

## Section 2

### Medical Supplies and Durable Medical Equipment

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## Introduction

The *Utah Medicaid Provider Manual, Section 2, Medical Supplies and Durable Medical Equipment* is designed to be used in conjunction with the *Utah Medicaid Provider Manual, Section I: General Information (Section I: General Information)* as well as other sections and attachments. Refer to Utah Medicaid website at <https://medicaid.utah.gov>.

The purpose of the Medical Supplies – Durable Medical Equipment (DME) Program is to provide to members supplies and DME, ordered by a qualified practitioner within their scope of practice under State law, and the scope of services provided within the program. Not all medical supplies or durable medical equipment with coverage are specifically mentioned in this manual. However, the Coverage and Reimbursement Code Lookup contains information related to the coverage status and limitations for specific items, listed by Healthcare Common Procedure Code (HCPCS). The Coverage and Reimbursement Code Lookup is available on the Utah Medicaid website at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

Information in this manual represents services available when medically necessary. Services may be more limited or may be expanded if the proposed services are medically necessary and are more cost effective than alternative services.

## Provider Participation Requirements

To enroll as a Medicaid provider for medical supplies/DME and be eligible for reimbursement, providers must have a current business license, a tax I.D. number, proof of Medicare Certification, a stationary physical place of business, and an inventory.

## Member Eligibility

A Medicaid member is required to present the Medicaid Identification Card before each service. It is the responsibility of the provider to verify the member's eligibility each time before service is rendered. Possession of a Medicaid Member Card does not guarantee eligibility, because eligibility and health plan enrollment may change month-to-month. To verify member eligibility, use one of these tools: AccessNow, Eligibility Lookup Tool, or ANSI 270 and ANSI 271. For a brief description of each resource and for more information regarding eligibility, refer to *Section I: General Information* (<https://medicaid.utah.gov/>).

## Fee-For-Service or Managed Care Organization

Refer to *Section I: General Information* for information regarding (MCOs) and how to verify if a Medicaid member is enrolled in an MCO.

## Transition of Care

When medical equipment is prior authorized for purchase and ordered for a member and the member is enrolled in another plan (MCO or Fee-For-Service) before receiving the equipment, the plan that prior authorized the purchase of the equipment is responsible for adjudicating the claim and payment.

Refer to the Utah Medicaid website provider manual, *Section I: General Information* at <https://medicaid.utah.gov/>.

## Manual Organization

Introduction

Part 1 - General Information. Information applicable to both Medical Supplies and Durable Medical Equipment (DME).

Part 2 – Medical Supplies. Information applicable to Medical Supplies, except for supplies that are used exclusively with DME items, e.g., liquid and gaseous oxygen are with oxygen equipment.

Part 3 – Durable Medical Equipment. Information applicable to DME equipment and certain medical supplies used only with a specific type of DME, e.g., prosthetic socks are with prosthetics.

## Part 1 – General Information

Part 1 contains information applicable to both Medical Supplies and Durable Medical Equipment (DME).

### 1-1 Definitions

Definitions specific to the content of this manual are provided below. Definitions of terms used in other Medicaid programs are available in *Section I: General Information*.

The following definitions apply to medical supplies and DME covered by Medicaid:

#### **Disposable**

A medical supply or equipment intended for one-time use and not for re-use.

#### **Enteral nutrition (EN)**

The provision of nutritional requirements through a tube into the stomach. It may be administered by syringe, gravity, or pump.

#### **High Flow Concentrator**

An oxygen concentrator with a flow of greater than or equal to 10 liters per minute.

#### **Intravenous Therapy (IV)**

A sterile solution, drug, or an infusion injected into a vein for treatment of infection, pain, hydration, blood factor replacement, chemical or electrolyte replacement, etc.

#### **National Drug Code (NDC)**

Unique product identifier used in the United States for drugs intended for human use.

#### **Orthotic device**

An orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

**Prosthetic device**

Prosthetic devices mean replacement, corrective or supportive devices ordered by a qualified practitioner within the scope of his practice as defined by state law.

