The Division of Medicaid reimburses durable medical equipment, orthotics, prosthetics and medical supplies according to a fee schedule and the following policies.

Coding / Modifiers

DOM will utilize the Healthcare Common Procedure Coding System (HCPCS) for durable medical equipment, medical supplies, and orthotics and prosthetics. The DME supplier must report the appropriate code on the Plan of Care submitted to the ~~Peer/Utilization Review Contractor.~~ Utilization Management/ Quality Improvement Organization (UM/QIO)

Procedures should be reported with the HCPCS codes that most comprehensively describe the equipment, medical supplies, and orthotics and prosthetics provided. Providers must not unbundle codes. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.

DME ~~suppliers must~~ providers may refer to the current fee schedule for the acceptable codes and fee schedule allowances available under Medicaid. However, DME providers are responsible for using valid HCPCS codes that describe the item(s) provided, and providers are strongly encouraged to obtain official HCPCS coding references annually.

One of the following modifiers must always be reported with the code:

Modifier	Description
RR	Rental (use the RR modifier when DME is to be rented)
KR	Rental item, billing for partial month
NU	New Equipment
RP	Replacement and Repair
UE	Used durable medical equipment
SC	Medically necessary service or supply

Use a code with modifier RR for full monthly rentals. Use a code with a modifier KR for a partial monthly rental. For example, if the rental item is for a total of 45 days, the rental should be coded twice, with modifier RR to cover the first 30 days and modifier KR for the remaining 15 days.

Certification

Certification is a condition for reimbursement and is not a guarantee of payment. All durable medical

equipment, medical supplies, and orthotics and prosthetics, except for the following items listed, must be certified. Certification requests may be submitted prior to or within thirty (30) days of delivery on the appropriate form to DOM's ~~Peer/Utilization Review Contractor~~ UM/QIO with the appropriate documentation. The beneficiary cannot be billed if the DME provider chooses to deliver the item/service prior to submitting a certification request and approval is not given. The ~~Peer/Utilization Review Contractor~~ UM/QIO will make the determination of medical necessity using the criteria set forth by DOM and will assign an approval number. If a claim is submitted without an approval number, no reimbursement will be paid. No certifications will be given via the telephone. All terms of DOM's reimbursement and coverage criteria are applicable.

It is the responsibility of the provider to check the eligibility status of each beneficiary at the time the service is provided and to be sure that the beneficiary continues to be eligible before submitting each claim.

Retroactive certification after the 30-day period is authorized only in cases where the beneficiary was approved for retroactive eligibility and is not applicable to any other situation.

On July 1, 2003, the Division of Medicaid authorized the following items as exempt from certification.

HCPCS Code (prior to 10/01/03)	HCPCS Code (after 10/01/03)	Item Description
Z7703, Z7704, Z7705 Z7707, Z7720, Z7880	A4250	Diabetic urine test strips or tablets
Z7700, Z7706	A4253	Blood glucose test strips for glucometer
Z8250, Z8252	A4259	Lancets – 100 count
Z8360	A4245	Alcohol prep pads
Z8510	S8490	Insulin Syringes
E0607	E0607	Glucometer
A4256	A4256	Glucometer Control Solution (high and low)
A4254	A4254	Replacement batteries for glucometer
A4258	A4258	Spring lancet devices
A4614	A4614	Peak flow meters
A4627	A4627	Asthma spacers

Although certification is not required, suppliers must still comply with policy coverage criteria, and there must be documentation supporting medical necessity, including physician's prescription.

On all other items not listed above, the DME supplier, physician, physician assistant, or nurse practitioner must utilize appropriate DME supplier certification request forms and certificates of medical necessity as required by the ~~Peer Review Organization~~ UM/QIO. Providers must comply with procedures set forth by the ~~PRO~~ UM/QIO.

Warranty

All standard DME must have a manufacturer's warranty of a minimum of one year. 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 year. The warranty begins the date of the delivery (date of service) to the beneficiary, and the original copy is left with the beneficiary. The DME provider must keep a copy in the beneficiary's file. DOM reserves the right to request copies for audit/review purposes when necessary. DOM will investigate 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 DOM for investigation and notify the beneficiary that the cost for

repairs/replacement may be the responsibility of the beneficiary if DOM finds malicious damage, neglect, or wrongful misuse of the equipment.

Extended warranties are not covered under the Mississippi Medicaid Program.

Repairs

Reimbursement for repair, including labor and delivery, of DME that is owned by the beneficiary will not exceed 50% of the maximum allowable reimbursement for the cost of replacement.
The DME supplier must submit a request for prior approval on the Generic DME Certification Form and include an estimated cost of necessary repairs, including labor, and a statement from the physician stating that there is a continued need for the equipment (that it continues to serve a medical purpose).
Labor and delivery charges are included in the repair cost and may not be billed separately. No payment will be made for repair of a rental item. No authorization will be given for repairs where it has been determined that the equipment has been abused or neglected by the beneficiary, caregiver or family.

Under extenuating circumstances, as determined by the ~~Peer/Utilization Review Contractor~~ UM/QIO~~,~~ rental of an item may be approved on a short-term basis while equipment owned by the beneficiary is being repaired.

