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 1.4: 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 to correspond with MS SPA 22-0027 (effective 10/01/2022) effective 01/01/2023; Revised eff. 07/01/2021; Revised eff. 09/01/2018. Revised Miss. Admin. Code Part 209, Rule 1.4.A, D.1, J., and K. eff. 01/02/2015.

Part 209 Chapter 2: Medical Supplies

Rule 2.2: Covered Medical Supplies

The Division of Medicaid covers the following medical supplies when they are medically necessary and considered standard care for the treatment of a beneficiary's medical condition and dispensed in quantities that meet a beneficiary's medical needs without excessive utilization, including, but not limited to: [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 the criteria for:

1. Blood glucose monitors (BGM):

a) Test strips,

b) Lancets,

c) Insulin syringes,

d) Control solutions,

e) Replacement battery,

f) Spring lancet device,

g) Autoclix lancets (spring), and

h) Urine test or reagent strips.

2. Continuous glucose monitoring (CGM):

a) CGM supply allowance covers supplies as a bundle which includes disposable sensors and transmitter. Supplies billed separately will not be covered.

b) DME receiver to display glucose data,

1) A DME receiver is covered if used alone or in conjunction with a non-DME device including, but not limited to: a watch, smartphone, tablet, laptop computer.

2) Non-DME devices will not be covered.

3) If a DME receiver is never used, the supply allowance will not be covered.

c) Replacement batteries.

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 any non-institutional setting where the beneficiary's normal life activities take place.

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. The Division of 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. The Division of 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.

AA. Incontinence Garments

1. The Division of Medicaid covers the following disposable incontinence garments:

    a) Diapers,

    b) Pull-ons, and

    c) Underpads.

2. The Division of Medicaid covers up to six (6) units of incontinence garments per day for beneficiaries aged three (3) and above only when certified as medically necessary. Prior authorization is required for quantities in excess of the limit.

    a) One (1) unit is equal to one (1) diaper or one (1) pull-on or one (1) underpad.

    b) The six (6) units can consist of any combination of diapers, pull-ons and/or underpads.

3. A beneficiary must have a diagnosis of incontinence or must meet one (1) of the following criteria due to a documented medical condition in order for the incontinence garments to be considered medically necessary:

    a) Inability to utilize regular toilet facilities.

    b) Inability to physically turn self or reposition self.

    c) Inability to transfer self from bed to chair or wheelchair without assistance.

4. The physician must order all incontinence garments and maintain documentation of the medical necessity and diagnosis of incontinence in the beneficiary's medical record.

5. The durable medical equipment (DME) provider must maintain in the beneficiary's record a current certificate of medical necessity (CMN), signed by the ordering physician and must include:

    a) An initial physician's order,

    b) The beneficiary's diagnosis along with associated diagnoses and code(s),

    c) The anticipated frequency and duration of need,

d) The requested quantity per month,

e) A detailed description of the item(s) including the type, size and corresponding Healthcare Common Procedure Coding System (HCPCS) code for each,

f) The ordering physician's signature and date of signature. Signature stamps, date stamps, or the signature of anyone other than the ordering physician is not acceptable.

6. The DME provider must have a current physician's order and CMN to initiate or continue the provision of incontinence garments to a beneficiary.

   a) The CMN must be renewed every six (6) months.

   b) For those cases where there is documentation justifying the need for incontinence garments for beneficiaries whose medical condition is chronic, recertification is only required every twelve (12) months.

7. The DME provider must maintain documentation of proof of delivery of incontinence garments including:

   a) Beneficiary's name,

   b) Date of delivery which must be the date the beneficiary received the item; including the dates of service the delivered quantity is expected to last,

   c) Delivery address,

   d) Detailed description of incontinence garments delivered,

   e) Quantity delivered, and

   f) The signature of the beneficiary, caregiver, or family member who received the supplies.

      1) During a national or statewide emergency, a signature is not required.

      2) During a national or statewide emergency, the provider must document the emergency and confirmation of delivery by an alternate means including, but not limited to:

         (a) Telephone,

         (b) Text message, or

         (c) Other electronic communication.

8. DME providers:

    a) Are allowed to deliver incontinence garments in quantities expected to last no more than a one (1) month's supply.

    b) Are not allowed to dispense items to a beneficiary who already has at least a one (1) month's supply on hand.

    c) Must make contact, either orally or in writing, with each beneficiary and/or their legal representative or guardian to confirm the current need before delivering additional incontinence garments.

    d) Must keep documentation of the monthly contact on file.

9. DME providers must supply size, waist, and weight appropriate incontinence garments based on the beneficiary's current measurements.

10. The DME provider must submit a new CMN form signed and dated by the ordering physician detailing changes and medical necessity to the Division of Medicaid or designee if DME provider needs to amend the initial order for incontinence garments being delivered due to a change in the beneficiary's size or underlying medical condition.

11. DME providers must maintain documentation of measurements and medical conditions in the beneficiary's record which supports reimbursement for the specific size of incontinence garments.

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

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