-1 Donor Human Milk

Utah Medicaid allows reimbursement for human breast milk from a donor human milk bank enrolled as a Utah Medicaid provider and certified by the Human Milk Bank Association of North America or meets such other standards as may be adopted by the Utah State Medicaid Program.

Prior authorization is required and is awarded when the request is for a Medicaid-eligible infant, birth through 11 months of age, provided all of the following criteria are met:

- The requesting physician is the infant's treating physician and has documented medical necessity in accordance with guidance below.
- The requesting physician has addressed the benefits and risks of using donated milk, such as HIV, freshness, effects of pasteurization, nutrients, and growth factors to the parent or guardian. The physician also must address donor screening, pasteurization, milk storage, and transport of the donated milk. The physician may obtain this information from the donor milk bank.
- The parent or guardian has signed and dated an informed consent form indicating the risks and benefits using banked donor human milk have been discussed with them.

These policies and procedures apply to all requests for Medicaid coverage for donated human milk in a home setting. This policy does not apply to coverage or reimbursement for donated human milk provided in an inpatient setting.

A physician making an initial or continuing request for authorization for donated human milk must complete and submit a Donor Human Milk Request Form [https://medicaid.utah.gov/utah-medicaid-forms] with their prior authorization request. A Donor Human Milk Request Form must be completed every 180 days and copies must be maintained in the members' records of both the ordering physician and the providing milk bank. The physician ordering the donor milk must complete all fields in part A of the original form, including documentation of medical necessity. This information must be substantiated by written documentation in the clinical record.

A copy of the Donor Human Milk Request Form must also be maintained in the client's records at the providing milk bank. The donor milk bank providing the human milk must complete all fields in Part B of the original form.

Documentation of Medical Necessity

A request for authorization must include documentation from the treating physician to support a finding that donated human breast milk is medically necessary for the intended recipient. The documentation must address all of the following criteria:

- Why the infant cannot survive and grow as expected on any other formula (e.g., elemental, special, or routine formulas or food) or any enteral nutritional product other than donor human milk.
- Why human milk must be used to correct or ameliorate a documented condition or defect.
- That a clinical feeding trial of an appropriate nutritional product has occurred every 180 days. If the infant is too fragile for a feeding trial, documentation must support the illness that makes the infant too fragile to test.
- That the informed consent details for the parent or guardian the risks and benefits of using donor human milk.

A request for authorization for donor milk must specify the quantity and time frame in the Quantity Requested field (e.g., cubic centimeters per day or ounces per month.)

A request for authorization for donor milk must be signed by the treating physician.

The donor milk bank providing the milk must complete all the fields in Part B of the original form and specify the quantity and time from in the Quantity Provided Field.

2 -2 Nutrition - General

Enteral and parenteral nutrition is covered by Utah Medicaid according to this section. All enteral and parental nutrition requires prior authorization and coverage is limited to those products listed in the Coverage and Reimbursement Code Lookup Tool. Associated supplies and equipment are controlled by quantity limits.

Prior authorization information and requirements are found in Section I: General Information.

All requests for Enteral or Parenteral nutrition must include the following documentation:

- An order from the prescribing practitioner (physician, physician assistant, or nurse practitioner) including:
  - Diagnosis(es),
  - The product name,
  - The total daily prescribed intake amount (e.g. ml, gram, etc.),
  - The daily frequency of ingestion, and
  - The duration or period of time the product is to be used (e.g. days, weeks, months, etc.)
- Height and weight of patient. Any history regarding significant changes should be included.
- Medical documentation to support the need for enteral or total parenteral nutrition.

If less expensive nutritional products are available, documentation to justify the more costly product.

Total Nutrition by Enteral Tube

Total nutrition by enteral tube feeding is covered when a member receives at least 90% of their daily nutritional intake via tube feed. Members weaning from total tube feed will be covered for up to 3 months and then transition to the supplemental nutrition policy.

Members under 1 year of age are not covered, as most enteral products are a breast milk substitute.

Oral or Tube Supplemental Nutrition and Total Oral Nutrition:

Total oral nutrition and supplemental enteral nutrition (oral or tube) for EPSDT eligible receiving less than 90% of their daily nutritional intake via tube feed is a covered benefit if the member is in one of the following categories and has one or more of the following medical conditions:

- The member's nutritional needs exceed the WIC programs monthly allotment,
- The member's nutritional needs cannot be met by WIC,
- The member is ineligible for WIC (age 5 or older),
- The member is awaiting WIC enrollment **or**
- The formula request is listed in the WIC Database as a WIC Exempt Infant Formula or Medical Food.

AND

The member has one or more of the following medical conditions:

- Acquired Immune Deficiency Syndrome,
  - Be in a wasting state,
  - Have a Weight for Length (WFL) <=5th percentile for 3 years of age or under,
  - Body Mass Index (BMI) <=5th percentile (ages 4-17),
  - BMI <=18.5 percentile (ages 18-20),
  - BMI <=25 percentile with an unintentional weight loss of five percent in one month, seven and a half percent in three months, or 10 percent in six months.
- Metabolic Disorders requiring a specialized nutrition product.
- Cancer:
  - Receiving chemotherapy and/or radiation therapy,
  - Up to 3 month following completion of chemotherapy and/or radiation therapy.
- Chronic Renal Failure,
- Decubitus Pressure Ulcers,
  - Stage three or greater,
  - Stage two with documentation that member is malnourished.
- Malnutrition/Malabsorption as a result of a stated primary diagnosed disease and
  - Have a WFL <= 5th percentile for 2 year old or younger,
  - BMI <= 5th percentile (ages 3-17),
  - BMI <=18.5 percentile (ages 18-20),
  - BMI <= 25 percentile with an unintentional weight loss of 5% in one month, 7.5% in three months, or 10% in six months,
  - Maintenance patient with an increase of less than 10 BMI percentile points or an increase of less than 2 BMI in the past year.
- Failure to Thrive *and* calorie packing options not available or failed attempt *and* inadequate rate of growth or weight gain as described below,
  - No weight gain for more than 1 month in a child < 2 years of age,
  - No weight gain for more than 3 months in a child > 2 years of age,
  - Decreased rate of weight gain so that weight percentile has dropped continuously for at least 6 months,
  - Weight deceleration crossing more than two major percentile lines; major percentile lines used are 5, 10, 25, 50, 75, 90, 95.

Inborn Errors of Metabolism

For children and adults, oral supplemental nutrition is covered to treat inborn errors of metabolism. In members with inborn metabolic errors, the metabolic pathway is disrupted and excessive accumulation of an amino acid or other product may result. These medical food supplements are available through NDC codes open in the Pharmacy Program, but are not available through HCPCS codes in the Medical Supplies Program. Refer to the Pharmacy Services Provider Manual (https://medicaid.utah.gov).

Coverage Limitations for Nutritional Products

- Oral nutritional supplements for adults are not a Medicaid benefit except for members with inborn errors of metabolism.
- Items not listed in the WIC database are not covered.
- Members under 1 year of age are not covered, as most enteral products are a breast milk substitute.

Nutritional Products and Residents of Long Term Care Facilities

Parenteral solutions and total enteral therapy administered through a tube is covered for members residing in long term care facilities when criteria is met.

