

Title 23: Division of Medicaid

Part 209: Durable Medical Equipment and Medical Supplies

Chapter 1: Durable Medical Equipment

Rule 1.4: Reimbursement

- A. The Division of Medicaid covers Durable Medical Equipment (DME). [Refer to Miss. Admin. Code Part 207 for DME coverage in a long-term care facility.]
- B. The Division of Medicaid requires certification requests be submitted prior to or within thirty (30) days of delivery of the DME. The Division of Medicaid does not allow the beneficiary to be billed if the DME provider chooses to deliver the item/service prior to submitting a certification request and approval is not given.
- C. All standard DME, excluding custom motorized/power wheelchair systems, must have a manufacturer's warranty of a minimum of one (1) year.
 1. If the provider supplies equipment that is not covered under a warranty, the provider is responsible for any repairs, replacement or maintenance that may be required within one (1) year.
 2. The warranty begins on the date of the delivery to the beneficiary.
 3. The DME provider must keep a copy of the warranty and repair information in the beneficiary's file.
 4. The Division of Medicaid reserves the right to request copies of the warranty and repair information for audit/review purposes when necessary.
 5. The Division of Medicaid investigates cases suggesting malicious damage, neglect, or wrongful misuse of the equipment. If the provider suspects such damage of equipment, the provider should report it immediately to the Division of Medicaid for investigation and notify the beneficiary that the cost for repairs/replacement may be the responsibility of the beneficiary if the Division of Medicaid determines malicious damage, neglect, or wrongful misuse of the equipment.
 6. DME suppliers must provide a two (2) year warranty of the major components for custom motorized/power wheelchairs.
 - a) The main electronic controller, motors, gear boxes, and remote joystick must have a two (2) year warranty from the date of delivery.
 - b) Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects, if the surface does not remain intact due to normal wear.

- c) Powered mobility bases must have a lifetime warranty on the frame against defects in material and workmanship for the lifetime of the beneficiary.
 - d) If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the provider is responsible for any repairs, replacement or maintenance that may be required within two (2) years.
 - e) The warranty begins the date of delivery to the beneficiary.
- D. The Division of Medicaid covers repairs, including labor and delivery, of DME that is owned by the beneficiary not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.
- 1. DME suppliers providing custom wheelchairs, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8) a.m. and five (5) p.m. Monday through Friday. Each technician must keep, on file, records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.
 - 2. The Division of Medicaid requires prior authorization from the Utilization Management/Quality Improvement Organization UM/QIO for the repair and must include an estimated cost of necessary repairs, including labor, and a statement from the practitioner stating that there is a continued need for the equipment.
 - 3. Labor and delivery charges are included in the repair cost and are not covered separately.
 - 4. The Division of Medicaid does not cover repair of a rental item.
 - 5. The Division of Medicaid does not cover repairs when it has been determined that the equipment has been abused or neglected by the beneficiary, caregiver or family.
 - 6. The Division of Medicaid covers, under extenuating circumstances as determined by the UM/QIO, rental of an item on a short-term basis while equipment owned by the beneficiary is being repaired.
- E. The Division of Medicaid covers the replacement of DME necessitated by wear, theft, irreparable damage, or loss by disasters only if there is sufficient documentation that warrants the need for replacement.
- 1. The Division of Medicaid covers for replacement every three (3) years if the item cannot be repaired, and if it is more cost effective to replace it. The Division of Medicaid covers, under extenuating circumstances, requests to replace items at a lesser frequency on an individual consideration basis.

2. The Division of Medicaid covers replacement of power wheelchairs, hospital beds, and ventilators at a minimum of every five (5) years, unless there are extenuating circumstances.
 3. The Division of Medicaid requires a report from law enforcement or a fire department in cases of theft or fires.
 4. The Division of Medicaid covers the purchase of DME when it is determined by the UM/QIO to be more economical than renting and when the period of need is estimated by the physician to be ten (10) or more months.
- F. The Division of Medicaid covers rental of equipment up to ten (10) months, or up to the purchase price, whichever is the lesser.
1. After rental benefits are paid for ten (10) months, the DME becomes the property of the beneficiary, unless otherwise authorized by Medicaid through specific coverage criteria.
 2. There cannot be sales tax on “rental only” items as there is no sale or purchase.
 3. A trial period for equipment must be applied toward the ten (10) month rental.
 4. The rental allowance includes the equipment, delivery, freight and postage, set-up, all supplies necessary for operation of the equipment, education of the patient and caregiver, all maintenance and repairs or replacement, labor including respiratory therapy visits, and servicing charges.
- G. The Division of Medicaid defines a trial period as the time required to assess the effectiveness and beneficiary compliance.
1. The initial trial period may be waived for the replacement of an identical or existing piece of equipment.
 2. The Division of Medicaid applies the rental fees paid for any trial period toward the maximum reimbursement for purchase.
 3. The Division of Medicaid does not cover a rental trial period in addition to the full purchase price.
 4. The DME item must be returned to the DME provider after it is no longer required, if the rental period is less than ten (10) months.
- H. The Division of Medicaid covers DME at the lesser of the provider charge or the Medicaid allowable fee. Medicaid allowable fees are set as follows:
1. Purchased items are set at eighty percent (80%) of the Medicare fee.