**Semi-disposable**

Designed to be thrown away after use or when used up.

**Total Parenteral Nutrition (TPN)**

Nutritional support given by means, such as intravenously (IV), other than through the GI tract.

**1-2 Child Health Evaluation and Care Coverage**

The Child Health Evaluation and Care (CHEC) (also known as Early Periodic Screening, Diagnosis, and Treatment (EPSDT)) program may approve medically necessary medical supplies and DME for children enrolled in Traditional Medicaid and are age birth through twenty. Refer to the *Utah Medicaid Provider Manual, CHEC Services* for specific information.

**1-3 Requirements for Obtaining Medical Supplies or DME**

Obtaining medical supplies or DME requires following conditions be met:

- Item is medically necessary and documentation is submitted to support that standard.
  - Medical necessity does not include supplies or DME used primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort.
- Item is provided to the member pursuant to a signed and dated order from an enrolled licensed practitioner, practicing within the scope of their license, that includes the following:
  - Member's name
  - Prescribing Physician's name
  - Date of the order and the start date, if the start date is different from the date of the order
  - Date of birth
  - Diagnoses
  - Detailed description of the item(s) For items provided on a periodic basis, including drugs, the written order must include:
    - Item(s) to be dispensed
    - Dosage or concentration, if applicable
    - Route of Administration
    - Frequency of use
    - Duration of infusion, if applicable
    - Quantity to be dispensed
    - Number of refills, if applicable
      - Refills (if applicable) expire 12 months from the date of initial signature
  - Duration of use
  - Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed
    - Reimbursement shall be based on the specific utilization amount only
    - Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable
  - Physician signature (if a written order) or supplier signature (if verbal order)

- Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements

#### 1-4 Quantity Limits

Information is now found in [Section I: General Information Provider Manual](#), Chapter 9.

#### 1-5 Long Term Care Facilities - Medical Supply and DME Coverage

For details on coverage for members residing in a Long-Term Care Facility, refer to the Utah State Plan, Attachment 4.19-D 430.

##### Medical Supply Coverage

Long term care facilities must be contracted as a Medicaid Provider and are reimbursed at a per diem rate to provide most medical supplies in addition to room, dietary services, routine services, and equipment.

The contract requires the facility provide routine medical supplies even though they may be considered ancillary by the facility. These items may not be billed independently to Medicaid, nor be billed to the Medicaid member by either the facility or the medical supplier.

##### DME Coverage

Specific information regarding coverage and limitations for members residing in a long-term care facility is in the Utah State Plan.

##### Nursing Facility Reimbursement

For details refer to the Medicaid website at <http://health.utah.gov/medicaid/stplan/longtermcare.htm>.

#### 1-6 Prior Authorization

Prior authorization (PA) is required for certain medical supplies and DME. Providers must determine if a PA is necessary before providing services. Failure to obtain a PA may result in payment denial by Medicaid. Providers are expected to obtain prior authorization for all codes with a prior authorization requirement. Providers are responsible for obtaining a PA even if a member has other coverage through another payer. Detailed PA requirements are on the Medicaid website at <https://medicaid.utah.gov> and *Section 1: General Information*.

##### 1-6.1 Medicare and Prior Authorization

Except for paid Medicare crossover claims, the PA requirement for Medicaid applies to all medical supplies and DME items subject to a PA regardless of third party liability coverage or eligibility.

When a member has both Medicare and Medicaid:

- A Medicaid claim cannot be paid if the item is eligible for Medicare coverage but the Medicare claim has not yet paid.
- The Provider must comply with Medicare prior authorization requirements and Durable Medical Equipment, Prosthetic/Orthotic, and Supplies (DMEPOS) when applicable, before Medicaid will authorize payment for any medical supplies or DME item.

- Medicaid does not require a PA when Medicare is the primary payor. The claim must be submitted to Medicare before it is submitted to Medicaid.
- If a DME or medical supply item is not covered by Medicare but is covered by Medicaid, follow Medicaid’s criteria.
- When Medicaid requires a PA and the member resides in a nursing home, a PA from Medicaid is required.

