



Utah Department of  
**Health & Human Services**  
Integrated Healthcare

# Utah Medicaid Provider Manual

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## Medical Supplies and Durable Medical Equipment

**Division of Integrated Healthcare**

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## 1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email [dmhfmedicalpolicy@utah.gov](mailto:dmhfmedicalpolicy@utah.gov) if any of the links do not function properly, noting the specific link that is not working and the page number where the link is.

For general information regarding Utah Medicaid, refer to [Utah Medicaid Provider Manual, Section I: General Information](#).

### 1-1 Medical supplies and durable medical equipment (DME) services

This manual is designed to be used in conjunction with Section I: General Information and other sections and attachments. Refer to the Utah Medicaid website at <https://medicaid.utah.gov> for additional resources.

Not all medical supplies and DME are mentioned within this manual. However, the [Coverage and Reimbursement Code Lookup](#) contains information about coverage status and limitations for specific items listed by Healthcare Common Procedure Code (HCPCS).

Information in this manual represents services available when medically necessary. For information regarding medical necessity, refer to [Section I: General Information](#) Chapter 8-1 Medical necessity.

For information specific to EPSDT eligible members, refer to the [EPSDT Services Manual](#).

## 2 Health plans

For more information about Managed Care Entities (MCEs), refer to [Section I: General Information](#), Chapter 2, Health plans.

Refer to [Section I: General Information](#) Chapter 1-7, Fee for service and managed care, for managed care entities (MCEs), and verify if a Medicaid member is enrolled in an MCE.

### 3 Provider participation and requirements

To enroll as a Medicaid provider for medical supplies and DME, refer to [Section I: General Information](#) Chapter 3, Provider participation and requirements.

### 4 Record keeping

Refer to [Section I: General Information](#), Chapter 4, Record keeping.

### 5 Provider sanctions

Refer to [Section I: General Information](#), Chapter 5, Provider sanctions.

### 6 Member eligibility

Refer to [Section I: General Information](#), Chapter 6, Member eligibility, for information about verifying a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

### 7 Member responsibilities

For information on member responsibilities, including establishing eligibility and co-payment requirements, refer to [Section I: General Information](#), Chapter 7, Member responsibilities.

### 8 Programs and coverage

#### 8-1 Definitions

The following definitions are specific to the content of this manual.

Definitions of terms used in multiple Medicaid programs are in [Section I: General Information](#), Chapter 1-9, Definitions and [Utah Administrative Code R414-1](#).

**Carve-out services:** Services not included in the Medicaid contract with an MCE are carve-out services and paid through fee for service. Example: Apnea monitors are a carve-out service

**Customized manual wheelchair:** A wheelchair that has been measured, fitted, or adapted in consideration of the member's body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for individual member's use following instructions from the member's physician

**Durable medical equipment or equipment:** Items that are primarily and customarily used to serve a medical purpose and are not generally beneficial to an individual in the absence of a disability, illness, or injury, can withstand repeated use, and can be reusable or removable

**Enteral nutrition (EN):** EN is the provision of nutritional requirements through a tube into the gastrointestinal (GI) tract and administered by syringe, gravity, or pump

**Maintenance:** Servicing of equipment that, based on the manufacturer's recommendations, needs to be performed by a provider

**Manual wheelchair:** A wheelchair that can be self-propelled or pushed by another individual and is not a power wheelchair

**Medical supplies or supplies:** Items that are consumable, disposable, or cannot withstand repeated use by more than one individual that is required to address an individual medical disability, illness, or injury

**National drug code (NDC):** Unique product identifier used in the United States for drugs intended for human use

**Optimally configured manual wheelchair:** A manual wheelchair with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories

**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

**Physician:** Defined in sections [1861\(r\)\(1\)](#) and [1861\(aa\)\(5\)](#) of the Social Security Act and acting within their scope of practice

**Power wheelchair:** A wheelchair propelled utilizing an electric motor rather than manual power

**Prosthetic device:** Replacement, corrective or supportive devices prescribed by a physician to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunctions (including promotion of adaptive functioning), or support a weak or deformed part of the body

**Repair:** To fix or mend and put the equipment back in good condition after damage or wear

**Replacement:** To change an existing piece of equipment with an identical or nearly identical item

**Total parenteral nutrition (TPN):** Nutritional support given by means, such as intravenously (IV), other than through the GI tract

**Warranty:** A guarantee to the purchaser or owner of equipment promising to repair or replace, if necessary, within a specified period

## 8-2 Requirements for obtaining medical supplies or DME

Orders for equipment or supplies require:

1. documentation supporting medical necessity maintained in the member's medical records
  - a) submission of documentation for PA
2. a physician's order including the following information:
3. member's name
4. date of the order
5. the start date, if the start date is different from the date of the order
6. diagnosis
7. a detailed description of equipment or supplies



8. duration of use
9. for items used periodically, the written order must include dosage and duration frequency of use
10. number of refills
11. refills expire 12 months from the date of initial signature
12. quantity to be dispensed
13. route of administration
14. a physician's signature following [Section I: General Information](#) Chapter 4-6, Signature requirements

Medical supplies filled monthly may be refilled between days 25 and 30 to ensure that the member has the needed product for subsequent usage.