- Covered supplies include:
  - Parenteral solutions.
  - A monthly parenteral nutrition administration kit which includes all catheters, pump filters, tubing, connectors, and syringes relating to the parenteral infusions.
  - Enteral solution for total enteral therapy given by tube and includes all supplies.
- Long term care facilities and home health agencies must have personnel trained to place and care for TPN and EN tubes.
- Equipment such as I.V. poles, disposable swabs, antiseptic solutions and dressings for the catheter are not reimbursable by Medicaid for residents of a long term care facility.

2 - 3 Parenteral Therapy

Eligible Medicaid members with chronic illnesses, trauma, or terminal disease who are able to live at home or in a long term care facility, but who cannot be sustained with oral feeding and, therefore, rely on total parenteral nutrition (TPN) to sustain life are covered under this program.

2 - 4 I.V. Therapy

Pharmaceuticals, injectables and diluents are billed to Medicaid using NDC numbers, through the Pharmacy Point-of-Sale electronic billing system. These are not billable as medical supplies. Refer to the Pharmacy Services Provider Manual (https://medicaid.utah.gov).

Long term care facilities and home health agencies must have personnel trained to place and care for I.V. catheters. Intravenous catheters are reimbursable to either a pharmacy or medical supplier through the Medical Supplies program.

Procedure Codes

Procedure codes for I.V. therapy, enteral, or parenteral services are in the Coverage and Reimbursement Code Lookup tool. Providers must use these procedure codes when billing.

2 -5 Decubitus Care: Beds, Pads, Mattresses, and Overlays

The provision of decubitus care products such as beds, pads, mattresses, and overlays is not a substitute for extensive and diligent nursing care. Rather, the provision of these products is to assist the establishment of a comprehensive program for treating and limiting decubitus ulcers.

Decubitus care products are for Medicaid members who have stage II III, or IV decubitus ulcers of the trunk only which have not responded to prolonged intensive nursing care, including dressing applications, and proper nutrition. Treatment for pressure ulcers on the head, heel or extremities is not covered. Decubitus care includes burns and post-surgical skin grafts. Equipment and supplies are for use in a long term care facility or home. The intensive nursing must be documented, including nutritional intake measurements, hydration, and laboratory tests.

Decubitus care is designed to provide a proactive approach to decubitus treatment. Facilities and care givers should work hand in hand to prevent ulcers before they get to a stage that is more difficult to control. This approach should assist the prevention of stage II ulcers from progressing to stage III. If progression to stage III or IV occurs, an investigation from Medicaid Long Term Care Certification team will be recommended.

Dressings
The use of dressings designed for decubitus ulcers is encouraged. Refer to the Coverage and Reimbursement Code Lookup tool (http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php)

LONG TERM CARE FACILITIES

A. **Prior Authorization** is required for beds, pads, mattresses and overlays for residents of long term care facilities. The request must include the following:

A. statement of the presence, location and size of stage II, III, or IV pressure ulcer.

1. Documentation which shows:

a. member has been turned and repositioned every 2 hours at minimum,
b. Adequate nutritional status and hydration with intake measurements, including supplements and diet sheets,
c. Albumin within normal limits with appropriate lab tests. If albumin is abnormal, describe the measures taken to address adequate protein intake,
d. Weight reduction diet if needed,
e. Current or most recent MDS sheet submitted,
f. Inability and/or unsuccessful attempts to position off the area,
g. Location and picture of ulcers,
h. Physician's order for DME,
i. Documentation of limited mobility (22 hours or more of confinement to bed.),
j. Appropriate dressings/debridement,
k. Nurse's notes and information showing member would cooperate with treatment.

B. **Mattresses and/or Overlays**
In the event that intensive nursing, measured nutrition, debridement and physician consultation are documented, and these interventions have not been adequate to reduce the pressure ulcer, the use of mattresses and/or overlays may be authorized. In addition to the mattresses and overlays described

in the Coverage and Reimbursement Code Lookup tool, the equipment listed below requires prior authorization.

E0277RR, Powered pressure-reducing air mattress
E0193RR, Powered air flotation bed (low air loss)
E0373, Advanced pressure relieving mattress (purchase only)
E0194LL, Air fluidized bed

Code E0373 is a mattress which can be purchased for a specific member to be used only by the owner/member to reduce a now intractable or multi-stage III ulcer and prevent further, repeated tissue breakdown.

An extended care nurse, home health nurse or physician must determine the specific product appropriate for the member, but only a physician may order the bed, mattress, pad, or overlay.

1. Stage II pressure ulcers, Long Term Care Facility

After aggressive nursing intervention, as described in item B above, a pressure reducing mattress or overlay, such as code E0277, may be authorized for maximum of 14 days rental.

2. Stage III pressure ulcers, **Long Term Care Facility**

After aggressive nursing care, as described in item B above, and the member has tissue that is still breaking down, the following additional criteria will apply:

1. Requests for services for new admits to a facility from home or hospital must be made within 2 weeks of the admission.
2. New admits from other facilities must undergo two months of aggressive nursing care to resolve the pressure ulcer and fulfill the documentation requirements before requesting a mattress or overlay.
3. Current MDS sheet submitted.
4. Physician's orders and plan of care.
5. Documentation of location and size of Stage III pressure ulcer.
6. Code E0373, advanced pressure relieving mattress, may be authorized for purchase for the member. (This mattress becomes the property of the member and must be transferred with the member.)

3. Stage IV pressure ulcers, **Long Term Care Facility**
After aggressive nursing care as indicated in the above documentation, and the member has tissue that is still breaking down and progressed to a stage IV, the following additional criteria apply:

1. Only available for new admits to a facility from home or hospital. Transfers from long term care facilities are not covered. If the facility allowed a stage IV to occur under their care they are responsible for the beds, mattresses and overlays.

2. The request must be made within 2 weeks of the admission.
3. Current MDS sheet submitted.
4. A physician's order and prescription for plan of care which should include a flap procedure or the reason a flap procedure is contraindicated.
5. Code E0373, advanced pressure relieving mattress, may be authorized for purchase for the member.

MEMBERS RESIDING AT HOME

Coverage for decubitus care does **not** include hospital beds used in the home for bed bound members nor mattresses for those hospital beds. These are covered for other conditions for non-mobile members in other sections of the Medicaid Medical Supplies Manual. The members must provide a bed frame and foundation when a mattress is provided for use in the home.

Most members residing at home will have Medicare coverage, and providers must bill Medicare first. If a member is **not** covered under Medicare, the following guidelines apply.

A. **Prior Authorization** is required for beds, pads, mattresses, and overlays and must include the following:

1. Treating physician's orders.
2. Statement of inability to position off area.
3. History of appropriate dressings/debridement.
4. Information showing member would cooperate with treatment.
5. Statement indicating there is adequate nutrition to maintain skin integrity.

B. **Stage II pressure ulcers, member resides at home**

1. Home Health nursing must be involved in the member's care and provide training for appropriate treatment for decubitus ulcers and the use of the overlay mattress, if approved.
2. An overlay mattress such as, E0277, may be authorized for 14 days for stage II pressure ulcers after documentation by home care nursing notes:
   a. Member turning every two hours,
   b. Adequate nutrition and hydration,
   c. Need for additional services beyond routine wound care.

