Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

In order to participate as a DME supplier in the Mississippi Medicaid program, a provider must:

- Be certified to participate as a DME supplier under Title XVII (Medicare) of the Social Security Act and provide current documentation of their authorization to participate in the Title XVII program to DOM.
- Meet all applicable requirements of law to conduct business in the State.
- Execute a participation agreement with DOM.

A DME supplier's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, he/she must accept the Medicaid payment as payment in full for those services covered by Medicaid. He/she cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

A DME provider cannot submit a claim until the DME item(s) or service(s) have been delivered/provided to the beneficiary. A DME provider also cannot withhold a service or item pending payment of a claim for that service or item.

Durable medical equipment, orthotics, prosthetics, and medical supplies are covered by Mississippi Medicaid when billed by DME providers. A Mississippi Medicaid DME supplier provider number will not be issued to physicians and clinics. For dual eligible beneficiaries covered by both Medicare and Medicaid, the Division of Medicaid will reimburse the Medicare deductible and co-insurance for these items on crossover claims.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid Policy as it relates to these factors is initiated by DOM.

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 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 unbundled codes. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.

DME 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 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 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(Prior to 01/01/06)	A4233, A4235 (After 01/01/06) A4234, A4236	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 UM/QIO. Providers must comply with procedures set forth by the 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 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 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 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 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 quality improvement organization, 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 rental trial period in addition to the 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.

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 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.

Drugs

Mississippi Medicaid does not reimburse DME providers for drugs, including oral, intravenous, intramuscular, topical or inhaled.

Medicare crossover claims will be paid to DME and Pharmacy DME providers for drugs covered under Medicare Part B.

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.

DME Provider Numbers for Physicians and Clinics

Durable medical equipment, orthotics, prosthetics, and medical supplies are covered by Mississippi Medicaid when billed by DME providers. A Mississippi Medicaid DME supplier provider number will not be issued to physicians and clinics. For dual eligible beneficiaries covered by both Medicare and Medicaid, the Division of Medicaid will reimburse the Medicare deductible and co-insurance for those items on crossover claims.

NOTE: **DOM requires that DME providers must utilize and complete all forms and paperwork required by the Utilization Management/Quality Improvement Organization (UM/QIO) in determining medical necessity.**