2. Rental items are set at ten percent (10%) of the Medicaid allowable fee.
 3. Used DME and repairs are set at fifty percent (50%) of the Medicaid allowable.
- I. The Division of Medicaid manually prices items that do not have a Medicaid allowable fee.
1. The UM/QIO performs the manual pricing of the item.
 2. When requesting manually priced items, the DME provider must indicate the name of the product, the product number, and the name of the manufacturer or distributor and must provide the required documentation for pricing.
 3. The Division of Medicaid uses two (2) methods for manual pricing:
 - a) Most manually priced items are priced at the Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%).
 - 1) It is expected that most items will have a retail price; therefore, providers should request MSRP pricing for all manually priced items unless there is absolutely no retail price.
 - 2) Other acceptable terms that represent MSRP include suggested list price, retail price, or price.
 - 3) The provider must submit clear, written, dated documentation from a manufacturer or distributor that specifically states the MSRP for the item. This documentation must be provided with an official manufacturer's or distributor's letterhead, price list, catalog page, or other forms that clearly show the MSRP.
 - 4) A manufacturer's or distributor's quote may be substituted for an MSRP if the manufacturer does not make an MSRP available. The quote must be in writing from the manufacturer or distributor and must be dated.
 - b) Items that do not have a fee or MSRP may be priced at the provider's cost plus twenty percent (20%).
 - 1) The provider must attach a copy of a current invoice indicating the cost to the provider for the item dispensed and a statement that there is no MSRP available for the item.
 - 2) If the provider purchases from the manufacturer, a manufacturer's invoice must be provided.
 - 3) If the provider purchases from a distributor and not directly from the manufacturer, the invoice from the distributor must be provided.

- 4) Quotes, price lists, catalog pages, computer printouts, or any form of documentation other than an invoice are not acceptable for this pricing solution.
- 5) The invoice must not be older than one (1) year prior to the date of the request. Exceptions to the one (1) year requirement may be approved only for unusual circumstances.

J. [Reserved]

K. [Reserved]

Source: Social Security Act § 1834(a); Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 209, Rule 1.4.A, D.1, J., and K. eff. 01/02/2015.

Rule 1.47: Wheelchairs

- A. The Division of Medicaid defines a wheelchair as a seating system that is designed to increase the mobility of beneficiaries who would otherwise be restricted by inability to ambulate or transfer from one place to another.
- B. The Division of Medicaid covers wheelchairs for all beneficiaries when ordered by the appropriate medical professional, is medically necessary and prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO) for rental up to purchase amount or for purchase as follows:
 1. The provider must fully assess the beneficiary's needs and must ensure that the prescribed wheelchair is adequate to meet those needs, including measuring to ascertain proper height, width and weight and providing an automatic or special locking mechanism for those who are unable to apply manual brakes to prevent falls.
 2. The beneficiary, family or caregiver and supplying vendor must be present for the wheelchair assessment. It is also recommended that each of these people be present at the delivery of the wheelchair.
 3. At a minimum, all wheelchairs must include a seat, back, armrests (may be desk or full length, fixed or removable), leg rest (may be fixed, swing away detachable, or elevating), footplates, safety belts, anti-tipping device, wheels, and an appropriate type of wheel-locking mechanism, manual or automatic.
 4. A standard wheelchair is covered when the beneficiary's condition is such that without the use of a wheelchair, he/she would be otherwise bed or chair confined.
 5. An amputee wheelchair is covered if the beneficiary has had an amputation of one (1) or both lower extremities.