### **8-3 Face-to-face requirements**

Under [42 CFR 440.70](#), providers must comply with the face-to-face requirements related to equipment and supplies. Therefore, providers must be aware of the equipment and supplies required for a face-to-face evaluation as mandated by the Center for Medicare and Medicaid Services (CMS). See the CMS [Face-to-Face Encounter Requirement for Certain Durable Medical Equipment](#) for details.

For the initiation of equipment and supplies requiring a face-to-face evaluation, the evaluation must be related to the primary reason the member needs the item. In addition, it must occur no more than six months before services start.

Documentation must support that the face-to-face encounter is related to the primary reason the member requires medically necessary equipment or supplies and occurred within the timeframes needed before services start.

In addition, documentation must indicate:

1. the evaluating physician
2. the date of the face-to-face
3. if the evaluation was conducted via telehealth

Medicaid will deny equipment or supplies coverage unless the physician documents a face-to-face encounter with the member consistent with the requirements outlined in this manual, [Utah Administrative Code R414-1-30](#), and [42 CFR 440.70](#).

All other criteria, in addition to the face-to-face requirement, for equipment and supplies, must be met to qualify for coverage.

#### **8-4 Quantity limits**

Providers can find information regarding quantity limits in [Section I: General Information](#), Chapter 9-3.5, Quantity limits. In addition, specific HCPCS code quantity limits for equipment and supplies are found using the [Coverage and Reimbursement Code Lookup](#).

#### **8-5 Long-term care facilities – medical supply and DME coverage**

For details on covered equipment and supplies for members residing in a long-term care facility, refer to the [Utah State Plan, Attachment 4.19-D](#) 430 Non-Routine Services.

##### **8-5.1 Nursing facility reimbursement**

For details, refer to Medicaid's [Long-Term Care Resources](#).

##### **8-5.2 Equipment and supplies within the per diem rate**

For this manual, equipment, supplies, and services for members residing in long-term care facilities covered in the per diem rate include, but are not limited to, the following:

1. Routine personal hygiene items and services as required to meet the needs of the member:

basins	denture cleaner	soaps
bedpans	deodorant	tissues
brush	disinfecting soaps	toothbrush
comb	hair hygiene supplies	toothpaste
cotton balls	moisturizing lotion	towels
cotton swabs	sanitary napkins	washcloths
dental floss	razor	water pitchers

denture adhesive                      shaving cream

2. Items stocked at nursing stations or on the floor in gross supply:

adhesive bandages	CPAP/Bi-PAP supplies	oxygen masks
alcohol wipes	gauze	oxygen tubing
applicators	hospital gowns	routine dressings
catheters	incontinence supplies	suppositories
colostomy bags	irrigation supplies	syringes
compression stockings	IV equipment	tape
cotton balls	ostomy supplies	tongue depressors

3. Items used by individual patients which are reusable and expected to be available such as:

bed rails	traction equipment
canes	standard beds
crutches	walkers
ice bags	wheelchairs

4. Special dietary supplements for tube feeding or oral feeding except those indicated as ancillary services.

5. Specialized cleaning agents when indicated to treat unique skin problems or to fight infection.

### 8-5.3 Equipment and supplies reportable as ancillary services

Ancillary equipment, supplies, and services reportable outside of the per diem coverage are:

1. Oxygen
2. Enteral or parenteral nutrition meeting the criteria found in [Chapter 8-9 Nutrition general](#)
3. Prosthetic devices to include:
  - a) Artificial legs
  - b) Artificial arms
  - c) Artificial eyes

- d) Special braces
- 4. Equipment approved by Medicaid for individual members. This equipment is currently limited to:
  - a) Air or water flotation beds
  - b) Mattresses or overlays for the treatment of decubitus ulcers
  - c) Power wheelchairs
  - d) CPAP/Bi-PAP machine
  - e) Customized wheelchairs meeting the criteria outlined in the Utah Medicaid definition
  - f) Negative pressure wound therapy equipment and supplies

## **8-6 Purchases and rentals**

DME may be available for purchase, capped rental, or continuous rental. Items identified as capped rental or continuous rental must be reported with a correct modifier. Failure to use the correct modifier will result in denial of the submitted claim.

### **8-6.1 Purchased equipment**

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

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

### **8-6.2 Capped rental**

Certain DME is reimbursable as a capped rental. After 12 consecutive months, Medicaid considers the equipment to be paid in full and owned by the member.

If there is an interruption of 60 consecutive days or more during the capped rental period, and the equipment is returned to the provider. In that case, a new 12-month rental period will begin if reordered at a later date.

Providers must submit claims for capped rental DME with an LL modifier on the claim.

### 8-6.3 Continuous rental

Providers may furnish limited specialized equipment to the member on a permanent rental basis as indicated in the coverage policy.

The continuous rental rate includes maintenance and backup equipment if needed.

Providers must submit claims for continuous rental DME with an RR modifier.