The above policy is also applicable to orthotics and prosthetics except that repairs, adjustments, and modifications are the responsibility of the DME supplier for six months following the date of delivery.

Replacement

DOM will consider 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. The policy is to allow for replacement every three (3) years if the item cannot be repaired and if it is more cost effective to replace it. However, under extenuating circumstances, DOM will consider requests to replace items at a lesser frequency on an individual consideration basis. Cases suggesting malicious damage, neglect or wrongful misuse of the equipment will be investigated. Requests for equipment will be denied if such cases are confirmed.

For some items, such as power wheelchairs, hospital beds, ventilators, etc., replacement is not considered at a frequency less than five (5) years unless there are extenuating circumstances.

The same policy is applicable to orthotics and prosthetics except it is recognized that these items may require replacement on a more frequent basis due to changes in the beneficiary's needs and growth of children.

In the case of fires and/or theft, the DME supplier must submit a law enforcement or fire department report that documents the theft or fire. In the event such report is not provided, the DME supplier must submit a written statement from the beneficiary or legal guardian, with a witness signature, documenting that the item was lost due to a theft or fire. The date of the incident must be recorded on the statement.

Purchase

Purchase of DME is allowed when it is determined by the ~~Peer/Utilization Review Contractor~~ UM/QIO to be more economical than renting. When the period of need is estimated by the physician to be ten (10) or more months, the provider should request approval for purchase instead of rental.

Orthotics and prosthetics are always considered purchase items.

For medical supplies, the ~~Peer/Utilization Review Contractor~~ UM/QIO determines the certification period

for the purchase of the items based on documentation of medical necessity. The recertification dates are established by the ~~Peer/Utilization Review Contractor~~ UM/QIO based on the medical criteria for coverage or the documentation of medical necessity. They may be dispensed only when the beneficiary requests them and the appropriate documentation is current. Supplies may **never** be shipped on an automatic basis.

The maximum reimbursement for purchase of all items supplied by DME suppliers **includes all sales tax.** The purchase allowance includes the item, delivery, freight and postage, labor and set-up if necessary, education of the beneficiary and caregiver, and the initial supplies necessary for the operation of the equipment.

Rental

Equipment may be rented for up to ten (10) months or up to the purchase price, whichever is the lesser. After rental benefits are paid for ten (10) months, the DME becomes the property of the beneficiary unless otherwise authorized by DOM through specific coverage criteria. There should be no sales tax on rental only items as there is no sale or purchase. A trial period for equipment must be applied toward the ten (10) month rental.

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.

Initial Trial Periods

Some items are designated in policy as requiring initial trial periods. The purpose for a trial period is to assess effectiveness and beneficiary compliance. In some instances, at the discretion of the ~~peer review organization~~ UM/QIO, the trial period may be waived for the replacement of an identical or existing piece of equipment.

The rental fees paid for any trial period will apply toward the maximum reimbursement for purchase. Medicaid will not pay for a trial period then pay full purchase price. The DME item should be returned to the DME provider after it is no longer required if the rental period is less than ten (10) months.

~~Rental for trial periods will apply toward the purchase of the DME item.~~

Maintenance and Servicing Fee

Maintenance contracts and servicing fees are not covered under the DME program. For charges related to repair of durable medical equipment, refer to the section on Repairs in this manual section.

Individual Consideration

Some items are considered for coverage on an individual consideration basis. Items for which there are no codes and/or coverage criteria, must be submitted under an unspecified or miscellaneous code with the appropriate modifier.

When requesting these items, the supplier must indicate the name of the product, the product number and the name of the manufacturer.

The following pricing methodology will be applied to manually priced items:

- All items, including ostomy supplies, that have a current Medicare fee will be reimbursed according to the methodology established in the Medicaid state plan:

"Medicare minus 20% for purchases; up to 50% of the Medicaid purchase price for repairs and used DME".

- Items that do not have a Medicare fee will be reimbursed at the MSRP for the item minus 20%
- Items that do not have a Medicare fee or MSRP will be reimbursed at cost plus 20%. Cost includes shipping charges if the provider includes a line item for shipping on the invoice, pro-rated by item.

The Division of Medicaid will reimburse for shipping, on manually priced items only, from the manufacturer to the supplier and from the supplier to the beneficiary. The provider is totally responsible for pro-rating shipping for bulk items. The provider must submit an itemization of the shipping charges. Shipping charges from the manufacturer to the supplier and from the supplier to the beneficiary cannot be combined.

The provider must:

- submit a MSRP on official manufacturer's letterhead. If no MSRP is provided, reimbursement will be cost plus 20%
- attach a copy of the current manufacturer invoice indicating the cost to the supplier for the item dispensed.

A copy of the catalog page and/or manufacturer's quote indicating the cost to the supplier is not acceptable as an invoice. A manufacturer's quote on the manufacturer's letterhead may be acceptable.

If the manufacturer's invoice is older than one (1) year, the provider must submit written justification for the use of the invoice.

Billing

The DME supplier must bill DOM on or after the delivery date. The DME supplier may not bill prior to an item being delivered to the beneficiary.