6. Hemi-wheelchairs are covered with appropriate documentation and medical necessity justification.
 7. A tilt-in-space wheelchair is one that maintains the congruency of the seat to back angle while tilting the patient in space.
- C. Standard manual wheelchairs with added accessories do not qualify as custom wheelchairs. Standard manual wheelchairs must be ordered by a physician, physician assistant or nurse practitioner.
1. A heavy duty standard manual wheelchair:
 - a) Is covered if the beneficiary meets the criteria for a standard manual wheelchair and meets one of the following criteria:
 - 1) Weighs more than two hundred fifty (250) pounds, or
 - 2) Body measurements do not conform to a standard manual wheelchair, or
 - 3) Has severe spasticity.
 - b) Documentation must include:
 - 1) Specific weight or measurements that cause the beneficiary to require this type chair, or
 - 2) The specific condition causing the beneficiary to be unable to function with a standard manual wheelchair.
 2. An extra heavy duty standard manual wheelchair:
 - a) Is covered if the beneficiary meets the criteria for a standard manual wheelchair and meets one of the following criteria:
 - 1) Weighs more than three hundred (300) pounds, or
 - 2) Body measurements do not conform to a standard wheelchair.
 - b) Documentation must include:
 - 1) Specific weight and measurements causing the beneficiary to be unable to function with a standard manual wheelchair, and
 - 2) Specific measurements causing the beneficiary to be unable to function with a standard manual wheelchair.

3. A high strength lightweight manual wheelchair is covered with appropriate documentation and medical necessity justification.
 4. A lightweight manual wheelchair:
 - a) Is covered if a beneficiary meets all of the following criteria:
 - 1) Meets the criteria for a standard manual wheelchair,
 - 2) Cannot self-propel in a standard manual wheelchair using arms and/or legs, and
 - 3) Is able to and does self-propel in a lightweight manual wheelchair.
 - b) Documentation must reflect the specific cause or condition that hinders the beneficiary from being able to function with a standard manual wheelchair.
 5. An ultra-light manual wheelchair is covered with the appropriate documentation of medical necessity.
 6. The Division of Medicaid defines a custom manual wheelchair as one uniquely constructed or substantially modified for a specific beneficiary. Custom manual wheelchairs must be ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist.
- D. Standard motorized/power wheelchairs with added accessories do not qualify as an individualized beneficiary specific custom motorized/power wheelchair. The Division of Medicaid covers standard motorized/power wheelchairs when all the following criteria are met:
1. Ordered by a physician, physician assistant, or nurse practitioner experienced in evaluating specialized needs for the purpose of prescribing motorized/power wheelchairs after a face-to-face examination of the beneficiary.
 2. Medically necessary with comprehensive documentation including, but not limited to:
 - a) That a manual wheelchair cannot meet the beneficiary's needs,
 - b) The beneficiary requires the motorized/power wheelchair for six (6) months or longer.
 - c) The beneficiary must:
 - 1) Be bed/chair confined and have documented severe abnormal upper extremity dysfunction or weakness.

- 2) Expect to have physical improvements or the reduction of the possibility of further physical deterioration, from the use of a motorized/power wheelchair or be for the necessary treatment of a medical condition.
- 3) Have a poor prognosis for being able to self-propel a functional distance in the future.
- 4) Not exceed the weight capacity of the motorized/power wheelchair being requested.
- 5) Have sufficient eye/hand perceptual capabilities to operate the prescribed motorized/power wheelchair safely.
- 6) Have sufficient cognitive skills to understand directions, such as left, right, front, and back, and be able to maneuver the motorized/power wheelchair in these directions independently.
- 7) Be independently able to move away from potentially dangerous or harmful situations when seated in the motorized/power wheelchair.
- 8) Demonstrate the ability to start, stop, and guide the prescribed motorized/power wheelchair within a reasonably confined area.
- 9) Be in an environment conducive to the use of the prescribed motorized/power wheelchair.
 - (a) The environment should have sufficient floor surfaces and sufficient door, hallway, and room dimensions for the prescribed motorized/power wheelchair unit to turn and enter/exit, as well as necessary ramps to enter/exit the residence.
 - (b) The environmental evaluation must be documented and signed by the beneficiary/caregiver and supplier for the prescribed motorized/power wheelchair.
 - (c) If the residential environment cannot accommodate the prescribed motorized/power wheelchair, the wheelchair is not covered.
- 10) Or the caregiver must be capable of maintaining the motorized/power wheelchair or be capable of having the motorized/power wheelchair repaired and maintained.
- 11) Have appropriate covered transportation for the prescribed motorized/power wheelchair.