### 8-7 Incontinence products

Incontinence products are covered for traditional Medicaid members with documentation supporting 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.

1. members on traditional Medicaid programs - 156 per 30-day period
2. members on a waiver program do not have a quantity limit

Incontinence supplies are not covered for normal infant use.

### 8-8 Urinary catheters

Refer to the [Coverage and Reimbursement Code Lookup](#) for specific coverage information by HCPCS code.

A coude tip catheter is considered medically necessary for male or female members only when the member cannot use a straight tip catheter.

### 8-9 Nutritional services

Medical foods, enteral formula, and parenteral formula are covered services when medically necessary. When reporting or requesting medical foods or enteral formula, providers must ensure the appropriate HCPCS code is used and is listed as covered in the [Coverage and Reimbursement Code Lookup](#). Medicaid uses the [Pricing, Data Analysis and Coding \(PDAC\)](#) to ensure the appropriate HCPCS code is requested for each product.

As a primary payor to the Utah Women, Infants and Children (WIC) Program, Medicaid covers medically necessary nutritional services. When nutritional services are non-covered, providers are encouraged to direct members to WIC when the member meets the criteria for receiving WIC benefits. Members younger than five years of age or pregnant are eligible for the WIC program.

Medical foods and enteral formulas require prior authorization for members 21 years old and older. Quantity limits control the associated supplies and equipment.

Requests for enteral formula and medical foods must include the following documentation:

1. A physician's order includes:
  - a) Diagnosis(es)
  - b) Product name
  - c) Total daily prescribed intake amount (e.g., ml, gram, etc.)
  - d) Daily frequency of ingestion
  - e) Duration or period the product is to be used (e.g., days, weeks, months, etc.)
  - f) Height and weight of the member
    - i. History regarding significant changes should be included.
2. Documentation supporting medical necessity
  - a) If less expensive nutritional products are available, documentation to justify the costlier product.

### **8-9.1 Donor human milk**

Medicaid coverage for human donor 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.

The member must meet the following criteria:

1. Member is Medicaid eligible and age birth through 11 months
2. The requesting prescriber is the infant's treating practitioner
3. Completed feeding trial
4. The requesting prescriber has addressed with the parent or guardian the benefits and risks of using donated milk. Refer to the FDA for additional information on the Use of Donor Human Milk

5. The prescriber has given the parent or guardian information concerning donor screening, pasteurization, milk storage, and transport of the donated milk
6. An informed consent signed and dated by the parent or guardian, outlining the risks and benefits using banked donor human milk
  - a) Prior authorization obtained
7. The request must be resubmitted every 180 days
8. To request a PA, the infant's treating physician will submit:
  - a) Request for Prior Authorization Form
  - b) Donor Human Milk Request Form
  - c) 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

### **8-9.2 Total nutrition by enteral tube**

Total nutrition by enteral tube is covered when a member receives 90% or more of their daily nutritional requirements via an enteral tube. Members weaning from total enteral tube feedings are covered for three months and then transition to the supplemental nutrition policy.

Enteral formula is non-covered for members under one year of age. An exception to this policy is found under Chapter 8-9.4, Inborn errors of metabolism.

### **8-9.3 EPSDT oral and supplemental enteral nutrition:**

The policy for EPSDT eligible members requiring oral nutrition or supplemental enteral nutrition requires the member to have one of the following medical conditions:

1. Acquired Immune Deficiency Syndrome (AIDS),
2. Malnutrition/malabsorption because of a stated primary diagnosed disease and being in a wasting state
  - a) Have a Weight for Length (WFL)  $\leq$ 5th percentile for three years of age or under
  - b) Body Mass Index (BMI)  $\leq$ 5th percentile (ages 4-17)

- c) BMI  $\leq$ 18.5 percentile (ages 18-20)
- d) 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
- 3. Metabolic disorders requiring a specialized nutrition product
- 4. Cancer
  - a) Receiving chemotherapy or radiation therapy
  - b) Up to 3 months following completion of chemotherapy or radiation therapy
- 5. Chronic renal failure
- 6. Decubitus pressure ulcers
  - a) Stage three or greater
  - b) Stage two with documentation that member is malnourished
- 7. Maintenance patients with an increase of less than 10 BMI percentile points or an increase of less than 2 BMI in the past year

Medical foods or enteral formulas are not covered as calorie packing options or used to treat failure to thrive, inadequate growth, or weight gain.

Oral or supplemental enteral nutrition is non-covered for adults 21 years of age or older except for members with inborn errors of metabolism. Refer to Chapter 8-9.4, Inborn errors of metabolism, for additional information.

#### **8-9.4 Inborn errors of metabolism**

Enteral formula and medical foods for the treatment of inborn errors of metabolism are covered services. Both services are covered for members under one year of age. Reporting of these services is limited to the following:

1. Members 21 years or older should report the following code regardless of delivery method.
  - a) B4157 - Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
2. EPSDT members receiving enteral formula or medical foods for the



treatment of inborn errors of metabolism are reported with the following:

- a) B4162 - Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
- b) S9435- Medical foods for inborn errors of metabolism.