Items Supplied to Nursing Facility Residents

The DME supplier may bill DOM for ostomy supplies, oxygen cylinders, and ventilators provided to beneficiaries in a nursing facility if (1) the item is not covered by Medicare, and (2) the nursing facility does not include the cost of the items in their annual cost report. Supplies and equipment (other than an oxygen cylinder and its contents) that are required for the administration of oxygen may not be billed directly to DOM. Ostomy supplies, oxygen cylinders, and ventilators must be prior approved by the ~~Peer/Utilization Review Contractor~~ UM/QIO and must satisfy all medical criteria.

Ventilators provided to beneficiaries in a private nursing facility for the severely disabled (PNF-SD) are excluded from the ventilator DME benefit. The cost of ventilators is included in the PNF-SD per diem rates, and the cost of ventilators must be included in the cost reports.

Implantable Devices

Implantable devices such as implantable pumps, cochlear implant devices, implantable breast prostheses, etc. are not covered through the DME Program.

Hospice

DME, medical supplies, orthotics, and prosthetics related to the terminal illness for those Medicaid beneficiaries receiving benefits in the Hospice Program may not be reimbursed through the DME Program.

Medicaid Beneficiary Eligibility

It is the responsibility of the DME supplier to check the beneficiary's eligibility status. The eligibility status must be checked each month.

NOTE: DOM requires that DME providers must utilize and complete all forms and paperwork required by the ~~Peer/Utilization Review Contractor~~ UM/QIO in determining medical necessity.

Based on medical necessity and satisfaction of the criteria below and all other terms of the Mississippi Medicaid program, this item is available for coverage for:

___ Beneficiaries under age 21

___ Beneficiaries age 21 and over who are receiving services through the home health program

_X_ All beneficiaries (no age restriction)

___ Beneficiaries who are pregnant

The provider must refer to the current fee schedule for the acceptable codes and fee schedule allowances available under Medicaid.

The following criteria for coverage apply to apnea monitors:

This item may be approved for :

___ Rental only

___ Purchase only

X ~~Rental for 6 months, then recertification is required (purchase may be approved by the Peer Review Organization when documentation supports long term use)~~ Rental up to 10 months or purchase when medically indicated as documented by the physician, nurse practitioner, or
___ physician assistant

___ Rental up to the purchase amount or purchase when indicated

This item must be ordered by a physician, nurse practitioner, or physician assistant. It is expected that physicians, nurse practitioners, and physician assistants order only items within the scope of their specialty. For example, specialized items such as custom wheelchairs or prosthetics and orthotics should be ordered by specialties such as orthopedics and physicians specializing in rehabilitation. Other items are handled through other specialties.

An apnea monitor is a device used to monitor respiratory movements. This may be accomplished by use of an apnea alarm mattress or by use of alarm sensitive devices to measure thoracic and abdominal movement and heart rate.

Apnea monitors will not be approved for terminally ill beneficiaries or for those who have "do not resuscitate" orders.

~~Following the initial six (6) month certification, apnea monitors must be recertified with a new prescription or letter of medical necessity every three (3) months unless otherwise authorized by the Division of Medicaid's Peer Review Organization. Supplies, such as battery pack, safety lead wires, electrodes, electrode belts, remote alarms (if ordered), etc., are included in the rental fee. Event Recording~~

~~(Download) is also covered in the rental fee. The apnea monitor should be returned to the DME supplier after it is no longer required.~~ Following an initial three (3) month certification, apnea monitors may be recertified up to seven (7) additional months with a new prescription or letter of medical necessity. Medicaid will not pay for a three (3) month trial period then pay full purchase price. Supplies, such as battery pack, safety lead wires, electrodes, electrode belts, remote alarms (if ordered), etc., are included in the rental fee. Event Recording (Download) is also covered in the rental fee. The apnea monitor should be returned to the DME provider after it is no longer required if the rental period is less than ten (10) months.

The parent or caregiver will be required to sign a Parent Responsibility List prior to placement of the apnea monitor. Noncompliance with any policy criteria will result in the discontinuation of the apnea monitor.

Apnea monitors are covered if at least one of the following applies:

- The beneficiary is an infant who has a diagnosis of apnea of prematurity.
- The beneficiary is a preterm infant with continued symptomatic apnea past 36 weeks gestational age.
- The beneficiary has been observed having or has a recorded episode of prolonged apnea (>20 seconds or bradycardia episodes <60 bpm for > 5 seconds) within the last three months that is documented by medical personnel and associated with bradycardia, reflux, cyanosis, or pallor.
- The beneficiary is an infant who is a sibling of a child with sudden infant death syndrome (SIDS), or has two (2) siblings with a diagnosis of apnea.
- The beneficiary has had an event or events requiring vigorous stimulation or resuscitation within the past three (3) months.
- The beneficiary has a tracheotomy.
- The beneficiary is an infant with bronchopulmonary dysplasia who requires oxygen and displays medical instability.
- The beneficiary, adult or child, has demonstrated symptomatic apnea due to neurological impairment, craniofacial malformation, central hyperventilation syndrome, or is secondary to gastrointestinal reflux.

Diagnoses not included above may be considered on an individual basis with appropriate documentation.