### 1-6.2 Healthcare Common Procedure Coding System (HCPCS) Miscellaneous Codes

Items not described by a specific HCPCS may be submitted on a claim with a miscellaneous code. All items submitted with a miscellaneous code require a PA and are manually priced. Evidence of the provider’s actual acquisition cost, a picture of the item, and documentation of medical necessity must be submitted with the PA request.

### 1-6.3 Retroactive Authorization

In certain cases, a service is authorized after it is given (retroactive authorization). Refer to *Section 1: General Information* for details.

## 1-7 Billing

Medical supplies and equipment may be billed electronically through an electronic data exchange or on a CMS-1500 (2/12) claim form. When documentation of the order is required, the medical supplier must submit the documentation with the claim to receive reimbursement.

Providers must accept Medicare assignment for members eligible for both Medicare and Medicaid reimbursement. Medicare must be billed first using the HCPCS codes.

### 1-7.1 Modifiers

When ordering, an item requiring PA that could be used bilaterally, append the applicable modifier(s) to the PA request **and** claim. (Refer to the [Coverage and Reimbursement Code Lookup](#).)

Below are examples of how to report modifiers for bilateral and unilateral use.

#### Example 1 - Bilateral Use

Code L8420: Prosthetic sock, multiple ply, below knee, each. Allowed 24 per year, per side without a PA.

Ordered: L8420 x 12 for bilateral use.

Report 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
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**Example 2 - Unilateral Use**

Code L8420: Prosthetic sock, multiple ply, below knee, each. Allowed 24 per year, per side without a PA.

Ordered: L8420 x 12 to use on the left side.

Report on one claim using two lines with the applicable modifier:

	<b>Unit(s)</b>	<b>Code</b>	<b>Modifier 1</b>	<b>Modifier 2</b>
Correct	12	L8420	LT	
Incorrect	12	L8420		

**1-8 Returned Medical Supplies or DME**

If a member returns a medical supply or DME purchased with a Medicaid card, a cash refund must not be given to the member. The provider must refund the payment to Medicaid or call the Bureau of Medicaid Operations, Medicaid Claims team and request the claim be reversed.

**Part 2 - Medical Supplies**

Medical supplies are disposable or semi-disposable items. 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 month usage.

**2-1 Medical Supplies Coverage and Limitations**

Coverage and limitations for certain medical supplies are addressed below. The list is not all inclusive. Refer to the [Coverage and Reimbursement Code Lookup](#) for specific coverage information by HCPCS code.

**2-1.1 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.

Non-covered:

- First aid supply kits
- Routine minor first aid needs
- Household remedies such as Band-Aids, hydrogen peroxide, etc.

**2-1.2 Disposable Incontinence Products**

Disposable incontinence products are covered for traditional Medicaid members with documentation of medical necessity.



The following quantity limits apply to any combination of the covered incontinence supply codes for a one-month supply. If the member's need exceeds these limits, PA is required.

- Members on traditional Medicaid programs - 156 per 30 day period
- Members on a waiver program do not have a quantity limits

Disposable incontinence supplies are not covered for:

- Normal infant use, or
- Members residing in a long-term care facility, as they are furnished by the facility

### 2-1.3 Urinary Catheters

Covered - Indwelling catheters

Covered - 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.

### 2-2 Donor Human Milk

Medicaid coverage for donor human milk applies to members residing in a home setting. The provider must be a donor human milk bank certified by the Human Milk Bank Association of North America and enrolled as a Utah Medicaid provider.

All the following criteria must be met:

- Member is Medicaid eligible and age birth through 11 months
- The requesting prescriber is the infant's treating practitioner
- Completed feeding trial
- The requesting prescriber has addressed with the parent or guardian the benefits and risks of using donated milk, such as
  - HIV
  - Freshness
  - Effects of pasteurization
  - Nutrients
  - Growth factors
- The prescriber has given the parent or guardian information concerning donor screening, pasteurization, milk storage, and transport of the donated milk. (The prescriber may obtain this information from the donor milk bank.)
- An informed consent signed and dated by the parent or guardian, outlining the risks and benefits using banked donor human milk. (The consent is usually signed in the hospital.)
- Prior Authorization obtained. (The request must be resubmitted every 180 days.)