Specific medical food coverage information is found in the [Coverage and Reimbursement Code Lookup](#).

### **8-9.5 Nutritional products and residents of long-term care facilities**

When criteria are met, parenteral solutions and total enteral therapy administered through a tube are covered for members residing in long-term care facilities.

Covered supplies include:

1. Parenteral solutions
2. A monthly parenteral nutrition administration kit which includes all catheters, pump filters, tubing, connectors, and syringes relating to the parenteral infusions
3. Enteral solution for total enteral therapy given by tube and includes all supplies

### **8-9.6 Parenteral therapy**

Specific coverage information is found in the [Coverage and Reimbursement Code Lookup](#).

### **8-9.7 Coverage limitations for nutritional products**

Oral nutritional supplements for adults are not a Medicaid benefit except for members with inborn errors of metabolism.

Enteral formula is not covered for members under one year of age, as most enteral products are breast milk substitutes.

## 8-10 Prosthetic and orthotic devices

Providers can find code coverage for prosthetic and orthotic devices on the Medicaid [Coverage and Reimbursement Code Lookup](#).

## 8-11 Speech generating devices (SGD) and augmentative alternative communication devices (AAC)

Medicaid covers SGD and AAC. Coverage of this equipment is determined using evidence-based criteria.

Further information regarding code coverage for SGDs and AACs can be found on the Medicaid [Coverage and Reimbursement Code Lookup](#).

## 8-12 Oxygen and respiratory related equipment

The oxygen benefit comes in four forms:

1. Oxygen concentrator with backup oxygen supply
2. Stationary gaseous oxygen system
3. Portable gaseous oxygen
4. Liquid oxygen

### 8-12.1 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 MCE in a non-mandatory county. See [Section I: General Information](#) for county-specific information.

### 8-12.2 Stationary gaseous oxygen system

Gaseous oxygen systems require PA and may be delivered by any willing Medicaid DME provider. Coverage of a stationary gaseous oxygen system is limited to the following circumstances:

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

3. When the member requires a flow rate higher or lower than the capacity of an oxygen concentrator.

### **8-12.3 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 PA.

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

### **8-12.4 Liquid oxygen systems**

Liquid oxygen systems 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 or contents may be approved only when:

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

See [Chapter 11-2](#) Billing for claim submission of liquid oxygen.

### **8-12.5 Ventilators**

Information regarding code coverage for ventilators can be found on the Medicaid [Coverage and Reimbursement Code Lookup](#).

## **8-13 Monitoring equipment**

### **8-13.1 Blood glucose monitors**

Blood glucose monitors are available to Medicaid members through the pharmacy benefit. Members can obtain blood glucose monitors from the manufacturers of preferred test strips from a pharmacy. For additional information, refer to the [Pharmacy Manual](#).

Blood glucose monitors available through DME services are limited to those with special features (e.g., voice synthesizers) and must be medically necessary for an individual member. These are approved on a case-by-case basis and require PA.

## **8-14 Wheelchairs**

### **8-14.1 General information**

When requesting a wheelchair:

1. Providers are required to demonstrate medical necessity per [Utah Administrative Code R414-1-2\(18\)](#) and the [Utah Medicaid Provider Manual, Section I: General Information Chapter 8 Medical necessity](#).
2. Wheelchairs, accessories, attachments, components, and options require PA or have a quantity limit.
  - a) PA requests are evaluated using evidence-based criteria.
  - b) PA requests will not be approved when a member owns an appropriate wheelchair that meets medical necessity.
3. Maintain documentation of physician orders within the DME provider's member record.

Wheelchairs are limited to one every five years and are not replaceable until the member's current wheelchair no longer meets medical necessity.

The member owns wheelchairs purchased by Medicaid.

The provider cannot submit claims to Medicaid until the wheelchair and all related items have been received and signed for by the member or their authorized representative.

In addition to criteria outlined within Chapter 3-5 Wheelchairs, wheelchair requests are considered using evidence-based criteria.

### **8-14.2 Wheelchair evaluation forms**

When requesting a wheelchair, DME providers must:

1. complete and submit the required wheelchair evaluation forms
2. submit the applicable form(s) with the PA request
3. maintain the original wheelchair evaluation forms within the DME provider member record

#### *Wheelchair Initial Evaluation Form*

1. required as part of the wheelchair PA request
2. completed before requesting a wheelchair
3. performed by a physician, licensed physical therapist, or licensed occupational therapist

#### *Wheelchair Final Evaluation Form*

1. required for claims related to power wheelchairs, ultra-lightweight wheelchairs, and manual wheelchairs equipped with tilt in space
  - a) when a claim is submitted without a properly executed Wheelchair Final Evaluation Form, the entire claim will be denied
  - b) for claims submission, the provider must fax this form to 801-536-0481
2. completion of the form must be within ten business days from the date of delivery
3. forms that contain a checkbox marked as "NO" or an unanswered question will be denied as incomplete
4. a caregiver is permitted to sign the form when the member is incapable of signing for themselves due to medical-related reasons
  - a) a caregiver is any person working or living with the member in their place of residence while assisting with ADLs or MRADLs in addition to ongoing care
  - b) a caregiver is not:
    - i. an evaluating therapist
    - ii. an evaluating or ordering provider
    - iii. an ATP
    - iv. a vendor delivering the equipment
    - v. any person whose signature is used elsewhere on the form

### *Wheelchair Training Checklist (Power Wheelchair)*

1. required as part of the power wheelchair PA request
2. performed by a physician, licensed physical therapist, or licensed occupational therapist

The wheelchair evaluation forms are located at [Utah Medicaid Forms](#).