3. The ordering practitioner must document:

- a) The face-to-face examination in a detailed narrative note in the beneficiary's chart and must clearly indicate that the reason for the visit was a mobility examination.
- b) Whether or not the beneficiary currently possesses a motorized/power wheelchair not previously purchased by the Medicaid program.
- c) And provide a certificate of medical necessity with comprehensive documentation that describes the medical reason(s) why a motorized/power wheelchair is medically necessary such that no other type of wheelchair can be utilized including, but not limited to:
 - 1) The diagnosis/co-morbidities and conditions relating to the need for a motorized/power wheelchair.
 - 2) Description and history of limitation/functional deficits.
 - 3) Description of physical and cognitive abilities to utilize equipment.
 - 4) History of previous interventions/past use of mobility devices.
 - 5) Description of existing equipment, age and specifically why it is not meeting the beneficiary's needs.
 - 6) Explanation as to why a less costly mobility device is unable to meet the beneficiary's needs.
 - 7) Description of the beneficiary's ability to safely tolerate/utilize the prescribed motorized/power wheelchair.
 - 8) The type of chair and each individual attachment required by the beneficiary.
4. An initial evaluation documented by a physical therapist (PT) or occupational therapist (OT), not employed by the DME supplier or the manufacturer, within three (3) months of the written prescription date to determine individualized needs of the beneficiary which includes whether the beneficiary currently possesses a motorized/power wheelchair not previously purchased by the Medicaid program.
5. An agreement documented by both the prescribing physician and the PT or OT performing the initial evaluation that the motorized/power wheelchair being ordered is appropriate to meet the needs of the beneficiary.
6. A subsequent evaluation documented after the delivery of the motorized/power wheelchair by a PT or OT, not employed by the DME provider or the manufacturer, to determine if the motorized/power wheelchair is appropriate for the resident's needs. The DME provider cannot bill the Division of Medicaid until the PT/OT documentation

verifies on the subsequent evaluation that the motorized/power wheelchair is appropriate for the resident's needs.

7. Documentation during the PT/OT initial and subsequent evaluations must include appropriate seating accommodation for beneficiary's height and weight, specifically addressing anticipated growth and weight gain or loss.
 8. The DME provider must fully assess the beneficiary's needs and ensure that the motorized/power wheelchair is adequate to meet those needs.
- E. The Division of Medicaid defines an individualized, beneficiary specific custom motorized/power wheelchair as one that has been uniquely constructed or substantially modified for a specific beneficiary. Individualized, beneficiary specific custom motorized/power wheelchairs must meet the following criteria:
1. Be ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist.
 2. Meet all the requirements in Miss. Admin. Code Part 209, Rule 1.47.D.2– 8.
 3. Coverage for a customized electronic interphase device, specialty and/or alternative controls require documentation of an extensive evaluation of each customized feature required for physical status and specification of medical benefit of each customized feature to establish that the beneficiary is unable to manage a motorized/power wheelchair without the assistance of said device.
 - a) For a joystick, hand or foot operated, device the beneficiary must demonstrate safe operation of the motorized/power wheelchair with extremity using a joystick. The beneficiary can manipulate the joystick with fingers, hand, arm, or foot.
 - b) For a chin control device, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the chin control device. The beneficiary must have a medical condition which prevents the use of their hands/arms but is able to move their chin and safely operate the chair in all circumstances.
 - c) For a head control device, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the head control device. The beneficiary must have a medical condition which prevents the use of their hands/arms but is able to move their head freely with control of their head and can safely operate the chair in all circumstances.
 4. For an extremity control device, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the extremity control device. The beneficiary must have a medical condition which prevents or limits fine motor skills during the use of their extremities but is able to move their hands/arms/legs to safely operate the chair in all circumstances.