To request a PA, the infant's treating physician will submit:

- Request for Prior Authorization form
- Donor Human Milk Request Form [<https://medicaid.utah.gov/utah-medicaid-forms>]
- Documentation supporting the finding that donated human breast milk is medically necessary for the intended recipient and why the mother cannot supply the breast milk.

## 2-3 Nutrition - General

Enteral and parenteral nutrition is covered by Utah Medicaid per this chapter. All enteral, parenteral, and metabolic formula nutrition require PA. Coverage is limited to products listed in the [Coverage and Reimbursement Code](#) Lookup. Associated supplies and equipment are controlled by quantity limits.

Refer to *Section I: General Information* for PA information and requirements.

All requests for enteral or parenteral nutrition must include the following documentation:

- An order including
  - Diagnosis(es)
  - Product name
  - Total daily prescribed intake amount (e.g., ml, gram, etc.)
  - Daily frequency of ingestion
  - Duration or period the product is to be used (e.g., days, weeks, months, etc.)
- Height and weight of patient  
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 costlier product

### 2-3.1 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 are 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.

### 2-3.2 Oral or Tube Supplemental Nutrition and Total Oral Nutrition:

Total oral nutrition and supplemental enteral nutrition (oral or tube) for EPSDT eligible members 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, OR
- The member's nutritional needs cannot be met by WIC, OR
- The member is ineligible for WIC (age 5 or older), OR

The member is awaiting WIC **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)  $\leq$ 5th percentile for 3 years of age or under
  - Body Mass Index (BMI)  $\leq$ 5th percentile (ages 4-17)
  - BMI  $\leq$ 18.5 percentile (ages 18-20)
  - BMI  $\leq$ 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
- Cancer:
  - Receiving chemotherapy and/or radiation therapy
  - Up to 3 months 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 because of a stated primary diagnosed disease and
  - Have a WFL  $\leq$  5th percentile for 2-year-old or younger
  - BMI  $\leq$  5th percentile (ages 3-17)
  - BMI  $\leq$  18.5 percentile (ages 18-20)
  - BMI  $\leq$  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 child  $<$  2 years of age
  - No weight gain for more than 3 months in 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

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.

### 2-3.3 Inborn Errors of Metabolism

For Medicaid members, supplemental nutrition is covered to treat inborn errors of metabolism. These medical food supplements are available through use of HCPCS codes and requires a PA. Specific coverage information is found in the [Coverage and Reimbursement Code Lookup](#).

### 2-3.4 Coverage Limitations for Nutritional Products

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

### 2-3.5 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 are 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

- Equipment such as IV poles, disposable swabs, antiseptic solutions and dressings for the catheter are not reimbursable by Medicaid for residents of a long-term care facility

## 2-4 IV and Parenteral Therapy

IV and parenteral therapy is covered for eligible members with chronic illnesses, trauma, or terminal disease able to live at home or in a long term care facility, but cannot be sustained with oral feeding and rely on total parenteral nutrition (TPN) to sustain life. Providers supplying parenteral therapy must be enrolled with Medicaid as a DME provider or as a pharmacy provider.

Pharmaceuticals, injectable, 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 *Utah Medicaid Provider Manual, Pharmacy Services* (<https://medicaid.utah.gov>).

## Part 3 – Durable Medical Equipment

Part 3 contains information applicable to DME equipment and certain medical supplies used only with a specific type of DME, e.g., prosthetic socks are with prosthetics. Durable medical equipment (DME) is medical equipment able to withstand repeated use, is used to serve a medical purpose, and is not useful to a person in the absence of an illness or injury.

### Carve-out Services

Services *not* included in the Medicaid contract with an MCO are carve-out services and paid through Fee-for-Service. Apnea monitors are the only DME carve-out item from the MCO plans; the contractor is Apria Healthcare.