Based on medical necessity and satisfaction of the criteria below and all other terms of the Mississippi Medicaid program, this item is available for coverage for:

___ Beneficiaries under age 21

___ Beneficiaries age 21 and over who are receiving services through the home health program

_X_ All beneficiaries (no age restriction)

___ Beneficiaries who are pregnant

The provider must refer to the current fee schedule for the acceptable codes and fee schedule allowances available under Medicaid.

The following criteria for coverage apply to Bilevel Positive Airway Pressure Device (BIPAP):

This item may be approved for :

___ Rental only

___ Purchase only

X ~~Rental for 3 months, then recertification is required for purchase~~ Rental for initial 3 months trial period, then recertification is required for purchase (the 3 month rental trial period will apply toward the maximum reimbursement for purchase)

___ Rental up to the purchase amount or purchase when indicated

This item must be ordered by a physician, nurse practitioner, or physician assistants. It is expected that physicians, nurse practitioners, or physician assistants order only items within the scope of their specialty. For example, specialized items such as custom wheelchairs or prosthetics and orthotics should be ordered by specialties such as orthopedics and physicians specializing in rehabilitation. Other items are handled through other specialties.

BIPAP is a non-continuous, bi-level airway management device that cycles between the inspiratory and expiratory pressure levels in response to the patient's respiratory effort. The rise in pressure during inspiration supports the patient's breathing by splinting the airway to overcome the additional collapsing forces from inspiratory efforts. When inspiration has ended, the pressure drops at the point of exhalation removing the sensation of expiratory effort while still maintaining a therapeutic level of pressure in the circuit necessary to overcome collapsing forces in the airway. For this reason, patients are sometimes able to tolerate BIPAP rather than the continuous pressures of CPAP.

All related supplies are considered an integral part of the rental or purchase allowance of the BIPAP unit and separate charges for supplies or respiratory services are not payable.

An in-line heated humidifier, when used in conjunction with and attached to the BIPAP unit, may be billed separately.

If a beneficiary owns the BIPAP unit, the DME supplier may bill for the supplies listed in the following table. The table represents the usual maximum amount of accessories expected to be medically necessary. The claims for more than the usual maximum replacement amount will be denied as not medically necessary unless the claim is accompanied by documentation that justifies a larger quantity in the individual case.

HCPCS Code	Description	Frequency
A7030	Full face mask used with positive airway pressure device	1 every 3 months
A7031	Face mask interface, replacement for full face mask, each	1 every 3 months
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	1 every 3 months
A7032	Replacement cushion for nasal application device, each	1 every month
A7033	Replacement pillows for nasal application device, pair	1 pair every month
A7035	Headgear used with positive airway pressure device	1 every 6 months
A7036	Chin strap used with positive airway pressure device	1 every 6 months
A7037	Tubing used with positive airway pressure device	1 every month
A7038	Filter, disposable, used with positive airway pressure device	2 every month
A7039	Filter, non-disposable, used with positive airway pressure device	1 every 6 months
A7044	Oral interface used with positive airway pressure device, each	1 every 3 months

A BIPAP unit is covered when one or more of the following apply:

- The beneficiary was unable to tolerate the necessary CPAP pressures.
- The beneficiary has frequent central apneas that do not resolve with administration of CPAP.
- The beneficiary's baseline hypoxemia in cases involving chronic lung disease or hypoventilation syndromes is not corrected with administration of CPAP.

After the three (3) month trial period, the provider must submit a plan of care requesting purchase along with a physician's certifying statement that the BIPAP treatment was effective and that the beneficiary was compliant in using the equipment or the equipment must be returned to the vendor. Continued rental beyond the initial 3 month trial period will not be approved. The rental fees paid will apply toward the maximum reimbursement for purchase.

Based on medical necessity and satisfaction of the criteria below and all other terms of the Mississippi Medicaid program, this item is available for coverage for:

___ Beneficiaries under age 21

___ Beneficiaries age 21 and over who are receiving services through the home health program

_X_ All beneficiaries (no age restriction)

___ Beneficiaries who are pregnant

The provider must refer to the current fee schedule for the acceptable codes and fee schedule allowances available under Medicaid.

The following criteria for coverage apply to Continuous Positive Airway Pressure:

This item may be approved for :

___ Rental only

___ Purchase only

X ~~Rental for 3 months, then recertification is required for purchase~~ Rental for initial 3 months trial period, than recertification is required for purchase (the 3 month rental trial period will apply toward the maximum reimbursement for purchase)

___ Rental up to the purchase amount or purchase when indicated

This item must be ordered by a physician, nurse practitioner, or physician assistant. It is expected that physicians, nurse practitioners, or physician assistants order only items within the scope of their specialty. For example, specialized items such as custom wheelchairs or prosthetics and orthotics should be ordered by specialties such as orthopedics and physicians specializing in rehabilitation. Other items are handled through other specialties.

CPAP is a non-invasive provision of air pressure through nasal administration and a flow generator system to prevent collapse of the oropharyngeal walls during sleep.

All related supplies are considered an integral part of the rental or purchase allowance of the CPAP unit and separate charges for supplies or respiratory services are not payable.

An in-line heated humidifier, when used in conjunction with and attached to the CPAP unit, may be billed separately.