5. For a sip and puff feature, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the sip and puff control. The beneficiary cannot move their body at all and cannot operate any other driver except this one.
- F. Standard and custom motorized/power wheelchairs are limited to one (1) per beneficiary every five (5) years based on medical necessity. Reimbursement:
1. Is made only for one (1) wheelchair at a time.
 2. Includes all labor charges involved in the assembly of the wheelchair and all covered additions, accessories and modifications.
 3. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.
 4. Is made only after the PT or OT subsequent evaluation is completed.
- G. Standard and custom motorized/power wheelchairs are not covered if the use of the standard and custom motorized/power wheelchair primarily benefits the beneficiary in their pursuit of leisure or recreational activities. Motorized/power wheelchairs are not covered for the convenience of the caregiver, ambulatory beneficiaries and non-compliant beneficiaries.
- H. The Division of Medicaid does not cover home, environment, and vehicle adaptations, equipment and modifications for motorized/power wheelchair accessibility.
- I. The DME provider providing standard and/or custom motorized/power wheelchairs to beneficiaries must have at least one (1) employee with Assistive Technology Professional (ATP) certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) who specializes in wheelchairs and who must be registered with the National Registry of Rehab Technology Suppliers (NRRTS).
1. The NRRTS and RESNA certified personnel must have direct, in-person, face-to-face interaction and involvement in the motorized/power wheelchair selection for the beneficiary.
 2. RESNA certifications must be updated every two (2) years.
 3. NRRTS certifications must be updated annually.
 4. If the certifications are found not to be current, the prior authorization request for the motorized/power wheelchair will be denied.
- J. DME providers must provide a two (2) year warranty of the major components for custom motorized/power wheelchairs. [Refer to Part 209, Chapter 1, Rule 1.4.]

1. If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the DME provider is responsible for any repairs, replacement or maintenance that may be required within two (2) years.
 2. The warranty begins the date of delivery to the beneficiary.
 3. A powered mobility base must have a lifetime warranty on the frame against defects in material and workmanship for the lifetime of the beneficiary.
 4. The main electronic controller, motors, gear boxes, and remote joystick must have a two (2) year warranty from the date of delivery.
 5. Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects or if the surface does not remain intact due to normal wear.
- K. DME suppliers providing custom manual and/or motorized/power wheelchairs, customized electronic interphase devices, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8:00) a.m. and five (5:00) p.m. Monday through Friday. Each technician must keep on file records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.
- L. The Division of Medicaid covers repairs, including labor and delivery, of DME that is owned by the beneficiary not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.
1. Major repairs and/or replacement of parts require prior authorization from the UM/QIO and must include an estimated cost of the necessary repairs, including labor, and a documentation from the practitioner there is a continued need for the custom manual and/or motorized/power wheelchair.
 2. An explanation of time involved for repairs and/or replacement of parts must be submitted to the UM/QIO.
 3. Manufacturer time guides must be followed for repairs and/or replacement of parts.
 4. The Division of Medicaid defines repair time as point of service and does not include travel time to point of service.
 5. No payment is made for repairs or replacement if it is determined that intentional abuse, or misuse, of the wheelchair or components has occurred, which includes damage incurred due to inappropriate covered transportation for the prescribed motorized/power wheelchair.

6. Reimbursement will be made for up to one (1) month for a rental of a wheelchair while the beneficiary's wheelchair is being repaired.

M. The Division of Medicaid does not cover a travel wheelchair that is lightweight and foldable.

Source: Social Security Act § 1834; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/02/2015. Revised eff. 01/01/2013.

Chapter 2: Covered Medical Supplies

Rule 2.2: Covered Medical Supplies

The Division of Medicaid covers medical supplies. [Refer to Miss. Admin. Code Part 207 for coverage of medical supplies in a long-term care facility.]

- A. Alcohol preps, swabs, wipes and bottle are covered for quantity or number of pints appropriate for the plan of care for all beneficiaries for injection site cleanings, for self-administration, or care giver administration of intramuscular or subcutaneous injections ordered by a practitioner.
- B. Apnea monitor supplies for beneficiaries who have an apnea monitor.
 1. Electrodes,
 2. Lead wires, and
 3. Battery pack.
- C. Diabetic supplies for all beneficiaries who meet criteria for glucometer.
 1. Test strips,
 2. Lancets,
 3. Insulin syringes,
 4. Control solutions,
 5. Replacement battery,
 6. Spring lancet device,
 7. Autoclix lancets (spring), and
 8. Urine test or reagent strips.

D. Dressing supplies for all beneficiaries.

1. 4x4 non-sterile gauze pads,
2. 4x4 sterile gauze pads, including drain sponges,
3. Tape,
4. Sterile normal saline solution, 1000 ml, and
5. Gloves, sterile and non-sterile.