### Warranty

Some DME include a warranty at no additional cost with the purchase. Record of the warranty must be retained in the member's file with the DME provider.

### Face to Face Requirement

Effective July 1, 2017, the Utah Medicaid Program for fee for service members will adopt the same regulatory requirements of Medicare regarding face-to-face encounters for certain DME. Refer to R414.1-30 for complete information.

All other criteria, in addition to the face-to-face requirement, for specific DME must be met to qualify for reimbursement, e.g. quantity limits, DMEPOS, prior authorization, age limits, etc.

## 3-1 Equipment - Purchase or Rental

DME may be available for purchase, capped rental, or continuous rental. Items for capped rental or continuous rental must be reported with a correct modifier.

### 3-1.1 Purchased Equipment

DME purchased under the Medicaid program must be new, unused equipment. The DME provider must retain invoices in the member's file documenting the equipment is new.

Refurbished, rebuilt, or used equipment is not covered for purchase by Medicaid, unless specifically authorized in writing from Medicaid.

### 3-1.2 Capped Rental

Certain DME may be reimbursed as a capped rental for twelve months only. After 12 consecutive\* months, Medicaid considers the equipment to be paid in full and owned by the member. Capped rental claims for DME must be billed with a LL modifier on the claim.

\*If an interruption of 60 consecutive days or more occurs during the capped rental period, and the equipment is returned to the vendor, a new 12-month rental period will begin if the member needs the equipment again.

Six months after a capped rental has converted to purchase, maintenance and service may begin when appropriate for a DME item. PA is required, and requests must include a physician order and statement of continuing medical necessity. Maintenance and service may be requested no more than once every 6 months and is reported using the MS modifier. Maintenance and service includes technician time and supplies consumed to keep the equipment operating properly and is reimbursed one month's rental rate. Maintenance and service does not include supplies consumed by the member in routine use of the equipment.

### 3-1.3 Continuous Rental

Limited specialized equipment may be furnished to the member on a permanent rental basis. The continuous rental rate includes maintenance and backup equipment, if needed. Claims for continuous rental items must be submitted with a RR modifier.

### 3-2 Prosthetic Devices

Information regarding specific codes can be found on the Medicaid [Coverage and Reimbursement Code Lookup](#).

### 3-3 Oxygen and Related Respiratory Equipment

The oxygen benefit comes in four forms:

- Oxygen Concentrator with backup oxygen supply
- Stationary gaseous oxygen system
- Portable gaseous oxygen
- Liquid oxygen

#### 3-3.1 Oxygen Concentrator and Backup Oxygen Supply

- Oxygen concentrators, and backup oxygen supply, are provided exclusively through a contract with Alpine Home Medical Equipment (1-888-988-2469), for fee-for-service members and members who have voluntarily enrolled in an ACO in a non-mandatory county. See *Section I: General Information* for county-specific information.

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 DME provider for fee-for-service members. PA must be obtained through the Medicaid Prior Authorization unit.

### 3-3.2 Stationary Gaseous Oxygen System

Gaseous oxygen systems require PA and may be furnished by any willing Medicaid DME provider. A stationary gaseous oxygen system may be covered only in the following circumstances:

- Electrical power to run an oxygen concentrator is not available, or
- When other equipment necessary for the member requires a saturation percentage higher than the capacity of an oxygen concentrator, or
- When the member requires a liter flow rate higher or lower than the capacity of an oxygen concentrator.

### 3-3.3 Portable Gaseous Oxygen

Portable gaseous oxygen systems and contents must be medically necessary and require orders for delivery by any willing Medicaid DME provider. Portable oxygen systems and contents do not require a PA.

Portable oxygen systems and contents are not benefits to members requiring oxygen only intermittently or part-time.

### 3-3.3 Liquid Oxygen Systems

Liquid oxygen systems and/or contents require PA and may be furnished by any willing Medicaid DME provider. Content is included and not separately reimbursed in stationary systems. A liquid oxygen system and/or contents may be approved only when:

- Multiple pieces of equipment are being used by the member in a series, such as compressors or, ventilators, or
- Gaseous oxygen systems will not provide the liter flow per minute or the percent of concentration required by the member.