If a beneficiary owns the CPAP unit, the DME supplier may bill for the supplies listed in the following table. The table represents the usual maximum amount of accessories expected to be medically necessary. The claims for more than the usual maximum replacement amount will be denied as not

medically necessary unless the claim is accompanied by documentation that justifies a larger quantity in the individual case.

HCPCS Code	Description	Frequency
A7030	Full face mask used with positive airway pressure device, each	1 every 3 months
A7031	Face mask interface, replacement for full face mask, each	1 every 3 months
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	1 every 3 months
A7032	Replacement cushion for nasal application device, each	1 every month
A7033	Replacement pillows for nasal application device, pair	1 pair every month
A7035	Headgear used with positive airway pressure device	1 every 6 months
A7036	Chin strap used with positive airway pressure device	1 every 6 months
A7037	Tubing used with positive airway pressure device	1 every month
A7038	Filter, disposable, used with positive airway pressure device	2 every month
A7039	Filter, non-disposable, used with positive airway pressure device	1 every 6 months
A7044	Oral interface used with positive airway pressure device, each	1 every 3 months

For Mississippi Medicaid purposes, apneas and hypopneas physiologically represent the same compromise, will be considered as equivalents, and will be referred to as "respiratory events".

A CPAP unit is covered when ~~less aggressive treatment modalities have been tried and failed and~~ the beneficiary has one or more of the following ~~apply~~:

- The beneficiary is an adult and the polysomnogram demonstrates a minimum recording time of 6-7 hours with an average of five or more respiratory events per hour, each lasting a minimum of 10 seconds or more.
- The beneficiary is a prepubescent child and the polysomnogram demonstrates an average of one or more respiratory events per hour.
- The beneficiary is a child who has documented measurements of increased end-tidal CO2 values that confirm the presence of obstructive sleep apnea.
- The beneficiary has a diagnosis of upper airway resistance syndrome with the presence of at least 10 respiratory related 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.

CPAP may be considered for coverage with appropriate documentation for the following medical conditions:

- Persistent hypoxemia (SaO2 < 90%) during sleep even in the absence of obstructive sleep apnea
- Central sleep apnea
- Chronic alveolar hypoventilation syndrome
- Intrinsic lung disease
- Neuromuscular disease

After the three month trial period, the provider ~~may~~ must submit a plan of care requesting purchase along with a physician's certifying statement that the CPAP treatment was effective and that the beneficiary was compliant in using the equipment or the equipment must be returned to the vendor. Continued rental beyond the initial 3 month trial period will not be approved. The rental fees paid will apply toward the maximum reimbursement for purchase.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: ~~07/01/02~~ 05/01/06
Section: Durable Medical Equipment **Subject: Humidifier**	**Section: 10.42** **Pages: ~~1~~ 2** **Cross Reference:** **Reimbursement 10.02** **Documentation 10.07** **CPAP 10.27** **BIPAP 10.14**	

Based on medical necessity and satisfaction of the criteria below and all other terms of the Mississippi Medicaid program, this item is available for coverage for:

_X_ Beneficiaries under age 21

___ Beneficiaries age 21 and over who are receiving services through the home health program

___ All beneficiaries (no age restriction)

___ Beneficiaries who are pregnant

The provider must refer to the current fee schedule for the acceptable codes and fee schedule allowances available under Medicaid.

The following criteria for coverage apply to humidifiers:

This item may be approved for :

___ Rental only

_X_ Purchase only

___ Rental for X months, then recertification is required

___ Rental up to the purchase amount or purchase when indicated

This item must be ordered by a physician, nurse practitioner, or physician assistant. It is expected that physicians, nurse practitioners, or physician assistants order only items within the scope of their specialty. For example, specialized items such as custom wheelchairs or prosthetics and orthotics should be ordered by specialties such as orthopedics and physicians specializing in rehabilitation. Other items are handled through other specialties.

A humidifier is a mechanical device used to increase moisture content of the air in a room.

Humidifiers, when used in conjunction with oxygen, IPPB treatments, ~~CPAP or any other type of bi-level ventilating equipment, are included in the rental or purchase price of that equipment.~~ are included in the rental or purchase price of that equipment. This humidifier policy applies to humidifiers not attached to a BiPAP or CPAP. For policy related to humidifiers when used in conjunction with and attached to BiPAP and CPAP equipment, refer to section 10.14 BiLevel Positive Airway Pressure Device (BiPAP) with or without an In-Line Heated Humidifier or section 10.27 Continuous Positive Airway Pressure (CPAP) with or without an In-Line Heated Humidifier.

Humidifiers are covered for children under 21 years of age who have a chronic diagnosis(es) indicating a respiratory condition in which ease of breathing could be facilitated by increasing the moisture content of

the air. These diagnoses may include, but are not limited to, chronic bronchitis, asthmatic bronchitis, chronic asthma, bronchopulmonary dysplasia, and chronic airway obstruction. It must be documented that the patient or caregiver is able to use and care for the equipment. Humidifiers will not be covered for acute upper respiratory infections or chronic cough or colds unrelated to another diagnosis.