C. **Stage III pressure ulcers, member resides at home**

After nursing care provided for stage II pressure ulcers (item B above), and the member has tissue that breaks down to a stage III, the following additional criteria apply.

1. Home health nursing must be involved with the member's care.
2. The use of decubitus dressings /debridement and repositioning attempts must be documented.
3. Nutrition and hydration intake documented.
4. If the ulcer is progressing, consultation between the home health nurse and the physician should consider alternate placement in a long term care facility.
5. Code E0373, advanced pressure relieving mattress, may be authorized for purchase for the member. (If Medicaid purchased a mattress for use in the home, and the member is transferred to a long term care facility, the mattress must be transferred for use in the care facility.)
6. Stage IV pressure ulcers should be referred by the physician and treated in a long term care facility.

2 -6 Hospital Beds

All hospital beds require prior authorization. Criteria are that the member is bed confined and resides at home, not in an institution, care facility, etc. The term "bed confined" means that the member's medical condition is of such severity that essentially the member is confined to bed, although not necessarily 100 percent of the time. Typically, the bed confinement is 80 percent of the time (19 - 20 hours a day).

The member's condition must necessitate either (1) positioning of the body (especially the head, chest, legs, and feet) in a way which would not be feasible in an ordinary bed, or (2) attachments to the bed which could not be affixed to an ordinary bed.

1. A standard hospital bed is:
   a. Of a design and construction equal to the standard which is common within the industry, consisting of a modified catch spring assembly, mattress and bed ends with casters and manually operated foot end cranks which permit independent adjustment of the elevation of the head and knee sections;

   b. Capable of accommodating a standard trapeze bar when attached to the head end;

   c. Equipped with I.V. sockets;

   d. Capable of supporting an overhead frame and other accessories that utilize I.V. holes for mounting purposes; and

   e. Equipped to accommodate side rails, if required by the member's condition.

2. Side rails on hospital beds are not considered a standard feature of hospital beds and are not covered under the program, except when specifically prescribed as medically necessary and specifically included in the procedure code description.

3. Variable height beds are not a benefit of the Medicaid program.

4. Electric beds are not a benefit of Medicaid.

5. Air or water fluidation beds are a Medicaid benefit under the specific guidelines on the Coverage and Reimbursement Code Lookup tool. The beds require prior approval and may be requested for members who reside at home or in a long term care facility.

2 -7 Oxygen and Related Respiratory Equipment

Oxygen is a benefit of the Medicaid program. All oxygen requests must have a physician prescription (order). Only one oxygen system will be provided, except under specific circumstances.

The oxygen benefit comes in four forms:

1. Oxygen Concentrator and back up oxygen supply;
2. Stationary gaseous oxygen system;
3. Portable gaseous oxygen; and
4. Liquid oxygen.

2.7(a) Oxygen Concentrator and Backup Supply

1. Oxygen concentrators and back-up supply are provided exclusively through a contract with the Division of Medicaid and Health Financing for Traditional and Non-Traditional Medicaid members whose status is “fee-for-service” and for members enrolled in Select Health Community Care.
2. Oxygen concentrators covered under this contract are those capable of delivering an adjustable one-sixteenth to ten liters per minute at 90 to 94 percent oxygen concentration.

3. Effective October 1, 2011, Alpine Home Medical Equipment holds the contract for Oxygen Concentrators and Backup Supply.
4. All other oxygen systems in use will be replaced by an oxygen concentrator when it is more economical and/or more appropriate.
5. Oxygen concentrators, and accompanying backup supply for use during power outage or mechanical failure, must be prescribed by a physician. The prescription must include:
    - Diagnosis indicating that the member's ability to breathe is severely impaired, and
    - Liter flow per minute, duration of therapy, frequency (hours per day) and a statement indicating the oxygen concentrator is medically necessary.

NOTE: High Flow Concentrators are not part of the Oxygen Concentrator Contract with Alpine Medical. When a high flow concentrator is needed it may be provided by any willing Medicaid provider for fee-for-service members or members enrolled in Select Health Community Care. A prior authorization must be obtained through the Medicaid Prior Authorization unit.

2.7(b) Stationary Gaseous Oxygen System

Gaseous oxygen systems require a physician's order, must receive prior approval, and may be furnished by any willing Medicaid DME (durable medical equipment) provider. A Stationary Gaseous Oxygen System will be supplied only in two situations or circumstances:

1. Circumstances in which electrical power to run the concentrator is not available. Infrequently, a power source is not available to operate the concentrator. These cares are unique and require case by case evaluation.
2. When other equipment, necessary for the member, requires a saturation percentage higher than the capacity of the concentrator, or when the required liter flow is higher or lower than the concentrator's capacity.

2.7c) Portable Oxygen

Portable oxygen must be medically necessary and requires a physician's order. Gaseous oxygen will not require a prior authorization when the need does not exceed 100 cubic feet per month (or the equivalent of 4 E-tanks). Needs exceeding this amount must receive prior approval. All portable oxygen may be furnished by any willing Medicaid DME provider. Portable oxygen is allowed for the following purposes:

1. Transporting members to and from medical appointments;
2. Transporting individuals to and from school;
3. Moving members to and from different locations within an extended care facility, e.g. to dining room for meals; and
4. Allowing members to participate in structured exercise programs when there is an expectation for increased heart rate, muscle development, improved coordination, etc. The physician order must specify type of exercise, outdoors or indoors, length of time, etc. Clinical notes must document the exercise program.

The physician must specify on the order the diagnosis indicating the member's ability to breathe is severely impaired, liter flow per minute, anticipated number of medical appointments per month, length of visit and travel time to and from each visit, and expected length of use.

A portable gaseous system will not be approved if the member requires oxygen only intermittently or part-time.

2.7(d) Liquid Oxygen Systems

Liquid oxygen must be medically necessary, requires a physician's order, must receive prior approval, and may be furnished by any willing Medicaid DME provider. The request for prior approval must document in detail the need for the liquid oxygen systems and specify the equipment required. Liquid oxygen is approved only when:

1. Multiple pieces of equipment are being used by the member in a series, such as compressors, ventilators, etc., or
2. An explicit medical need has been established, or
3. Gaseous oxygen systems will not provide the liter flow per minute or the percent of concentration.

Liquid systems for mobility of the member outside the home are not a Medicaid benefit. Other portable gas systems are used to transport the member to medical appointments.

Liquid oxygen is billed in 10 pound increments. On a monthly basis, use code E0439RR for stationary liquid oxygen plus a 10 pound supply. If more than 10 pounds of liquid oxygen is used per month, use code E0442 for additional 10 pound increments. For example, if 20 pounds of oxygen are used after the original 10 pounds bill code E0442 with two units. Prior authorization is given by units.

NOTE: For a member who resides in a long term care facility, all oxygen and oxygen-related equipment (except for services covered under the oxygen concentrator contract) must be billed through the appropriate DME provider who is responsible to obtain appropriate prior authorization.

2.7(e) Ventilators

Home care of a member requiring a ventilator to sustain life is encouraged by Medicaid if the member's needs can be met adequately and safely, and if the service requested is cost-effective within Medicaid policy limitations.