E. Biofeedback/Electromyography (EMG) supplies for all beneficiaries who meet criteria for biofeedback/EMG.

1. Lead wires, and
2. Electrodes.

F. Enteral Feeding supplies for all beneficiaries who meet criteria for enteral feeding pump.

1. 4x4 non-sterile gauze,
2. 4x4 sterile gauze, including drain sponges,
3. Tape,
4. Sterile solution, 1000ml,
5. Gloves, sterile and non-sterile,
6. Feeding bag(s),
7. Feeding syringe, and
8. Sterile water, 1000ml.

G. Elbow and heel protectors for all beneficiaries when one (1) of the following criteria is met:

1. The beneficiary is bed/chair confined and has a history of decubitus ulcers on a heel or elbow.
2. The patient is bed/chair confined and currently has a decubitus ulcer on a heel or elbow.
3. The beneficiary exhibits signs of redness or discomfort at bony prominences or other areas of potential breakdown

- H. Hydrogen peroxide for all beneficiaries who have a tracheostomy and a wound.
- I. Insulin pen needles or pre-filled insulin syringe needles for all beneficiaries receiving a pre-filled insulin injection device through the pharmacy program. Needles are covered through the medical supply program only if one (1) of the following criteria is met:
 - 1. The patient has very poor eyesight and is unable to read the markings on a standard insulin syringe.
 - 2. The patient has a condition of the hands that will not allow them to manipulate a vial and syringe to draw up their insulin.
- J. Insulin pump supplies for all beneficiaries who meet criteria for insulin pump.
 - 1. Cartridges,
 - 2. Infusion sets with cannula,
 - 3. Skin cleanser,
 - 4. Skin prep,
 - 5. Alcohol prep,
 - 6. Adhesive remover,
 - 7. Replacement batteries, and
 - 8. Gloves, sterile.
- K. Intravenous (IV) Pump, also referred to as an Infusion Pump, and supplies for all beneficiaries who meet criteria for an IV pump.
 - 1. Cassette appropriate for pump type, and
 - 2. Replacement batteries.
- L. IV Supplies for all beneficiaries who meet criteria for an IV pump or an IV pole.
 - 1. Central line supplies,
 - 2. Administration set,
 - 3. Tubing and clamp,

4. Extension set,
5. IV start kit,
6. Butterfly needles, all sizes,
7. IV catheters, all sizes,
8. Non-coring needles,
9. 2x2 gauze, sterile,
10. Tape, all types,
11. Syringe, any size without needles,
12. Syringe, any type with needle,
13. INT,
14. Flush kit,
15. Iodine prep,
16. Alcohol preps,
17. Dial-a-flow,
18. Sterile normal saline for injection - 2ml, 2.5ml, 3ml, 5ml, 10ml, 20ml, 30ml, and 50ml supplied in bottles, ampules or vials, and
19. Gloves, sterile.

M. Nebulizer supplies for all beneficiaries when criteria for nebulizer are met.

1. Administration set, disposable, non-filtered,
2. Administration set, non-disposable, non-filtered,
3. Administration set, filtered,
4. Aerosol mask, and
5. Tubing.

- N. Neuromuscular Electrical Stimulator (NMES) supplies for all beneficiaries who meet criteria for neuromuscular electrical stimulator.
1. Electrodes, and
 2. Lead wires.
- O. Ostomy supplies for all beneficiaries who have a surgically established opening, or stoma to divert urine, feces, or illegal contents outside the body.
- P. Oxygen and oxygen related supplies are covered for all beneficiaries who meet criteria for oxygen therapy.
1. E cylinders, including delivery,
 2. H or K Cylinders, including delivery,
 3. Tubing,
 4. Face masks,
 5. Nasal cannulas, and
 6. Regulators.
- Q. Pulse oximeter supplies, which include an oxygen probe, are covered for all beneficiaries who meet criteria for pulse oximeter monitoring.
- R. A sling for all beneficiaries who have an injury or diagnosis which requires support or immobilization of an upper extremity to control pain, restrict motion, prevent further deformity, or protect the limb following trauma or surgery. The request for coverage must be supported by the beneficiary's diagnosis, the goals for use of the sling, and the expected duration of use.
- S. Suction pump supplies (respiratory or gastric) for all beneficiaries who meet criteria for a suction pump.
1. Respiratory suction supplies include:
 - a) Catheter kit, sterile,
 - b) Suction catheter, 8-15 FR,
 - c) Yankauer type respiratory suction,
 - d) Respiratory suction tubing,