Based on medical necessity and satisfaction of the criteria below and all other terms of the Mississippi Medicaid program, this item is available for coverage for:

_X_ Beneficiaries under age 21 - Mobile Suction Pump

___ Beneficiaries age 21 and over who are receiving services through the home health program

_X_ All beneficiaries (no age restriction) - Stationary Home Model Suction Pump

___ Beneficiaries who are pregnant

The provider must refer to the current fee schedule for the acceptable codes and fee schedule allowances available under Medicaid.

The following criteria for coverage apply to suction pumps:

This item may be approved for:

___ Rental only

___ Purchase only

___ Rental for X months, then recertification is required

_X_ Rental up to the purchase amount or purchase when indicated

This item must be ordered by a physician, nurse practitioner, or physician assistant. It is expected that physicians, nurse practitioners, or physician assistants order only items within the scope of their specialty. For example, specialized items such as custom wheelchairs or prosthetics and orthotics should be ordered by specialties such as orthopedics and physicians specializing in rehabilitation. Other items are handled through other specialties.

Respiratory Suction Pump

A mobile or stationary home model suction pump is a lightweight, compact, electric aspirator designed for upper respiratory oral, pharyngeal and tracheal suction for use in the home. A suction device must be appropriate for home use without technical or professional supervision. Those using the suction apparatus must be sufficiently trained to adequately, appropriately and safely use the device.

The stationary home model suction pump is covered if the beneficiary is unable to clear the airway of secretions by coughing secondary to, but not limited to, one of the following:

- cancer or surgery of the throat
- paralysis of the swallowing muscles

- tracheostomy
- comatose or semicomatose condition

A mobile unit may be covered ~~for beneficiaries age 21 and under if **all** of the following criteria are satisfied~~ if one of the following apply~~:~~

- prescribed because the beneficiary is subject to secretions that require suctioning during travel
- the beneficiary is not being transported by an ambulance
- there is sufficient documentation to justify the medical necessity for both stationary and portable units

A mobile suction machine includes a vacuum regulator and is battery operated. The device includes a rechargeable battery and charger device, vehicle adapter cable, canister or bottle, connector and carrying case.

Gastric Suction Pump

A mobile or stationary home model suction pump is a lightweight, compact, electric aspirator designed for gastric suction for use in the home. A suction device must be appropriate for home use without technical or professional supervision. Those using the suction apparatus must be sufficiently trained to adequately, appropriately and safely use the device.

The stationary home model suction pump is covered for gastric suction if the beneficiary has one of the following:

- gastric outlet obstruction and gastric atony
- high grade esophageal stenosis or complete esophageal obstruction, especially if there is a history of aspiration; and
- enterocutaneous fistula not manageable by "gravity tube drainage".