2 -8 Monitoring Equipment

Monitoring equipment is not covered for a resident of a long term care facility, skilled nursing facility or intermediate care nursing facility.

An automatic blood pressure monitor requires written prior authorization. (e.g., Dynamap or continuous pressure monitoring devices.) Digital blood pressure monitors are **not** covered.

Glucose monitors are provided free of charge by the manufacturer/distributor and are not covered by Medicaid. However, a blood glucose monitor with special features (for example, voice synthesizers, automatic timer, etc.) may be provided with written prior authorization.

Infant apnea/bradycardia monitors are supplied under contract with a single vendor, Apria, for both "fee-for-service" members and for those enrolled in an MCO.

Requirements for oxygen monitoring equipment are in the Coverage and Reimbursement Code Lookup tool.

2 -9 Wheelchairs

Wheelchairs are a Medicaid benefit when the member's condition is such that, without the equipment, bed confinement (or chair confinement) would be required. All wheelchairs are designed for use in the home. Specific designs or options for out of the home use are not covered.

Reimbursement is limited to the lowest commonly available charge for a standard wheelchair. Other chairs must be specifically prescribed and documentation provided concerning the medical condition of the member.

Medicaid has redefined the categories for wheelchairs to the Medicare categories and definitions: Standard, Customized, and Motorized. The term "specialized" is no longer used by Medicaid as a definition or category.

The Coverage and Reimbursement Code Lookup tool contains a list of wheelchairs, wheelchair accessories and replacement supplies. All wheelchairs, accessories, attachments, replacement supplies and repairs require prior authorization. The criteria for standard, customized, and motorized wheelchairs and procedures to obtain authorization from Medicaid are described in this chapter.

A. Wheelchairs Purchased by Medicaid

Medicaid will pay for one wheelchair which is the most cost effective that satisfies the medical condition of the Medicaid member. Wheelchairs purchased by Medicaid for a member belong to that member. Repairs to a wheelchair owned by a member are covered by Medicaid with a physician's order and a determination of cost-effectiveness.

A standard manual second wheelchair may be allowed only for members whose aggregated weight of member and power wheelchair exceeds the limitations of the power lifts on transportation vehicles. This is provided to allow members to be transported in a manual wheelchair to Medicaid covered medical appointment without exceeding the lift capacity of the transportation vehicle. The second wheelchair will be appropriately sized to accommodate the size and weight of the member. This is the only circumstance wherein a second wheelchair is allowed by Medicaid.

B. Replacement Parts for a Wheelchair

Replacement parts for a wheelchair, such as tires or wheels, must be prior authorized and medically necessary. These repairs or replacements cannot be approved more frequently than once per year.

C. Wheelchair for a Resident of a Long Term Care Facility

Wheelchairs and accessories are covered for a resident of a long term care facility as part of the per diem rate. A long term care facility is responsible to provide wheelchairs for its residents, including wheelchairs adapted to the shape and physical needs of the resident using stock parts or attachments assembled by the manufacture or the vendor. Medicaid does not consider these to be 'customized wheelchairs'. Medicaid is responsible for medically necessary customized wheelchairs which require a special manufactured frame, such as a tilt-in-space or hemi wheelchair (only with documentation of upper extremity amputation).

Additional accessories or attachments which are uniquely shaped or formed, such as a contour back or seat, for the member and cannot be reused by other members may be authorized by Medicaid and must meet the criteria for customized wheelchairs. Refer to item G, Customized Wheelchairs.

If a wheelchair is approved for a resident of a nursing facility, and the member leaves the facility, the member may take the wheelchair with him or her. Wheel chairs provided by the facility for the member remain the property of the facility. Motorized wheel chairs are covered if the criterions are met. Refer to item H, Motorized Wheelchairs.

Repairs to a wheelchair owned by a long term care facility are the responsibility of the facility. Alternately, a long term care facility may provide another suitable wheelchair if the physician has written "wheelchair bound" in the member chart.

D. Replacement Batteries

Replacement batteries are covered, including for a resident of a long term care facility.

E. Wheelchair Warranty

All wheelchairs must carry the maximum, most cost-effective warranty available as part of the purchase price.

F. Standard Wheelchairs

1. **Definition:** A standard wheelchair is one that generally satisfies the needs of the average-size patient, is fabricated to withstand normal usage and body weight, and has brakes and armrests. A standard wheelchair includes any stock frame and stock component parts or attachments assembled to fit the patient needs which can be reused and reconfigured for another patient. Refer to the Coverage and Reimbursement Code Lookup tool for codes.

   A youth chair is considered a standard wheelchair. All standard limitations apply to youth chairs.

2. **Criteria for Medicaid Member to Qualify for a Standard Wheelchair**

   A Medicaid member must meet the criteria listed below to qualify for a standard wheelchair

   a. The member's condition must be such that, without the use of a wheelchair, the member would be confined to bed or chair without functional ambulation. An individual may qualify for a wheelchair and still be considered bed confined.

      A wheelchair may be approved if it allows a member to become more independent, or maintain independence, within his or her living environment as documented.

   b. The member is not a resident of an ICF/ID (intermediate care facility) or a nursing facility. A standard wheelchair is not a benefit for a resident in an ICF/ID or in a nursing facility.

   c. A standard wheelchair is not a benefit for a resident of a nursing facility. Standard wheelchairs and attachments are provided by the facility through the per diem rate paid to the facility.

3. **Documentation Requirements for a Standard Wheelchair**

   a. Documentation submitted must be current.

   b. The Prior Approval Request Form must include the code and all relevant information.

c. Physician's order for the wheelchair.

d. A letter of medical need from the physician. The letter must include a detailed systems review of the member with the following information:

(1) Medical diagnosis and prognosis; and

(2) Medical reasons for wheelchair.

4. **Reimbursement**

a. All wheelchairs must be described in writing and identified by a HCPCS code.

b. All accessories and attachments added to a wheelchair costing more than $25.00 each, must be described in writing and identified by the proper HCPCS code. Component parts costing less than $25.00 and the related labor costs are covered by operating margins.

c. Reimbursement is by HCPCS code.

G. Customized Wheelchairs

1. Definition

A customized manual wheelchair is one which has been uniquely constructed or substantially modified for a specific person. The assembly of a wheelchair from modular components does not meet the requirements of a customized wheelchair. The use of customized options or accessories does not result in the wheelchair base being considered as custom. There must be customization of the frame for the wheelchair to be considered customized. This wheelchair type is for a person living at home.

A physical therapist (PT) or an occupational therapist (OT) and medical supplier representative may be involved the selection and fitting of a customized wheelchair.

2. Criteria for Medicaid Members to Qualify for a Customized Wheelchair for Use in the Home

A customized wheelchair must be medically necessary and customized for a Medicaid member to allow him or her to become more independent or maintain independence within his or her living environment. A chair to better sports rating, outdoor participation, is not covered.