### **Reporting evaluations**

Licensed physical and occupational therapists should report evaluations with the following CPT codes:

1. 97535 - Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes, or
2. 97542 - Wheelchair management (e.g., assessment, fitting, training), each 15 minutes

The wheelchair evaluations include completion of Wheelchair Initial Evaluation Form, Wheelchair Final Evaluation Form, and Wheelchair Training Checklist (Power Wheelchair) Form.

#### **8-14.3 Manual wheelchair**

Manual wheelchairs require the member:

1. has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair, or
2. has a caregiver who is available, willing, and able to assist with the wheelchair

Wheelchairs identified with HCPCS codes E1161 and K0005 must be provided by a supplier who employs a RESNA-certified Assistive Technology Professional (ATP) and has direct, in-person involvement in the wheelchair selection for the member.

#### **8-14.4 Power wheelchairs**

Power wheelchairs must be provided by a supplier who employs a RESNA-certified Assistive Technology Professional (ATP) and who has direct, in-person involvement in the wheelchair selection for the member.

1. Power wheelchair coverage requires the member does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair, and
  - a) has the mental and physical capabilities to operate the power wheelchair safely, or
  - b) The member is unable to use the power wheelchair safely and has a caregiver who is unable to propel an optimally configured manual wheelchair adequately but is available, willing, and able to operate the power wheelchair safely, and
  - c) weighs less than or equal to the weight capacity of the power wheelchair and greater than or equal to 95% of the weight capacity of the next lower weight class power wheelchair, and
  - d) use of a power wheelchair will significantly improve the member's ability to participate in MRADLs
  - e) for members with severe cognitive or physical impairments, participation in MRADLs may require the assistance of a caregiver.

#### **8-14.5 Accessories, attachments, components, and options**

Listed accessories, attachments, components, and options require meeting the following criteria.

1. Nonstandard seat frame dimensions
  - a) a nonstandard seat width or depth outside of standard wheelchair seating description requires the member's physical dimensions to justify the need
2. Wheels and tires for manual wheelchairs
  - a) a gear reduction drive wheel requires the member has been self-propelling in a manual wheelchair for at least one year
3. Power tilt and or recline seating systems

- a) a power seating system tilt only, recline only, or combination tilt and recline with or without power elevating leg rests require the member meets all the coverage criteria for a power wheelchair described in [Chapter 8-14.4 Power wheelchairs](#), and:
  - i. is unable to perform a functional weight shift, or
  - ii. utilizes intermittent catheterization for bladder management and is unable to transfer from the wheelchair to bed independently, or
  - iii. the power seating system is needed to manage increased tone or spasticity
4. Power wheelchair drive control systems
  - a) an attendant control may be covered when:
    - i. in place of a member-operated drive control system if the member meets coverage criteria for a wheelchair, and
    - ii. is unable to operate an optimally configured manual or power wheelchair, and
    - iii. the caregiver, who is unable to operate an optimally configured manual wheelchair, can safely operate a power wheelchair
5. Transit systems
  - a) when a member utilizes personal or public transportation for their transit needs, coverage of this equipment is considered medically necessary
  - b) transit systems are not covered for members residing in long-term care facilities or for members who utilize Medicaid non-emergency medical transportation broker as their primary source of transportation
6. Miscellaneous accessories
  - a) anti-rollback devices require the member to self-propel and use wheelchair ramps
  - b) safety belt/pelvic strap requires the member to have weak upper body muscles, upper body instability, or muscle spasticity, which requires the use of this item for proper positioning
  - c) manual fully reclining back option requires the member to have one or more of the following conditions:
    - i. is at high risk for the development of a pressure ulcer and is unable to perform a functional weight shift, or



- ii. utilizes intermittent catheterization for bladder management and is unable to transfer from the wheelchair to the bed independently

Criteria for equipment identified using an HCPCS code with the terms miscellaneous or not otherwise specified can be found in [Chapter 12-3 Healthcare Common Procedure Coding System \(HCPCS\) Miscellaneous Codes](#)

### Table A

Coverage of equipment in Column I (base equipment) includes items in Column II (add-on equipment). Equipment in Column II that is medically necessary must be provided to the member at the time of initial issue of equipment found in Column I. For equipment not identified within the table, use the standard process for requesting wheelchair-related items.