DME-RELATED SUPPLIES

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Alcohol (Isopropyl) • Preps, swabs or wipes • Bottle	None <21 years <21 years	See Diabetic Supplies. See Insulin Pump Supplies. For injection site cleansing. The beneficiary must be self administering, or receiving from a care giver, physician prescribed IM or SubQ injections. The quantity or number of ounces requested must be appropriate for the plan of care.
Apnea Monitor Supplies • Electrodes • Lead wires • Battery Pack	None None	~~See policy on Apnea Monitor for coverage criteria.~~ Beneficiary must meet criteria for Apnea Monitors.
Bed Pan • Standard, metal or plastic • Fracture, metal or plastic	< 21 years	The beneficiary must be bed-confined and unable to use a bedside commode or bathroom facilities. Limited to one per year.
Blue Pads/Underpads	>3 and <21 years	A medical condition must be present which causes incontinence of bowel and bladder. Blue pads are limited to a quantity of 6 per 24-hour period. For cases requiring more than 6 per day, refer to the criteria in the blue pad policy. They must be dispensed with appropriate documentation only at beneficiary request and cannot be shipped on an automatic basis. Blue pads may not be provided for a beneficiary for incontinent care if they are receiving diapers. For these cases where there is full documentation justifying the need for the bluepads/underpads for beneficiaries whose medical condition is not expected to improve, recertification will only be required every 12 months
BIPAP/CPAP Supplies	None	~~See policy on BI/PAP for coverage criteria.~~ See policy on BIPAP/ CPAP for coverage criteria.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Breast Pump Supplies (patient owned electric breast pump only)	None	~~See policy on Electric Breast Pumps for coverage criteria.~~ Beneficiary must meet criteria for Electric Breast Pump. Supplies or parts for manual breast pumps are not covered.
Diabetic Supplies • Test Strips • Lancets • Insulin Syringes • Control Solution • Replacement Battery • Spring Lancet Device • Autoclix lancets (spring) • Urine test or reagent strips • Alcohol preps or wipes	None	Beneficiary must meet criteria for Glucometers. See policy on Batteries/Battery Chargers. Amount to be dispensed is determined by medical necessity. These supplies must be dispensed only at patient request with appropriate documentation and cannot be shipped on an automatic basis.
Diapers	>3 and <21 years	See ~~policy on Diapers for coverage criteria.~~ See section 10.32 Diapers for coverage criteria.
Dressing Supplies ~~for Wound Care~~ • 4x4 non-sterile gauze pads • 4x4 sterile gauze pads (includes drain sponges) • tape • sterile normal saline solution, 1000ml • gloves, sterile and non-sterile • other	None ~~See criteria~~ <21 years old	These dressing supplies may only be provided for beneficiaries who have a PEG tube, and tube feedings are their sole source of nutrition. Dressing supplies for wounds are not provided for adult beneficiaries. ~~The supplies listed and other supplies~~ Other dressing supplies may be considered for children less than 21 years of age when the request is submitted with a plan of care.
Biofeedback / EMG • Lead Wires • Electrodes	<21 years old	Beneficiary must meet the criteria for EMG/Biofeedback. Quantity will be determined by medical necessity. A one month supply may be dispensed at a time for up to six (6) months, then recertification is required. They may be dispensed only at patient request with appropriate documentation and cannot be shipped on an automatic basis.
Enema Supplies • Enema bucket with soap • Fleets, regular • Fleets, mineral oil • Soap packet (castile) • Gloves, nonsterile	< 21 years	The beneficiary's condition must be such that the introduction of solution(s) into the rectum and colon are required in order to stimulate bowel activity and cause emptying of the lower intestine.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Enteral Feeding Supplies • 4 X 4 non-sterile • 4 X 4 sterile (Includes drain sponges) • Tape • Sterile saline solution,1000 ml • Gloves, sterile and non-sterile • Feeding bag(s) • Feeding syringe • Gloves • Sterile water, 1000 ml	None	Beneficiary must meet criteria for Enteral Feeding Pump.
Heel/Elbow Protectors	None	Heel/Elbow protectors are covered if one of the follow applies: * The beneficiary is bed/chair confined and has a history of decubitus ulcers on a heel or elbow. * The patient is bed/chair confined and currently has a decubitus ulcer on a heel or elbow. * The beneficiary exhibits signs of redness or discomfort at bony prominences or other areas of potential breakdown.
Humidifiers • Distilled water, 1000 ml	<21 years	Beneficiary must meet criteria for Humidifiers.
Hydrogen Peroxide • Bottle	None <21 years	Beneficiary must meet criteria for tracheostomy supplies. May be considered for children less than 21 years of age for wound care when the request is submitted with a plan of care. The quantity or number of ounces requested must be appropriate for the plan of care.
Infusion Pump Supplies	None	See IV Pump.
Insulin Pen Needles or Prefilled Insulin Syringe Needles	None	Beneficiary must be receiving a prefilled Novopen or cartridge through the pharmacy program. Needles will be covered through the DME program only if one of the following criteria is met: * The patient has very poor eyesight and is unable to read the markings on a standard insulin syringe. * The patient has a condition of the hands that will not allow them to manipulate a vial and syringe to draw up their insulin.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Insulin Pump Supplies • Cartridges • Infusion sets with cannula • Skin Cleanser • Skin prep • Alcohol prep • Adhesive remover • Transparent dressing • Replacement batteries	< 21 years	Beneficiary must meet the criteria for an Insulin Pump. See policy on Batteries/Battery chargers.
IPPB Supplies • Circuits, with mouthpiece • Aerosol mask	None	Beneficiary must meet criteria for IPPB.
IV Pump (Infusion Pump) Supplies • Cassette appropriate for pump type • Replacement batteries	None	Beneficiary must meet criteria for IV pump. See policy on Batteries/Battery Chargers.
IV Supplies (Includes central line supplies) • Administration set, (tubing and clamp) • Extension set • IV Start kit • Butterfly needles, all sizes • IV catheters, all sizes • Non-coring needles • 2 X 2 gauze, sterile • Tape, all types • Syringe, any size without needle • Syringe, any type with needle • INT • Flush kit • Iodine prep, alcohol pads • Dial-a-flow • Sterile normal saline for injection 2 ml, 2.5 ml, 3 ml, 5 ml, 10 ml, 20 ml, 30 ml, and 50 ml bottes, ampules and vials.	None	Beneficiary must meet criteria for IV Pump or IV Pole.