A Medicaid member must meet all of the following criteria to qualify for a customized wheelchair.

a. Be non-ambulatory (ability to walk only a few steps is considered non-ambulatory) or have a prognosis of not being able to ambulate within the next 12 months.

b. Require a mobility aid to participate in normal daily activities in the home.

c. Expect to have physical improvements, or the reduction of the possibility of further physical deterioration, from the use of a customized wheelchair; OR be for the necessary treatment of a medical condition.

d. The member or primary care giver must be capable of maintaining the wheelchair or be capable of causing the wheelchair to be repaired and maintained.

e. Repairs for a customized wheelchair require prior authorization

f. Must not currently own a medically appropriate type of chair for which reimbursement is being sought by Medicaid or must not have received a customized or motorized wheelchair within the previous five year period.

g. Due to the federal requirements relating to non-duplication of services, a member who requires a customized or motorized wheelchair for continued employment, or a member who has a reasonable expectation for vocational development, must be referred to the Office of Rehabilitation Services in the Department of Education for an evaluation of eligibility for vocational rehabilitation services. Either the physician or the PT/OT may make the referral to Rehabilitation Services.

3. **Documentation Requirements for a Customized Wheelchair**

a. Documentation submitted must be current.

b. The Prior Approval Request Form must include the HCPCS code for the wheelchair and HCPCS code for each attachment with all relevant information. An evaluation by a PT/OT must be performed as noted in item I, Motorized or Customized Wheelchair Final Evaluation.

c. Physician's order for the wheelchair.

d. A letter of medical need from the physician. The letter must include a detailed systems review of the member with the following information:

(1) Medical diagnosis and prognosis; and

(2) Medical reasons for wheelchair.

e. All customized wheelchairs must be described in writing and identified by a HCPCS code.

f. All accessories and attachments added to a wheelchair and costing more than $25.00 each must be described in writing and identified by the proper HCPCS code.

4. **Attachments for Customized Wheelchair**

a. The vendor must keep all physician requests for separate attachments on file. All attachments require prior authorization to prevent the addition of attachments which have not been prior authorized to a wheelchair which has been authorized.

b. Attachment codes are available to replace a part, repair a chair, etc., but require prior authorization.

5. **Reimbursement**

a. All wheel chairs must be described in writing and identified by a HCPCS code.

b. All accessories and attachments added to a wheelchair and costing more than $25.00 each must be described in writing and identified by the proper HCPCS code. Component parts costing less than $25.00 and the related labor costs are covered by operating margins.

c. Reimbursement is by HCPCS codes.

d. When the approved Prior Authorization is returned to the provider/vendor, the chair and attachments can be ordered. The medical supplier cannot bill for the chair and all attachments until the Motorized or Customized Wheelchair Final Evaluation is completed by a PT/OT, and the member or their authorized representative has signed accepting the equipment. The provider/vendor is to retain this completed form in the member's file as evidence the approved wheelchair/accessories and training was provided. Refer to item I (2) below.

H. Motorized Wheelchairs

A physician, a medical supplier, a physical therapist/occupational therapist, the long term care facility if the member is a resident of a long term care facility, and Medicaid Prior Authorization staff must be involved to obtain a motorized wheelchair for a Medicaid member. Motorized wheelchairs are for use within the home or residence.

1. Criteria for a Motorized Wheelchair

To qualify for a motorized wheelchair, a member must meet all the criteria for a customized wheelchair and the additional criteria listed below:

a. Have a poor prognosis for ever being able to self-propel a functional distance.

b. Manifest the cognitive and physical ability necessary to operate a power driven wheelchair.

c. Demonstrate the ability to safely operate a power driven chair. A member of any age should have had a minimum of two hours instructions and use in a motorized wheelchair. The physician and therapist documentation must indicate the member's cognitive ability to operate the power chair. The member must be able to manifest the physical, visual and mental ability to safely operate a wheelchair.

d. The demonstrated purpose must be appropriate for use within the home or facility of residence.

e. The member and primary care giver(s) shall have accepted or agree to accept education and training by a therapist to assist in adopting an attitude and fostering the expectation that the member will be allowed to be as independent as physically able.

2. Documentation Requirements for a Motorized Wheelchair

The medical supplier must complete the Medicaid Prior Approval Form and provide the documentation listed below with the request. Documentation submitted must be current.

a. Price list showing the catalog price of the base wheelchair, related components, and all attachments. Customized changes not specified in the catalog must be described on a separate form.

b. Physician's order for the motorized wheelchair.

c. A letter of medical need from the physician. The letter must include a detailed systems review of the member with the following information:

(1) Medical diagnosis and prognosis;

(2) Medical reasons for a motorized wheelchair; and

(3) The type of chair and attachments required by the member.

d. An initial wheelchair evaluation from a registered PT/OT. Refer to item I, Evaluation for a Customized or Motorized Wheelchair.

e. Copies of all warranties relating to the wheelchair. All wheelchairs must carry the maximum, most cost effective warranty available.

3. Motorized Wheelchair Billing

When the approved Prior Authorization is returned to the provider/vendor the chair and attachments can be ordered. The medical supplier cannot bill until the Motorized or Customized Wheelchair Final Evaluation is complete by a PT/OT, and the member or their authorized representative. The provider/vendor is to retain this completed form in the member's file as evidence the approved wheelchair/accessories and training was provided. Refer to item I (2) below.

4. Reimbursement

Motorized wheelchairs will be priced according to methods outlined in the Utah State Plan, Attachment 4.19-B. Component parts costing less than $25.00 and the related labor costs are covered by operating margins.

I. Evaluation for a Customized or Motorized Wheelchair

A registered, licensed physical therapist/occupational therapist must complete an initial wheelchair evaluation to assure appropriate wheelchair and attachments are considered for each member. When a motorized or customized wheelchair is approved for a member, a PT/OT must also complete the Motorized or Customized Wheelchair Final Evaluation form and return it to the provider/vendor for their records.

1. Initial Evaluation

The initial evaluation should be done at the time the member's measurements are taken and the wheelchair dimensions are assessed. For members age 21 and older, an initial evaluation must have been done within the last six months. For members from birth through age 20, an initial evaluation must have been done within the last three months.

The evaluation must include the following:

a. Age, height, weight of the member;

b. The treatment and goals of therapy intervention, if applicable;

c. Specific level of involvement;

d. Functional limitations and abilities;

e. Description of all disabilities and deformities;

f. Custom features needed by the member and the medical benefit that each feature provides for his or her medical condition;

g. Information regarding the member's previous wheelchair history, including whether or not the member has a medically appropriate chair purchased within the previous 5 years;

h. Motorized wheelchairs require documentation regarding the member's ability to learn the skills needed to operate the chair safely. All members must have had a minimum of two hours instructions and use in a motorized wheelchair.

The therapist will document on the "*Motorized Wheelchair Checklist*" that the member can perform the necessary skills. A copy of the checklist is included in the Forms section of the Medicaid website at https://medicaid.utah.gov.