Column I	Column II
Manual Wheelchair E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007	E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2224, E2225, E2226, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072, K0077
Power Wheelchair Group 2 K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0040, K0041, K0042, K0043, K0044,

	K0045, K0046, K0047, K0051, K0052, K0077, K0098
Power Wheelchair Groups 3 & 5 K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0858, K0860, K0861,	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017
K0862, K0863, K0864, K0890, K0891	K0018, K0019, K0037, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0077, K0098
Adjustable height, detachable armrest, complete assembly E0973	K0017, K0018, K0019
Tray E0950	E1028
Foot box, any type, includes attachment and mounting hardware, E0954	E1028
Elevating, complete assembly E0990	E0995, K0042, K0043, K0044, K0045, K0046, K0047
Power tilt and/or recline seating systems E1002, E1003, E1004, E1005, E1006, E1007, E1008	E0973, K0015, K0017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
Leg elevating systems E1009, E1010, E1012	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
Sip and puff E2325	E1028

Residual limb support system E1020	E1028
Leg strap, H style K0039	K0038
Footrest, complete assembly, replacement only K0045	K0043, K0044
Elevating leg rest, lower extension tube, replacement only K0046	K0043
Elevating leg rest, upper hanger bracket, replacement only K0047	K0044
Elevating footrests, articulating (telescoping) K0053	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047
Rear wheel assembly, complete, with solid tire, spokes or molded, replacement only K0069	E2220, E2224
Rear wheel assembly, complete, with pneumatic tire, spokes or molded, replacement only K0070	E2211, E2212, E2224
Front caster assembly, complete, with pneumatic tire, replacement only K0071	E2214, E2215, E2225, E2226
Front caster assembly, complete, with semi-pneumatic tire, replacement only K0072	E2219, E2225, E2226

Front caster assembly, complete, with solid tire, replacement only K0077	E2221, E2222, E2225, E2226
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#### **8-14.6 Members residing in long-term care facilities**

Wheelchairs are part of the per diem rate for members residing in long-term care facilities when the equipment provided is identified with HCPCS codes K0001-K0004, K0006, and K0007.

Manual wheelchairs that meet the Medicaid definition of a customized manual wheelchair may be reported outside the per diem rate.

For further details regarding wheelchair coverage for members residing in long-term care facilities, refer to the [Utah State Plan, Attachment 4.19-D](#) Section 400 Routine Services.

### **8-15 Equipment service requirements**

#### **8-15.1 General equipment service requirements information**

Maintenance, repairs, and replacements are services for medically necessary equipment and are covered benefits when criteria for services are met. Reimbursement of services may not include payment for parts and labor covered under warranty.

Requirements for all services include:

1. A physician order
2. Prior authorization
3. Equipment is a Medicaid-covered benefit
4. The member owns equipment
5. The member is using equipment

#### **8-15.2 Maintenance**

Maintenance is a covered service.

Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment, is not covered.

Upon receiving equipment, the member should be given an operating manual that describes the servicing an owner may perform to maintain the equipment properly. It is expected that a member or caregiver will perform this maintenance.

When requesting PA for maintenance, providers must use the MS modifier with the equipment's designated HCPCS code. Maintenance claims cannot be submitted until six months after the capped rental period and can only be submitted once every six months after that.

Maintenance includes the technician time and supplies used to keep the equipment operating correctly.

### **8-15.3 Repairs**

Repairs are covered when required to make equipment operable and will not exceed the cost of replacement.

The equipment warranty must be expired before Medicaid will cover repairs.

Documentation of repairs must be maintained in the member's record.

Medical necessity for repairs to equipment is established if Medicaid covered the item.

When Medicaid did not initially cover equipment, repair requests must be submitted with a treating physician's statement that the equipment being repaired continues to be medically necessary, and the repair itself is medically necessary.

#### **Coding for repairs**

The following tables contain the allowed units of service per each item repaired. When coding for repairs submit documentation indicating each item to be repaired, e.g., right and left armrest. Units of service include basic

troubleshooting, problem diagnosis, testing, cleaning, screws, nuts, and bolts. One unit of service equals 15 minutes.

### Power/Manual Wheelchair

Equipment	Allowed Unit(s) of Service
Armrest/arm pad	1 (any type, per armrest/pad)
Arm trough, with or without hand support	1 (per arm trough)
Positioning belt/safety belt/pelvic strap	1 (any type, per belt)
Safety vest	1
Ratchet assembly	1

### Manual Wheelchair Only

Equipment	Allowed Unit(s) of Service
Anti-tipping device	1
Hand rim	1 (any type/per hand rim)
Push activated power assist	1
One arm drive attachment	1
Adapter for amputee	1 (any type/ per adapter)
Solid seat insert	1
Wheel lock brake extension (handle)	1 (per handle)
Wheel lock assembly, complete, each	1 (any type, per assembly)
Wheel braking system and lock, complete, manual, disc brakes	1 (any type, per brake)
Anti-rollback device, each	1 (any type, per device)

### Power Wheelchair Only

Equipment	Allowed Unit(s) of Service
Joystick (programming not covered)	1

Harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware	2
Electronic connection between wheelchair controller, power seating system motors (any number of motors), includes all related electronics, including fixed hardware	2 (any type, per connection)
Power controllers or actuators	2 (any type)
Power w/c accessory, electronic interface to operate speech generating device using control interface	2
Charger	1
Drive wheel motors (single/pair)/gearbox and combos	2 single/ 3 pair
Drive belt	2

