Title 23: Division of Medicaid

Part 209: Durable Medical Equipment, Medical Appliances and Medical Supplies

Part 209 Chapter 1: Durable Medical Equipment and Medical Appliances

Rule 1.3: Definitions

The Division of Medicaid defines:

A. Durable Medical Equipment (DME) and/or medical appliance as an item meeting all five (5) criteria below:

   1. It can withstand repeated use,

   2. Is reusable or removable,

   3. Is primarily and customarily used to serve a medical purpose,

   4. Is generally not useful to a person in the absence of a disability, illness, or injury, and

   5. Is appropriate for use in any setting where the beneficiary's normal life activities take place other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made by the Division of Medicaid for inpatient services that include room and board.

B. Prior authorization, as used in this chapter, is defined as prior authorization for a service or item based on medical necessity review by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity.

C. An allowed non-physician practitioner is defined as a:

   1. A nurse practitioner, clinical nurse specialist or certified nurse midwife working in collaborative/consultative relationship under established protocol or practice guidelines with a Mississippi licensed attending physician enrolled as a Mississippi Medicaid provider,

   2. A physician assistant under the supervision of the Mississippi licensed attending physician enrolled as a Mississippi Medicaid provider as required by the Mississippi Board of Medical Licensure.

D. Home is defined as any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or any setting in which payment is or could be made by the Division of Medicaid for inpatient services that include room and board.

E. The Division of Medicaid defines a trial period as the time required to assess the effectiveness of an item and beneficiary compliance.

Source: 42 U.S.C. § 1395x(n); 42 C.F.R. § 440.70; Miss. Code Ann. § 43-13-121.

History: Revised eff. 05/01/2021, Revised eff. 09/01/2018.

Rule 1.4: Reimbursement

A. The Division of Medicaid reimburses for durable medical equipment (DME) and/or medical appliances when ordered by a physician or through the use of a collaborative practice agreement between the non-physician practitioner and the physician, and within the practitioner's scope of practice and collaborative agreement procedures. [Refer to Miss. Admin. Code Part 207 for DME coverage in a long-term care facility.]

B. The Division of Medicaid requires prior authorization be submitted prior to or within thirty (30) days of delivery of the DME and/or medical appliance. 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 prior authorization request and approval is not given.

C. All standard DME and/or medical appliance, excluding custom motorized/power wheelchair systems, must have a manufacturer's warranty of a minimum of one (1) year.

1. If the provider supplies DME or a medical appliance 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 intentional damage, neglect, or misuse of the DME and/or medical appliance. If the provider suspects such damage of DME and/or medical appliance, the provider must 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 intentional damage, neglect, or misuse of the DME and/or medical appliance.

6. DME providers 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 reimburses rental of DME and/or medical appliance up to ten (10) months, or up to the purchase price, whichever is the lesser, unless specified as a "rental only" item in Miss. Admin. Code Part 209.

1. After rental benefits are paid for ten (10) months, the DME becomes the property of the beneficiary, unless otherwise authorized by the Division of 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 DME and/or medical appliance must be applied toward the ten (10) month rental.

   a) The Division of Medicaid applies the rental fees paid for any trial period toward the maximum reimbursement for purchase.

   b) The Division of Medicaid does not reimburse a rental trial period in addition to the full purchase price.

4. The rental allowance includes the DME and/or medical appliance, delivery, freight and postage, set-up, all supplies necessary for operation of the DME and/or medical appliance, education of the patient and caregiver, all maintenance and repairs or replacement, labor including respiratory therapy visits, and servicing charges.

5. Rental benefits beyond the ten (10) month period must be:

   a) Prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity,

   b) Medically necessary, and

   c) Cost effective for the Division of Medicaid.

6. The DME and/or medical appliance must be returned to the DME provider after it is no longer required, if the rental period is less than ten (10) months.

E. The Division of Medicaid reimburses repairs, including labor and delivery, of DME and/or a medical appliance that is owned by the beneficiary not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.

1. DME providers 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 by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for the repair and must include an estimated cost of necessary repairs, including labor, and a statement from the physician stating that there is a continued need for the DME and/or medical appliance.

3. Labor and delivery charges are included in the repair cost and are not reimbursed separately.

4. The Division of Medicaid does not reimburse repair of a rental item.

5. The Division of Medicaid does not reimburse repairs when it has been determined that the DME and/or medical appliance has been intentionally damaged, neglected, or misused by the beneficiary, caregiver or family.

6. The Division of Medicaid reimburses, under extenuating circumstances as determined by the Division of Medicaid, UM/QIO, or designated entity rental of an item on a short-term basis while DME and/or medical appliance owned by the beneficiary is being repaired.

F. The Division of Medicaid reimburses the replacement of DME and/or a medical appliance, without a trial period, under the following circumstances: The initial trial period may be waived for the replacement of an identical or existing piece of DME or medical appliance.