Submit the Motorized Wheelchair Checklist to the Division of Medicaid and Health Financing, Prior Authorization Unit, with all other required prior authorization documentation.

i. Education and training of the member and primary care givers by a trained therapist to assist in adopting an attitude and fostering the expectation that the member will be allowed to be as independent as physically able. The purpose is to prevent learned helplessness and passive resignation.

j. An assessment of the ability of the member or primary care giver for reasonable maintenance and repair, or to cause such maintenance and repair;

k. Why the member's needs cannot be met with a standard Medicaid reimbursable wheelchair;

l. For residents in a nursing facility, the documentation must describe in detail how the request for a customized chair is supported by the Resident Assessment Process of the member and the goals of the member's care plan.

m. A video tape of the member in a motorized wheelchair may be submitted to Medicaid prior authorization with the initial request for prior authorization. If not submitted, Medicaid may request a video tape any time the need to clarify the need for a motorized wheelchair arises.

2. Motorized or Customized Wheelchair Final Evaluation

Motorized or customized wheelchairs require a post evaluation by a PT/OT before the provider will be reimbursed. A copy of the Motorized or Customized Wheelchair Final Evaluation form is included in the Forms section of the Medicaid website at https://medicaid.utah.gov.

The Motorized or Customized Wheelchair Final Evaluation is required to determine the following:

a. The member is fitted properly in the wheelchair;

b. All approved attachments to the wheelchair were in fact received by the member and are appropriate to meet his or her medical needs and;

c. When the wheelchair is motorized, the member must successfully complete the requirements of the motorized wheelchair checklist.

d. When the final evaluation has occurred:

- The completed Motorized or Customized Wheelchair Final Evaluation Form is sent to the provider/vendor if the criteria are all met. The claim can be submitted to Medicaid.
- If additional attachments or modifications are needed, a request must be submitted to the Medicaid Prior Authorization Unit for the needed changes. When modifications have been completed, the PT/OT will then complete the Motorized or Customized Wheelchair Final Evaluation Form and send it to the provider/vendor.

e. The wheelchair will be priced and the supplier notified when prior approval is given, but the claim cannot be submitted by the provider/vendor until they have received the completed Motorized or Customized Wheelchair Final Evaluation Form.

f. The Final Evaluation Form must certify that the wheelchair fits properly, any attachments required are present and appropriate, and the member has been trained in the use of the equipment. When those conditions are met, the PT/OT therapist and the member or their authorized representative sign the Motorized or Customized Wheelchair Final Evaluation Form and return it to the DME provider.

J. Modifications and Repairs to Wheelchairs

Prior authorization is required for all modifications, such as upgrades and attachments, and repairs. Members who own a motorized or customized wheelchair may obtain medically necessary modifications under the following conditions:

1. Modifications must be medically necessary.

   For example, a tray may be approved for support of the body when trunk involvement requires it, but not for a table, books, or toys. Pneumatic tires or balloon tires on wheelchairs may be approved when the medical condition of the member is such that the tires are necessary at his or her residence.

   Modifications are NOT reimbursable if the planned use is primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort.

2. All repairs must have prior authorization. Medicaid will authorize needed repairs and replacement parts.

   Repairs do not include routine maintenance, such as labor for changing tires, inspecting the chair, changing batteries, grease and oil, etc. Repairs for a rental chair are not covered.

   Medicaid will cover repairs for only one wheelchair, which will generally be the most recent wheelchair provided by Medicaid, unless the member has been qualified for two chairs. (See Section 2-9, A).

K. Replacement of Wheelchairs

Any replacement of a wheelchair purchased by Medicaid must have prior authorization. Wheelchairs are not replaced by Medicaid for five years after initial purchase. If a wheelchair is stolen, the medical provider requesting a new wheelchair must obtain the police report and send a copy with the request. Medicaid will not consider authorization until two months after the filing of the police report to ensure adequate time for possible recovery of the wheelchair. If the chair is necessary for the member to maintain employment, or independence, Medicaid will consider a short-term rental chair for a period not to exceed 120 days.

L. Pricing of Customized Wheelchair

Customized wheelchairs, whether motorized or manual, will be priced according to methods outlined in the Utah State Plan, Attachment 4.19-B. Component parts costing less than $25.00 and the related labor costs are covered by operating margins. All components used to customize a wheelchair costing more than $25.00 each, must be (1) described in writing, (2) priced using manufacturer's list and (3) have been prior authorized by Medicaid.

M. Attachments for Customized Wheelchair

All physician requests for separate attachments will remain on file with the vendor. All attachments require prior authorization.

N. Reimbursement for Pre and Post Wheelchair Assessment to PT/OT Providers

Wheelchair assessments by PT/OT providers, to determine the seating and other medically necessary requirements for the member, with confirmation that appropriate equipment has been received and training has occurred, are reimbursed using code G9012.

Online copies of the "Motorized Wheelchair Checklist" and "Motorized or Customized Wheelchair Final Evaluation Form" are included in the Forms section of the Medicaid website at https://medicaid.utah.gov.

3 LIMITATIONS

The maximum quantity for medical supplies and equipment is indicated on the Coverage and Reimbursement Code Lookup tool. If there is a need to exceed the stated limit, the medical supplier must request prior authorization. After prior authorization is obtained, the limit may be exceeded only as per the prior authorization received. If the limit is exceeded without prior authorization, the payment is subject to appropriate recovery action.

Medicaid will not reimburse providers for duplication of hospital equipment in a home or long term care facility. Medicaid is required to obtain the most cost effective service appropriate for the member. For some members, a long term care facility may be the most appropriate and cost effective setting.

Specific Limitations:

1. Disposable incontinence products are limited to 156 per month or less, no prior authorization is necessary. Up to 312 disposable incontinence products per month is available for those on a Home and Community-Based Waiver with no prior authorization.

2. Surgical stockings are limited to two pair every six months when medically necessary.

3. Sacro-lumbar or dorsal lumbar corset type supplies are NOT considered prosthetic devices or special appliances. These items are not a covered benefit of the Medicaid program.

4 PURCHASE OR RENTAL OF EQUIPMENT

Most medical supplies are available for purchase. The Coverage and Reimbursement Code Lookup tool designates codes for items available for lease, rental, capped rental, or purchase. Instructions for coding are found in Chapter 11 of this manual.

1. Medical supplies purchased under the Medicaid program must be new, unused equipment. The medical supplier must furnish invoices showing the equipment is new. Refurbished, rebuilt, or used equipment is not acceptable for purchase by Medicaid, unless specifically authorized in writing for an individual piece of equipment or unless specifically allowed under contract with the Division of Medicaid and Health Financing.

2. Certain durable medical equipment may be paid as a lease/rental for twelve months only. Other durable medical equipment may be paid as capped rental for twelve months only. After twelve months, Medicaid considers the equipment to be paid in full and owned by the member. Equipment which may be owned by the member after Medicaid has paid the capped rental for twelve months includes but is not limited to the following items: beds, vaporizers, nebulizers.

3. Rental of DME: Certain highly specialized equipment is so technical and costly to maintain that it is fiscally more responsible to furnish the equipment to a member on a permanent rental basis. This rental will include maintenance and back-up equipment if needed. This type of rental DME will have an RR modifier associated with the code. Such equipment includes but is not limited to ventilators and oxygen concentrators.