- e) Canister, disposable, and
 - f) Gloves, any type.
2. Gastric suction supplies include:
- a) Gastric suction catheter kit,
 - b) Gastric suction catheter, 8-15 FR,
 - c) Gastric suction whistle tip, with valve,
 - d) Gastric suction tubing,
 - e) Canister, disposable,
 - f) Gloves, any type, and
 - g) Gastric suction tube.
- T. Supplies for maintenance of drug infusion catheter, per week, for all beneficiaries who meet criteria for an IV pump.
- 1. Catheter insertion devices,
 - 2. Dressing for catheter site,
 - 3. Flush solutions not directly related to drug infusion,
 - 4. Cannulas,
 - 5. Needles,
 - 6. Infusion supplies, excluding the insulin reservoir, and
 - 7. Gloves, sterile.
- U. Supplies for external drug infusion pump, per cassette or bag, for all beneficiaries who meet criteria for an IV pump.
- 1. Cassettes,
 - 2. Bags,
 - 3. Diluting solution,

4. Tubing,
 5. Other administration supplies,
 6. Port charges, not used for syringe-type reservoir,
 7. Gloves, sterile.
- V. Syringes and needles are covered for self-administration of intramuscular and/or subcutaneous injectable medication for all beneficiaries that are performing the administration of injections in the home. The Division of Medicaid does not cover for caregivers to be hospice, home health, respite and/or other provider types.
- W. Transcutaneous Electrical Nerve Stimulator (TENS) supplies for all beneficiaries who meet criteria for Transcutaneous Electric Nerve Stimulator.
1. Electrodes, and
 2. Lead wires.
- X. Tracheostomy supplies for all beneficiaries who have a tracheostomy with documentation of the specific respiratory condition.
1. Trach mask or collar,
 2. Trach or laryngectomy tube,
 3. Trach, inner cannula,
 4. Replacement tracheal suction catheter, any type,
 5. Trach care kit, for new trach,
 6. Trach care kit, for established trach,
 7. Suction catheter kit, sterile,
 8. Sterile water, 1000 ml,
 9. Sterile normal saline for instillation, supplied in 2ml, 2.5ml, 3ml, 5ml, 10ml, 20ml, 30ml, and 50 ml bottle, ampule, or vial.
 10. Trach ties,
 11. Trach cleaning brush,

12. Heat and Moisture Exchangers (HME),
13. Trach shower protector,
14. Tracheostomy/laryngectomy, tube plug/stop,
15. Tracheostoma filter,
16. Gauze, and
17. Gloves, sterile.

Y. Urinary catheters

1. Urinary catheters are covered for all beneficiaries when one (1) of the following criteria is met:
 - a) Beneficiary must have an acute condition which requires intermittent catheterization for measuring residual, instilling medication, or other medically necessary indication,
 - b) Beneficiary has an acute condition which requires the short-term use of an indwelling catheter,
 - c) Beneficiary has a chronic condition which incontinence is exacerbating pressure sores that will not heal,
 - d) Beneficiary has a condition that requires accurate measurement of intake and output on a short-term basis, or
 - e) Beneficiary has urinary retention that cannot be relieved by medication.
2. Supplies include:
 - a) Insertion tray,
 - b) Irrigation tray, with bulb or piston syringe,
 - c) Irrigation syringe, bulb or piston,
 - d) Sterile solution for irrigation,
 - e) Female external collection device,
 - f) Indwelling catheter, foley, two-way,

- g) Indwelling catheter, three-way,
- h) Male external catheter, with or without adhesive,
- i) Intermittent catheter, straight tip,
- j) Bedside drainage bag,
- k) Leg bag with or without strap,
- l) Gloves, sterile.

- 3. Medicaid requires the beneficiary and/or caregiver to be capable of performing the catheterization procedure and report results and have been instructed in the procedure and properly demonstrated the ability to perform the procedure.
- 4. Medicaid covers condom catheters for beneficiaries with paraplegia, neurogenic bladder, or other medically necessary indications when requested with appropriate documentation.

Z. The Division of Medicaid covers supplies for manual and electric breast pumps.

Source: Social Security Act § 1834; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised Miss. Admin, Code Part 209, Rule 2.2.O eff. 01/02/2015; Added Miss. Admin. Code Part 209, Rule 2.2.Z., eff. 05/01/2014; Revised eff. 01/01/2013.