1. Wear and tear every five (5) years, unless there are extenuating circumstances.

2. Theft when there is documentation from law enforcement of a theft.

3. Fire when there is documentation from the fire department.

4. Natural disaster when there is documentation from the appropriate authorities.

G. The Division of Medicaid reimburses for the purchase of DME and/or medical appliance when it is determined by the Utilization Management/Quality Improvement Organization, the Division of Medicaid or designated entity to be more economical than renting and when the period of need is estimated by the physician to be ten (10) or more months.

H. The Division of Medicaid reimburses DME and/or medical appliances at the lesser of the provider charge or the Division of Medicaid's allowable fee 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 Division of Medicaid's allowable fee.

3. Used DME and/or medical appliances and repairs are set at fifty percent (50%) of the Division of Medicaid's allowable fee.

I. The Division of Medicaid manually prices items that do not have an assigned allowable fee.

1. The Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity 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. If there is no DMEPOS fee, the provider will be reimbursed a fee determined by the Division of Medicaid. The Division of Medicaid will utilize the lower of the Division of Medicaid's average/established fee or the average of the fees from other states, when available, or determine the fee from cost information from providers and/or manufacturers, survey information from national fee analyzers, or other relevant fee-related information. The fees will be updated as determined by the Division of Medicaid.

4. If there is no DMEPOS fee or a fee determined by the Division of Medicaid, the provider will be reimbursed a fee calculated through the following manual pricing hierarchy:

a) Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%) or,

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) If there is no MSRP, then the provider's invoice received from a wholesaler or manufacturer 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. When it is determined by DOM, based on documentation, that the Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule (DMEPOS) fee is insufficient for the Mississippi Division of Medicaid population or could result in a potential access issue, then a fee will be calculated using market research from the area.

K. [Reserved]

L. DME, medical appliances, and medical supplies related to the terminal illness for those Division of Medicaid beneficiaries receiving benefits in the Hospice Program cannot be reimbursed through the DME and medical appliances program.

M. The Division of Medicaid's fee schedule of DME is not comprehensive. The Division of Medicaid reimburses for items not listed on the DME fee schedule, on a case-by-case basis, when prior authorized as medically necessary by a UM/QIO, and the provider submits the following to the Division of Medicaid:

1. Paper claim, and

2. Approved prior authorization.

N. The following are not reimbursed by the Division of Medicaid under the DME program:

1. Additional charges for freight, postage and/or delivery and

2. Cost of replacing items that were not delivered to the beneficiary due to loss, theft or incomplete delivery.

O. The Division of Medicaid reimburses for the face-to-face encounter conducted by a physician or non-physician practitioner separately according to the appropriate fee schedule.

P. Evaluations and/or assessments including environmental evaluations in order to provide DME and/or medical appliances are not separately reimbursable.

Source: U.S.C. § 1395(m); Miss. Code Ann. § 43-13-121.

History: Revised eff. 05/01/2021; Revised eff. 09/01/2018. Revised Miss. Admin. Code Part 209, Rule 1.4.A, D.1, J., and K. eff. 01/02/2015.

Rule 1.6: Coverage Requests for Items and Services Not Listed as Covered through the DME Medical Appliance Program

A. The Division of Medicaid does not cover items or services through durable medical equipment (DME) and medical appliance program that do not meet:

1. The definition of DME and/or medical appliances,

2. Medical necessity or standard of care criteria,

3. Healthcare Common Procedure Coding System (HCPCS) code descriptors that represent the product, or

4. The approval of the appropriate government regulatory bodies.

B. The Division of Medicaid covers medically necessary DME items that are not listed on the fee schedule on a case-by-case basis when:

1. The provider submits documentation that meet the requirements listed in Rule 1.6.A.,

2. The request for coverage is limited to one (1) beneficiary, and

3. The request is not used to cover multiple items or multiple beneficiaries.

C. Maintenance contracts and servicing fees are not covered under the DME and medical appliance program. For charges related to repair of DME and/or medical appliances, refer to Miss. Admin. Code Part 209, Rule 1.4.

Source: 42 U.S.C. § 1395m(a); Miss. Code Ann. § 43-13-121.

History: Revised eff. 05/01/2021; Revised eff. 09/01/2018.

Rule 1.20: Continuous Positive Airway Pressure (CPAP) With or Without an In-Line Heated Humidifier

A. The Division of Medicaid defines continuous positive airway pressure (CPAP) with or without an in-line heated humidifier as a non-invasive provision of air pressure through nasal administration and a flow generator system to prevent collapse of the oropharyngeal walls during sleep. For the Division of Medicaid's purposes, apneas and hypopneas physiologically represent the same compromise, will be considered as equivalents, and will be referred to as "respiratory events."