4. Other rental DME may be capped and converted to a purchase after 12 months. These codes will have the modifier LL associated with the code. Some capped DME require maintenance and service may use the “ms” modifier once every six months, beginning six months after the rental has converted to a purchase and all rental charges have been billed for reimbursement for maintenance and service required to maintain the device. This may be billed using the HCPCs code with the LL modifier and adding the “ms” modifier as a second modifier on the CMS-1500 (08/05) form. The reimbursement for the “ms” modifier will be equal to one monthly rental fee. A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions must exceed 60 consecutive days plus the days remaining in the rental month in which the use cease in order for a new 12-month rental period to begin. A prior is required using the “ms” modifier. The prior requires a valid doctor’s order (written within the current year) indicating the member needs to continue using the equipment being serviced.

5. Wheelchairs allowed as a rental do not require a prior authorization. The only attachment allowed for rental-only wheelchairs is elevating leg rests (code E0990), when included in the doctor’s order. Rental wheelchairs are not allowed when a member’s medical condition, which requires a wheelchair, will be permanent.

6. The maintenance and service fee is for maintenance and service on the DME as needed to keep the equipment operating properly and includes all supplies, service and maintenance which are routinely supplied when the item was being provided as a monthly rental. Supplies, masks, tubing, etc. may be billed separately for CPAP and BIPAP’s.

7. Effective July 1, 2014, Claims programing is being changed so items with a quantity limit can be automatically processed against the allowed limits programmed. All codes requiring a right or left side modifier will be denied if the modifier is not used. Refer to the Medicaid website Coverage and Reimbursement Code Lookup tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php to determine the quantity limits. Quantity limits for items that could have a bilateral application, will indicate the quantity allowed for one side.

   When ordering a medical supply or a DME item that could be used bilaterally, the request and claim must state if the item is for bilateral use or single side use and for which side (right or left). The applicable modifier(s) must be on the claim.

Examples:

Bilateral Use
Code L8420: Prosthetic sock, multiple ply, below knee, each. Medicaid allows up to 24 per year without a prior authorization.

The provider orders 12 for bilateral use.

The reimbursement request is submitted on one claim using two lines with the applicable modifier:

	Unit(s)	Code	Modifier 1	Modifier 2
Correct	6	L8420	RT	
Correct	6	L8420	LT	

Incorrect	12	L8420	RT	LT

Unilateral Use
Code L8420: Prosthetic sock, multiple ply, below knee, each. Medicaid allows up to 24 per year without a prior authorization.

The provider orders 12 to use on the left side.

The reimbursement request is submitted on one claim using one line with the applicable modifier.

	Unit(s)	Code	Modifier 1	Modifier 2
Correct	12	L8420	LT	

Incorrect	12	L8420		

5 SUPPLIES FOR MEMBERS IN A LONG TERM CARE FACILITY and ICF/ID

Medicaid pays a per diem rate under contract with long term care facilities and ICFS/ID to provide room, dietary services, routine services, medical supplies and equipment. Under the contract, the facility must provide certain routine items, even though they may be considered ancillary by the facility. Medical supplies and equipment covered in the Medicaid contract are not reimbursable for residents of a long term care facility.

In the Coverage and Reimbursement Code Lookup tool, a row titled 'Billable for Nursing Home Residents' indicates which items are reimbursable for a Medicaid member who resides in a long term care facility or ICF/ID.

A. The supplies and equipment in the following list may not be billed independently to Medicaid for members residing in a long term care facility or ICF/ID, nor may these items be billed to the Medicaid member by either the facility or the medical supplier.

1. Items furnished routinely and relatively uniformly to all patients, such as patient gown, water pitchers, basins and bedpans.

2. Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such alcohol, applicators, cotton balls, Band-Aids, suppositories and tongue depressors.

3. Items used by individual patients, but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, customized wheelchairs, traction equipment and other durable medical equipment.

4. All other medical supplies and non-prescription pharmacy items normally provided by a long term care facility, including but are not limited to:

    a. Syringes
    b. Ostomy supplies
    c. Irrigation equipment and material for irrigation
    d. Dressings, except decubitus dressings at the present time
    e. Catheters: urinary, I.V., trachea
    f. Elastic stockings
    g. Test tape
    h. I.V. set up, tubing, clamps, catheters, dressings
    i. Colostomy bags
    j. Cervical collars
    k. Prosthetic and stump socks except for prosthetic shrinkers
    l. Nutritional supplements
    m. IBBP machines
    n. Equipment for administering oxygen
    o. Oxygen systems, with the exception of oxygen concentrators
    p. Ventilator equipment
    q. Standard wheelchairs
    r. Disposable incontinence products

B. Items not covered by the per diem and considered non-routine under the contract with the long term care facility or ICF/ID are considered ancillary services. Such items include prescription drugs (legend drugs), antacids, insulin, total nutrition (parenteral or enteral diet given through gastrostomy, jejunostomy, I. V. or stomach tube), antilipemic agents, hepatic agents, and high nitrogen agents. Ancillary items must be billed by the supplier, usually a pharmacy, directly to Medicaid. Non-routine items may not be billed by the facility.

6 PRIOR AUTHORIZATION

Certain medical supplies and equipment require prior authorization (PA) before the medical supply is dispensed or service is given in order to be reimbursable. PA requirements are found and at the Medicaid website at: https://medicaid.utah.gov, Health Care Provider menu, Prior Authorization, Medical Criteria. This online resource gives the provider the types of documentation that should be provided with requests.

Failure to provide the supporting documentation, which is needed to show criteria is met, will result in a denial of the request.

PA information is also found in the Coverage and Reimbursement Code Lookup tool.

For more information about the prior authorization process refer to in the provider manual Section 1: General Information, Prior Authorization.

For information specific to the Child Health Evaluation and Care (CHEC) Program, refer to the Utah Medicaid Provider Manual for CHEC Services.

1. Prior authorization to provide services beyond the designated limitations or not appearing in the Coverage and Reimbursement Code Lookup tool must be requested in writing in advance of the date of service. Verification will be provided by the Division of Medicaid and Health Financing.

2. All data elements on the Prior Authorization Request Form must be completed. Refer to the instructions for completion of the form in the General Attachments Section of this manual.

3. Documentation must be complete and extensive enough to justify the service or supply. For DME items that are impacted by the size of the member, documentation must include the height and weight of the member, as well as appropriate measurements to support the approval of the DME item. Requests that do not include this information will be considered incomplete and will not be processed. When a DME item is replacing an equivalent DME item, information regarding the current equipment must be included. Request must include the date the equipment was obtained, model and size, and documentation supporting the reason the DME item needs to be replaced.

4. If a quantity is requested that exceeds the quantity listed in the index, the exact total quantity must be present.

5. Requests for rental must specify the length of time the item is to be used.

6. All oxygen requires a prior authorization. The rate of oxygen flow and the hours per day must be specified on the physician's order, and a copy of the order must be retained on file with the Request for Prior Authorization.

7. When the prior authorization request is approved and a copy returned to the provider signed and dated with implementation and termination dates, service or supplies may be provided.

8. When the prior authorization is denied,

    a. the provider will be informed via fax.
    b. any further action will depend upon the nature of the denial.

9. All durable medical equipment requires prior authorization, even in situations where a third party pays the provider the major part of the cost. For billing instructions, refer to SECTION 1, Billing Third Parties.

10. Manual Pricing for DME

    Effective October 1, 2014, prior authorization (PA) numbers issued for manually priced items considered “miscellaneous” or “not otherwise specified (NOS)” will include a reimbursement amount and a brief description for each item.