Kits	See specific supply item for age restrictions. Ex. IV start kit, see IV supplies for age restriction.	See specific supply item for coverage criteria. Provider must supply information from the manufacturer listing and describing what items are included in the kit.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Lift • Sling seat, canvas or nylon	< 21 years	Beneficiary must meet criteria for patient lift. Sling seats are covered as a separate item as a replacement only.
Nebulizer Supplies • Administration set, disposable, nonfiltered • Administration set, non disposable, nonfiltered • Administration set, filtered • Aerosol mask • Tubing	None	Beneficiary must meet criteria for Nebulizer.
Neuromuscular Electrical Stimulator (NMES) Supplies • Electrodes • Lead wires	< 21 years	Beneficiary must meet criteria for Neuromuscular Electrical Stimulator.
Oral Hygiene Supplies • Tooth brushes • Dental floss • Toothpaste • Toothettes • Lemon Glycerin Swabs • Other non-specific oral hygiene items	Not covered for any age	Oral hygiene supplies are not covered for any age.
Osteogenic/ Bone Growth Stimulator Supplies • Electrodes • Lead wires	< 21 years	Beneficiary must meet criteria for Bone Growth or Osteogenic Stimulators.
Ostomy Supplies • As listed in current HCPCS codes	None	Ostomy supplies are covered for beneficiaries who have a surgically established opening (stoma) to divert urine, feces, or ileal contents outside the body. Quantity is determined by medical necessity. These supplies may be dispensed only at patient request with appropriate documentation in quantities sufficient for one month's use and cannot be shipped on an automatic basis. A new prescription or letter of medical necessity is required at the end of each 12 month period.
Oxygen Related Supplies • E Cylinders, includes delivery • H or K Cylinders, includes delivery • Tubing • Face Masks • Nasal Cannulas • Regulators	None	See criteria for Oxygen and Oxygen Related Equipment. Oxygen related supplies and refills may be billed to Mississippi Medicaid only if the beneficiary owns the equipment.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Paraffin Bath Supplies • Paraffin wax	None	Beneficiary must meet criteria for Paraffin Bath.
Parenteral Nutrition Supplies	None	See IV Pumps, IV Poles and IV Supplies.
Pulse Oximeter Supplies • Oxygen probe	<21 years	Beneficiary must meet criteria for Pulse Oximeter.
Sheepskin	< 21 years	The beneficiary must be exhibiting signs of redness or discomfort at bony prominences or other areas of potential skin breakdown.
Sling	<21	The beneficiary must 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.
Suction Pump Supplies (Respiratory) • Suction catheter kit, sterile • Suction catheter, 8-15 FR • Suction, whistle tip, with valve • Suction, Yanker type • Suction tubing • Canister, disposable, limit one per month • Sterile water, 1000 ml • Gloves, any type • Gastric suction tube	None None	Beneficiary must meet criteria for ~~Suction Pump~~ Respiratory Suction Pump. Beneficiary must meet criteria for Gastric Suction Pump.
Supplies for maintenance of drug infusion catheter, per week (list drug separately) • Catheter insertion devices • Dressing for catheter site • Flush solutions not directly related to drug infusion • Cannulas • Needles • Infusion supplies (excluding the insulin reservoir)	None	Beneficiary must meet criteria for IV pump.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Supplies for external drug infusion pump, per cassette or bag (list drug separately) • Cassettes, bags • Diluting solution • Tubing • Other administration supplies • Port charges (not used for syringe-type reservoir)	None	Beneficiary must meet criteria for IV pump.
Syringes and needles for self administration of intramuscular and/or subcutaneous injectable medication.	None	Beneficiary or caregiver must be administering the injections in the home. **Note: Caregiver does not include hospice, home health, respite and/or other provider types.** Medical necessity must be documented by the prescribing physician.
Transcutaneous Electrical Nerve Stimulator (TENS) Supplies • Electrodes • Lead wires	< 21 years	Beneficiary must meet the criteria for TENS.
Tracheostomy Supplies • Trach mask or collar • Trach or laryngectomy tube • Trach, inner cannula, replacement • Tracheal suction catheter, any type • Trach care kit, for new trach • Trach care kit, for established trach • Suction catheter kit, sterile • Sterile water, 1000 ml • Sterile normal saline for instillation. Supplied in 2 ml, 2.5 ml, 3 ml, 5 ml, 10 ml, 20 ml, 30 ml, and 50 ml bottle, ampule, or vial.	None	Beneficiary must have a tracheostomy with documentation of specific respiratory condition.
Urinal, male or female, limit one per year	< 21 years	Beneficiary must be bed confined and unable to use a bedside commode or bathroom facilities.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Urinary Catheters • Insertion tray • Irrigation tray (with bulb or piston syringe • Irrigation syringe (bulb or piston) • Sterile solution for irrigation • Female external collection device • Indwelling catheter, Foley, two way • Indwelling catheter, three-way • Male external catheter, with or without adhesive • Intermittent catheter, straight tip • Bedside drainage bag • Leg bag with or without strap	< 21 years	1) Beneficiary must have an acute condition which requires intermittent catheterization for measuring residual, instilling medication, or other medically necessary indication, **or** 2) Beneficiary has an acute condition which requires the short-term use of an indwelling catheter, **or** 3) Beneficiary has a chronic condition in which incontinence is exacerbating pressure sores that will not heal, **or** 4) Beneficiary has a condition that requires accurate measurement of intake and output on a short-term basis, **or** 5) Beneficiary has urinary retention that cannot be relieved by medication. The beneficiary and/or caregiver must be capable of performing the catheterization procedure and reporting results and have been instructed in the procedure and properly demonstrated the ability to perform the procedure. Condom catheters may be provided for individuals with paraplegia, neurogenic bladder, or other medically necessary indications when requested with appropriate documentation.
Urine Reagent Strips	None	Beneficiary has one of the chronic medical conditions listed below that require measurement of urine protein at least three (3) times a week for the monitoring of disease activity in order to initiate or modulate definitive therapy. • Minimal change disease • FocalSegmental Glomerulosclerosis • Membranoproliferative Glomerulonephritis
Vaporizer Supplies • Distilled water, 1000 ml	<21 years	Beneficiary must meet criteria for Vaporizers.
Pressure Support Ventilator Supplies	None	See policy on Pressure Support Ventilators.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Ventilator Supplies	None	See policy on Ventilators. For Ventilator being rented supplies are included in the monthly rental allowance. For beneficiary owned ventilators, supplies may be billed separately using appropriate HCPCS codes.