#### Billing for Liquid Oxygen

Liquid oxygen is reported monthly in 10 pound increments. (One 10-pound increment equals 1 unit). Report a stationary liquid oxygen system with HCPCS code E0439RR, which includes the first 10 pounds. If more than 10 pounds of liquid oxygen is used per month, report with code E0442 in additional 10 pound increments.

Note: For a member residing 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 PA.

### 3-3.4 Ventilators

In-home ventilator use, to sustain life, is covered by Medicaid when the member's needs are met adequately and safely, and if the service requested is cost-effective within Medicaid policy limitations.

### 3-4 Monitoring Equipment

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

Blood glucose monitors are available to Medicaid members through the pharmacy benefit. Blood glucose monitors from the manufacturers of preferred test strip can be obtained from a pharmacy. For additional information refer to the *Utah Medicaid Provider Manual, Pharmacy Services at <https://medicaid.utah.gov/>*.

Blood glucose monitors not covered through the pharmacy benefit may be provided with written PA. Blood glucose monitors available through the DME benefit will be limited to those that contain special features (e.g., voice synthesizers) that are medically necessary for an individual member and approved on a case by case basis.

Infant apnea/bradycardia monitors are supplied under contract with Apria (1-888-492-7742). This is a carve-out service and applies to fee-for-service and MCO members.

### 3-5 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 approved must be appropriate for a member's need.

Education and training of the member and primary care givers by a trained therapist is necessary to assist in adopting an attitude and fostering the expectation that the member will be allowed to be as independent as physically able.

The member must not currently own a medically appropriate type of chair that has been received within the previous five-year period.

All purchased wheelchairs, accessories, attachments, replacement supplies and repairs require PA and evidence of medical necessity. InterQual criteria is used to determine eligibility for manual, customized, and motorized wheelchairs. The vendor must keep all orders on file including the separate attachments requested.

#### 3-5.1 Wheelchairs Purchased by Medicaid

Medicaid will pay for a 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 an order and a determination of cost-effectiveness. Medicaid will pay for a wheelchair no more than once every five years.

A second manual 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 appointments 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, provided the member can transfer from one chair to the other and this accommodation will allow the member to be under the lift capacity of transportation vehicles.

### 3-5.2 Reimbursement

- The provider shall not bill Medicaid until the chair and all attachments have been received and signed for by the member.
- Motorized and customized wheelchairs may not be billed until the required “Motorized or Customized Wheelchair Final Evaluation Form” 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.

### 3-5.3 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/>.

For motorized wheelchairs, The “Motorized or Customized Wheelchair 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 and the member or their authorized representative sign the “Motorized or Customized Wheelchair Final Evaluation Form” and return it to the DME provider.

### 3-5.4 Replacement Parts for a Wheelchair

Replacement parts for a wheelchair, such as tires or wheels, require a PA and be medically necessary. Replaced part(s) are covered no more than once a year.

### 3-5.5 Modifications and Repairs to Wheelchairs

PA 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:

- Modifications must be medically necessary
- Modifications are NOT reimbursable if the planned use is primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort
- 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, unless the member qualified for two chairs
- Medicaid will cover repairs only once and are expected to last at least one year

### 3-5.6 Replacement of Wheelchairs

Any replacement of a wheelchair purchased by Medicaid must have PA. 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 may cover a short-term rental chair for a period not to exceed 120 days.

### **3-5.7 Manual Wheelchairs**

A manual wheelchair includes any stock frame and modular components, customized options or accessories assembled to fit the patient needs. Refer to the [Coverage and Reimbursement Code Lookup](#) for codes and additional requirements.

### **3-5.8 Customized Manual Wheelchair**

A customized manual wheelchair is one which has been uniquely constructed or substantially modified for a specific person. There must be customization of the frame for the wheelchair to be considered customized.