### Leg and Footrests

Equipment	Allowed Unit(s) of Service
Elevating leg rest, complete assembly	1 (any type, per leg rest)
Calf rest/pad	1 (any type, per pad)
Leg rest parts	1 (any type, per leg rest)
Cam release assembly, footrest or leg rests	1

### Headrest

Equipment	Allowed Unit(s) of Service
Replace headrest assembly	1 (any type, includes removal of previous)
Replace headrest pad	1 (any type)
Headrest extension	1 (any type)

### Miscellaneous

Equipment	Allowed Unit(s) of Service

Wheelchair tray	1
Heel loop/holder	1
Toe loop/holder	1
Foot box, any type, includes attachment and mounting hardware	1 (any type/ per foot)
Lateral trunk or hip support	1 (any type, including fixed mounting hardware, per side)
Lateral thigh or knee support, any type, including fixed mounting hardware	1 (any type, per side)
Medial thigh support	1 (any type, including fixed mounting hardware/per side)
Shoulder harness/straps or chest straps, including	1 (any type, includes mounting hardware)
Narrowing device	1 (any type)
Shock absorber manual/power	1 (any type, per side)
Residual limb support system for	1 (any type, per side)
Manual swing-away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	2
Ventilator tray fixed or gimbaled	2

### Seating Systems

Equipment	Allowed Unit(s) of Service
Power seating system, tilt only	2
Power seating system, recline only, without shear reduction	2
Power seating system, recline only, with mechanical shear reduction	2
Power seating system, recline only, with power shear reduction	2



Power seating system, combo tilt and recline without shear reduction	3
Power seating system, combo tilt and recline, with mechanical shear reduction	3
Power seating system, combo tilt and recline with power shear reduction	3
Addition to power seating system, mechanically linked leg elevation system including pushrod and leg rest	1 (per side)
Manual w/c nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches	2
Manual wheelchair nonstandard seat frame width, 24-27 inches	2
Manual wheelchair nonstandard seat frame depth, 20 to less than 22 inches	2
Manual wheelchair nonstandard seat frame depth, 22 to 25 inches	2
Manual wheelchair solid seat support base (replaces sling seat)	2 (includes any type mounting hardware)
Back, planar or contoured, for pediatric size wheelchair	2 (including fixed attaching hardware)
Seat, planar or contoured, for pediatric size wheelchair	2 (including fixed attaching hardware)
Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features	2
Power wheelchair accessory, nonstandard seat frame widths, depths	2
Cushions, positioning, seat	2 (any type)
Cushions, positioning, backs	2 (any type)

Seat height <17" or equal to or greater than 21" for a high strength, lightweight, or ultra-lightweight wheelchair	2
Semi-recline back and fully recline	2

### Oxygen

Equipment	Allowed Unit(s) of Service
CPAP/Bi-PAP (blower assembly)	2

### Hospital Beds

Equipment	Allowed Unit(s) of Service
Head/foot board	2
Pendent	2

### Lifts

Equipment	Allowed Unit(s) of Service
Hydraulic pump	2

Repairs require using the appropriate code with the number of units required:

1. K0739 - Repair or non-routine service for DME other than oxygen requiring the skill of a technician, labor component, per 15 minutes
2. K0740 - Repair or non-routine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes

Note: For hearing aid repairs, refer to the [Speech-Language Pathology and Audiology Services Provider Manual](#) and the [EPSDT Services Manual](#).

#### 8-15.4 Replacements

Equipment may be replaced if medically necessary or the item is lost, stolen, or damaged beyond repair.

Documentation supporting the need for the replacement of equipment will be maintained in the supplier's member record.

When submitting a claim for replacement, providers must use the appropriate modifier.

1. RA - Replacement of a DME item, due to loss, irreparable damage or when item has been stolen
2. RB – Replacement of a DME item as part of a repair

#### **8-15.5 Warranties**

1. A provider must notify a member of warranty coverage and honor all warranties.
2. A provider must not charge the member or the Medicaid program for services covered under warranty.
3. Record of the warranty must be retained in the member's record with the DME provider.

#### **8-15.6 Medical device recalls**

In the event of a medical device recall, the DME provider shall coordinate with the member and the manufacturer to return the defective DME and replace the item as needed. If the medical device is a continuous rental item, the device should be replaced with a suitable device that will meet the medical needs of the member.

If the medical device has been purchased, either as a one-time purchase or after a 12-month capped rental period, the DME provider is responsible for the following actions:

1. Register the device for repair or replacement
2. Furnish a replacement device during the period required for the manufacturer to repair or replace the device; and
3. Replace the equipment at no charge to the Medicaid program or member if the equipment doesn't last for the entire 5-year reasonable useful lifetime.