B. The Division of Medicaid covers the rental of a CPAP during the three (3) month trial period for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, when the following criteria is met:

1. [Reserved],

2. When one (1) of the following is met:

a) The beneficiary experiences fifteen (15) or more respiratory events per hour, or between five (5) and fourteen (14) respiratory events per hour with documentation of the following symptoms:

1) Excessive daytime sleepiness,

2) Impaired cognition,

3) Mood disorders or insomnia, or

4) Documented hypertension, ischemic heart disease, or history of stroke.

b) The beneficiary is a prepubescent child and the polysomnogram demonstrates an average of one (1) or more respiratory events per hour.

c) The beneficiary is a child who has documented measurements of increased end-tidal carbon dioxide (CO_2) values that confirm the presence of obstructive sleep apnea.

d) The beneficiary has a diagnosis of upper airway resistance syndrome with the presence of at least ten (10) respiratory related electroencephalogram (EEG) arousals per hour of sleep accompanied by a history of clinically significant daytime sleepiness or documented excessive daytime sleepiness as determined by a Multiple Sleep Latency Test, with a significant reduction in EEG arousals following administration of CPAP.

C. The Division of Medicaid will review, for determination of coverage for a CPAP, with appropriate documentation, the following medical conditions:

1. Persistent hypoxemia of oxygen saturation (SaO_2) less than ninety percent (90%) during sleep even in the absence of obstructive sleep apnea,

2. Central sleep apnea,

3. Chronic alveolar hypoventilation syndrome,

4. Intrinsic lung disease,

5. Neuromuscular disease.

D. After the initial three (3) month trial period, the CPAP may be recertified up to seven (7) additional months with a CPAP Compliance Certificate of Medical Necessity completed by the ordering physician.

1. If the equipment was not effective or, if the beneficiary was non-compliant, the equipment must be returned to the vendor.

2. The rental fees paid for the three (3) month trial period will apply toward the maximum reimbursement for purchase.

3. After ten (10) consecutive months of rental, including the trial period, the CPAP is owned by the beneficiary.

E. The Division of Medicaid reimburses the DME supplier for the supplies listed below:

1. Full face mask used with a positive airway pressure device, one (1) every three (3) months,

2. Face mask interface, replacement for full face mask, one (1) every month,

3. Replacement pillows for nasal application device, one (1) pair every month,

4. Nasal interface, either a mask or cannula type, used with positive airway pressure device with or without head strip, one (1) every three (3) months,

5. Headgear used with positive airway pressure device, one (1) every six (6) months,

6. Chin strap used with positive airway pressure device, one (1) every six (6) months,

7. Tubing used with positive airway pressure device, one (1) every three (3) months,

8. Disposable Filter, used with positive airway pressure device, two (2) every month,

9. Non-Disposable Filter, used with positive airway pressure device, one (1) every six (6) months, and

10. Oral interface used with positive airway pressure device, one (1) every three (3) months.

F. Division of Medicaid does not cover for more than the usual maximum replacement amount unless documentation is submitted that justifies a larger quantity in the individual case.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 05/01/2021; Revised eff. 09/01/2018.

Rule 1.22: Diapers and Underpads

Refer to Part 209, Chapter 2: Medical Supplies, Rule 2.2.AA.

History: Revised eff. 05/01/2021; Revised eff. 01/01/2013.

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), the Division of Medicaid or designated entity 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.

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 or heavy duty wheelchair.

b) Documentation must include:

1) Specific weight and measurements causing the beneficiary to be unable to function with a standard manual or heavy duty wheelchair, and

2) Specific measurements causing the beneficiary to be unable to function with a standard manual or heavy duty 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 physician experienced in evaluating specialized needs for the purpose of prescribing custom manual wheelchairs after a face-to-face examination of the beneficiary.

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 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 DME.

    4) History of previous interventions/past use of mobility devices.

    5) Description of existing DME, 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,

3. Includes all covered additions, accessories and modifications which providers must bill:

a) An appropriate procedure or service HCPCS code when available in unbundled HCPCS codes, and/or

b) A bundled HCPCS code for unlisted, custom or miscellaneous DME where there is no listed code or combination of HCPCS codes that adequately describes the item provided.

4. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.

5. 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 covers a travel wheelchair when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity and when the following criteria are met:

1. The travel wheelchair is not intended for extended daily use, or as a substitute or long-term replacement for other types of wheelchairs,

2. The beneficiary does not exceed the weight capacity of the travel wheelchair, and

3. The travel wheelchair is for the exclusive use of the beneficiary.

Source: 42 U.S.C. § 1395(m); Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 05/01/2020; Revised eff. 10/01/2020. Revised eff. 09/01/2018. Revised eff. 01/02/2015. Revised eff. 01/01/2013.