The assembly of a wheelchair from modular components, or addition of customized options or accessories, does not meet the requirements of a customized wheelchair.

### **3-5.9 Motorized Wheelchairs**

A qualified practitioner, medical supplier, physical therapist/occupational therapist, the long-term care facility (if applicable), and Medicaid Prior Authorization staff must be involved to obtain a motorized wheelchair. Motorized wheelchairs must be appropriate for use within the member's residence.

An 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 evaluation must have been done within six months of the PA request. For members from birth through age 20, an evaluation must have been done within three months of the PA request.

Motorized wheelchairs require documentation stating the member can learn the skills needed to operate the chair safely. All members must have had a minimum of two hours' instruction and use in a motorized wheelchair.

The therapist will document on the "Wheelchair Training Checklist - Motorized" that the member can perform the necessary skills to operate the wheelchair. Refer to the Medicaid website at <https://medicaid.utah.gov>, Forms section for a copy.

Submit the Motorized Wheelchair Checklist to DMHF, Prior Authorization Unit, with all other required PA documentation.

### **3-5.10 Wheelchairs for Members in a Long-Term Care Facility**

Manual wheelchairs are part of the per diem rate when a member resides in a long-term care facility. A long-term care facility is responsible to provide manual wheelchairs for its residents, including wheelchairs adapted to the shape and physical needs of the resident using stock parts or attachments assembled by the manufacturer or the vendor. These are not customized wheelchairs.

Medicaid may cover medically necessary customized or power wheelchairs when criteria is met.

A wheelchair supplied by Medicaid is owned by the member. If that member leaves the nursing facility the wheelchair goes with them. Wheelchairs provided by the facility for member use remain the property of the facility.

Repairs to a wheelchair owned by a long-term care facility are the responsibility of the facility.

### 3-6 DME Repairs and Replacement

Repair or replacement parts of DME is a benefit when:

- Equipment is a Medicaid-covered benefit
- Equipment is owned by the member
- Equipment is being used by the member
- Repair is not covered by manufacturer's warranty

Repairs require an order and PA. The documentation requires all items listed in Chapter 1-3, Obtain Medical Supplies or DME. Include the date when repair or replacement of current requested part or item last occurred.

#### 3-6.1 Coding Repairs

- When repair or non-routine service requires the skill of a technician, (e.g., repair of sealed components) use the appropriate code:
  - K0739 - DME other than oxygen equipment
  - K0740 - Oxygen equipment
- Document type of repair and time involved. Submit invoices with claim.
- Repairs for DME are limited to medically necessary repairs.

Note: Hearing aid repairs, refer to the *Speech-Language Pathology and Audiology Services Provider Manual*.

#### 3-6.2 Limit on Replacements

Durable medical equipment is not replaced more often than once in a five-year period. Exceptions may occur with a change in medical necessity or when the equipment is no longer size-appropriate. All exceptions to the established guidelines require PA.

### 3-7 Non-Covered Services

Some specific non-covered DME are listed below. The list is not all inclusive.

- Equipment whose primary purpose is convenience, cosmetic, or comfort.
- Equipment permanently attached or mounted to a building or a vehicle, including ramps, lifts, and bathroom rails.
- Equipment for a resident of a long-term care facility covered under contract.
- Sacro-lumbar or dorsal lumbar corset type supplies are NOT considered prosthetic devices or special appliances.
- Routine maintenance and service of non-covered DME.
- Repairs in the following circumstances:
  - The item is not owned by the Medicaid member or not being used by the member.

- The repairs or parts are for equipment which is not a benefit.
- The item is defective and under manufacturer's warranty.

#### **4**      **References**

42 Code of Federal Regulations: Part 440.70, 440.120(C), 441.15, 414 subpart D and subpart F  
Utah Administrative Rule R414-70. Medical Supplies, Durable Medical Equipment, and Prosthetic  
Devices  
Medicare Program Integrity Manual, Chapter 5 – Items and Services Having Special DME Review  
Considerations.  
Utah State Plan, Attachment 4.19-D