Claims submitted for miscellaneous or NOS items must include the PA number issued for the item(s) and a line item invoice with the reimbursement amount and the brief description given with the PA number.

11. For beneficiaries who have Medicare and Medicaid benefits, prior authorization of medical supplies, durable medical equipment, prosthetic devices, or braces will no longer be necessary if it is a Medicare covered item. The claim will go through the cross over claims process. For information on billing Medicare/Medicaid cross-over claims, refer to SECTION 1.

    NOTE: If the item is not a Medicare covered benefit and/or the member resides in a nursing home prior authorization from Medicaid is required.

Retroactive Authorization

Retroactive authorization is authorization given after service is given. Retroactive authorization will NOT be given except in either of the two circumstances defined below.

A. Retroactive Medicaid Eligibility

When a Medicaid member becomes eligible retroactively for Medicaid and has already received medical supplies and equipment which require prior authorization, Medicaid may allow a prepayment review for supplies and equipment dispensed, rather than denying reimbursement solely because prior authorization was not obtained.

B. Medical Emergency

Medical supplies and equipment that are time sensitive and are needed immediately.

Only the medical supplies and equipment listed below may be considered for retroactive authorization.

- Enteral or parenteral therapy equipment
- Enteral or parenteral nutrients
- Hospital bed and related equipment
- Oxygen and related respiratory equipment
- Concentrator
- Gaseous oxygen or liquid oxygen only when supplied to a private client who subsequently becomes Medicaid eligible
- Ventilator and related equipment
- Humidifier/nebulizer/pulmoaide
- Apnea monitor

7 REPAIRS AND REPLACEMENT

Repair or reconstruction of appliances is a benefit of the program. Maintenance, repairs, replacement parts, and labor for rented medical equipment are the responsibility of the provider.

Repairs and replacement parts are a benefit when:

1. The equipment is a Medicaid-covered benefit;
2. The equipment is owned by the member;
3. The equipment is being used by the member in his or her home;
4. The repair is NOT covered by manufacturer's warranty;
5. Repairs require prior authorization;
6. Documentation must demonstrate a medical need and include a doctor's order.
7. Documentation of the age of the equipment and when repair/replacement of current requested part or item last occurred.

Limits on Repairs

1. Repair or non-routine service (for example, sealed components) requiring the skill of a technician for DME other than oxygen equipment should use code K0739. Repair for oxygen equipment should use code K0740. Both codes require prior authorization.
2. Document type of repair and time involved. Submit invoices with claim.
3. Repairs for DME are limited to medically necessary repairs.
    a. Repairs do not include changes in upholstery, padding, or cushioning. When a repair is determined medically necessary for these items, they must be prior authorized. Include documentation attached to the request.
    b. For repairs on hearing aids; see the Audiology Provider Manual, Section 4-2.

Limit on Replacements

Durable medical equipment will not be replaced more often than once in a five year period. Certain exceptions may occur when the DME equipment is no longer size-appropriate for the member. All exceptions to the established guidelines will require prior authorization.

8 RETURNED MEDICAL SUPPLIES

If a customer returns a medical supply or equipment purchased with a Medicaid card, a cash refund should not be given.

Instead, the provider must refund the payment to Medicaid. Please call Medicaid Information about returns.

9 BILLING

Providers must accept Medicare assignment for members who are eligible for both Medicare and Medicaid reimbursement. Medicare must be billed first using the codes found in the Medicare provider manual.

Medical supplies and equipment may be billed electronically through an electronic data exchange or on a CMS-1500 (08/05) claim form. When Medicaid requires documentation of the physician's order, the medical supplier must submit the documentation with the claim in order to receive reimbursement.

10 NON-COVERED SERVICES

No item, durable medical equipment or supply, disposable or semi-disposable, is reimbursable if the planned use is primarily for hygiene, education, exercise, convenience, cosmetic purposes, social interaction or comfort. While the Division of Medicaid and Health Financing recognizes the benefits of such uses, reimbursement is limited to items determined by the Division staff. Items needed for some other purpose should be requested through another source, such as a benevolent organization, church or civic group, etc. Examples of non-covered items include, but are not limited to, items in the list which follows. In addition, no item is reimbursable if prior authorization is required and is not obtained.

1. Equipment whose primary purpose is convenience, cosmetics, or comfort is not a benefit. Examples of items not covered include hot tubs; exercise equipment, such as bikes, treadmills, stair climbers; fitness center memberships; scooters; elevators; wheelchair lifts; 'Lifeline' monitor; purification systems; wigs; and panty hose.

2. Modifications of durable medical equipment or supplies for reasons of convenience, cosmetics, or comfort, such as changes in upholstery, padding, cushioning, are not a benefit.

3. Equipment permanently attached or mounted to a building or a vehicle is not a benefit. This includes ramps, lifts, and bathroom rails.

4. Routine maintenance of equipment is not a benefit. The member is responsible for routine maintenance and upkeep of purchased equipment.

5. Repairs are not a benefit in the following circumstances:

    a. The item is not owned by the Medicaid member or not being used by the member.
    b. The repairs or parts are for equipment which is not a benefit.
    c. The item is defective and under manufacturer's warranty.
    d. Shoe repair is not a benefit.

6. Usual household remedies such as Band-Aids, hydrogen peroxide, antiseptics, cleaning supplies, etc., are not a benefit.

7. Baby foods, such as Similac, Enfamil, Mull-Soy, etc., and other breast milk substitutes not used for a diagnosis related medical condition are not a benefit (Refer to Chapter 2-2)..

8. Equipment and supplies for a resident of a long term care facility which are covered under contract.

9. Spring loaded member lifts are not a benefit.

10. Corsets are not a benefit.

11. Cervical pillows are not a benefit.

12. Shoes and accessories are not a benefit. Shoes include the following:

    a. Mismatched shoes.
    b. "Comfortable" shoes following surgeries such as, but not limited to, bunionectomies.
    c. Shoes to "support" an overweight individual.
    d. Shoes used as a "bandage" following foot surgery.
    e. Trade name or brand name shoes.
    f. Arch supports, foot pads, metatarsal head appliances, or foot supports.
    g. “Slip-in” orthotics
    h. Shoe repair

13. “Off the shelf” braces are not covered.

14. Reflux boards are not covered.

15. Mail order items, such as hearing aids and vision aids.

11 PROCEDURE CODES and INSTRUCTIONS

Effective January 1, 2013, the Medical Supplies Manual will be combined with the Medical Supplies List. The Medical Supplies List will be archived.

Procedure codes with accompanying criteria, comments, and limits can be found in the Coverage and Reimbursement Code Lookup tool on the Medicaid website at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

Instruction for Medical Supply and Durable Medical Equipment (DME) Codes:

Coverage and the Medicaid Prior Authorization requirements apply **ONLY** to medical supplies and DME to be provided to a Medicaid member not enrolled in an MCO. Medicaid does **NOT** process Prior Authorization (PA) requests for supplies/equipment to be provided to a Medicaid member who is enrolled in an MCO. Providers requesting PA for supplies/DME for a member enrolled in an MCO will be referred to that MCO.

INDEX