## **9 Non-covered services**

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

1. Equipment permanently attached or mounted to a building or a vehicle, including ramps, lifts, and bathroom rails.
2. Sacro-lumbar or dorsal lumbar corset type supplies are not considered prosthetic devices or special appliances.

## 10 Prior authorization

Prior authorization (PA) is required for certain equipment and supplies. Information regarding PA can be found in [Section I: General Information](#), Chapter 10, Prior authorization.

### 10-1 Medicare and prior authorization

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

Refer to [Section I: General Information](#), Chapter 11-5.1 Medicare crossover claims for further details.

### 10-2 Retroactive authorization

Refer [Section I: General Information](#), Chapter 10-3, Retroactive authorization.

### 10-3 Transition of care

When equipment or supplies are prior authorized for purchase and ordered for a member, and the member is then enrolled in another plan (MCE or fee for service) before receiving the equipment, the plan that prior authorized the item is responsible for adjudicating the claim.

## 11 Billing

Refer to [Section I: General Information](#), Chapter 11 Billing Medicaid.

### 11-1 Returned medical supplies or DME

If a member returns equipment or supplies purchased with a Medicaid card, a cash refund must not be given to the member. The provider must refund the reimbursement to Medicaid or call the Office of Medicaid Operations, Medicaid claims team and request the claim be reversed.

## 11-2 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 submitted through the appropriate DME provider who is responsible to obtain appropriate PA.

## 12 Coding

### 12-1 Repairs

See [Chapter 8-15.3 Repairs](#) Coding for repairs of this document for information related to coding for repairs.

### 12-2 Wheelchair evaluations

See [Chapter 8-14.2 Wheelchair evaluation forms](#) reporting evaluations of this manual for information related to coding wheelchair related evaluations.

### 12-3 Healthcare Common Procedure Coding System (HCPCS) miscellaneous codes

For the purposes of this manual, HCPCS codes using the terms miscellaneous or not otherwise specified are considered miscellaneous codes.

Equipment or supplies not described by a specific HCPCS code may be submitted using a miscellaneous code.

Equipment or supplies submitted with a miscellaneous code require PA.

PA requests for miscellaneous equipment or supplies is contingent upon documentation supporting the provider's actual acquisition cost, a picture of the equipment or supply, and medical necessity.

## 12-4 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 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	

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12	L8420	RT	LT
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Incorrect

### Example 2 - Unilateral use

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

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

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

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

Incorrect	12	L8420		
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## 13 Resource table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

For information regarding:	
Administrative Rules	<a href="#">Utah Administrative Code Table of Contents Rule R414-1. Utah Medicaid Program.</a> <a href="#">Utah Administrative Rule R414-70 Medical Supplies, Durable Medical Equipment, and Prosthetic Devices.</a>
General information including: Billing fee for service and managed care Member eligibility Prior authorization Provider participation	<a href="#">Section I: General Information</a> <a href="#">Claims</a> <a href="#">Managed Care: Accountable Care Organizations</a> <a href="#">Utah Medicaid Prior Authorization</a>  Administrative Rules <a href="#">Eligibility Requirements. R414-302.</a> <a href="#">Medicaid General Provisions. R414-301</a> <a href="#">Program Benefits and Date of Eligibility. R414-306.</a> <a href="#">Utah Medicaid Program. R414-1.</a>
Information including: Coverage and reimbursement resources National correct coding initiative Procedure codes with accompanying criteria and limitations	<a href="#">Office of Coverage and Reimbursement Policy</a> <a href="#">Coverage and Reimbursement Code Lookup</a> <a href="#">The National Correct Coding Initiative in Medicaid</a>
Information including policy and rule updates: Medicaid Information Bulletins (Issued bimonthly),	<a href="#">Utah Medicaid Official Publications</a> <a href="#">Utah State Bulletin</a>

Medicaid Provider Manuals, Utah State Bulletin (Issued on the 1 <sup>st</sup> and 15 <sup>th</sup> of each month)	
Medicaid forms including: PA Request Utah Medicaid Initial Wheelchair Evaluation Form Utah Medicaid Final Wheelchair Evaluation Form Utah Medicaid Power Wheelchair Training Checklist	<a href="#">Utah Medicaid Forms</a>
Medical supplies and DME	<a href="#">Medical Supplies and Durable Medical Equipment Provider Manual</a> <a href="#">Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.</a>
Patient (Member) Eligibility Lookup Tool	<a href="#">Eligibility Lookup Tool</a>
Prior authorization	<a href="#">Prior Authorization Form</a> <a href="#">Utah Medicaid Prior Authorization</a>
Provider portal access	<a href="#">Provider Portal Access</a>
Provider training	<a href="#">Utah Medicaid Provider Training</a>
References including: Social Security Act Code of Federal Regulations Utah Code	<a href="#">42 CFR 440.50</a> <a href="#">42 CFR 440.120(C)</a> <a href="#">42 CFR 441.15</a> <a href="#">42 CFR 414 subpart D and subpart F</a>



	<a href="#">Social Security Act 1905(a)</a> <a href="#">Social Security Act 1861 (r)</a> <a href="#">Utah Annotated Code Title 58</a>
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