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 provider must report the appropriate code on the Plan of Care submitted to the Utilization Management/ Quality Improvement Organization (UM/QIO) when certification is required, and on all claims for both certified and non-certified items.

Items 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 items that are covered by a single comprehensive code.

DME providers may refer to the current fee schedule for the 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, orthotics, and prosthetics 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.

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.

The DME provider, physician, physician assistant, or nurse practitioner must utilize appropriate DME 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.

For medical supplies, certification is only required for diapers and underpads. Other medical supplies do not require certification; providers should refer to the policy for coverage criteria and to the fee schedule for covered codes.

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.

The maximum reimbursement for purchase of all items supplied by DME providers **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.

Reimbursement

Fee-Based Pricing

Items for which there is a fee listed on the Mississippi Medicaid DME Fee Schedule, posted at www.dom.state.ms.us or https://msmedicaid.acs-inc.com, are paid at the lesser of the provider charge or the Medicaid allowable fee. Medicaid allowable fees are set in accordance with the Mississippi Medicaid State Plan as follows:

- Purchased items are set at 80% of the Medicare fee;
- Rental items are set at 10% of the Medicaid allowable;
- Used DME and repairs are set at 50% of the Medicaid allowable.

Manual Pricing

Items that do not have a fee listed on the Mississippi Medicaid DME Fee Schedule will be manually priced.

- Some items are considered for coverage on an individual consideration basis;
- Some items do not have a specific HCPCS code and must be submitted under an unspecified or miscellaneous code with the appropriate modifier;
- Some items do not have a Medicare fee.

Pricing will be determined through the prior authorization process by the Utilization Management/Quality Improvement Organization (UM/QIO) for items that require certification based on information presented by the DME provider. For medical supplies that do not require certification, providers must submit the required document with their claim to the fiscal agent for manual pricing. These procedures apply regardless of whether the DME provider is also the manufacturer, or the provider is purchasing from a manufacturer or from a distributor/supplier.

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. Providers are entirely responsible for submitting the correct documentation and requesting appropriate manual pricing. Providers should be able to produce documentation to show the charges can be substantiated if audited.

There are two (2) methods for manual pricing:

1. MSRP Pricing – Most manually priced items will be priced at the Manufacturer's Suggested Retail Price (MSRP) minus 20%. 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. Other acceptable terms that represent MSRP include suggested list price, retail price, or price.

   The provider must submit clear written, dated documentation from a manufacturer or distributor that specifically states the MSRP for the item. This documentation may be provided with an official manufacturer's or distributor's letterhead, price list, catalog page, or other forms that clearly show the MSRP. For items that require certification, the documentation may be sent to the UM/QIO contractor via regular mail, fax, or email; documentation for non-certified items must be sent to the fiscal agent. It is the responsibility of the provider to clearly note the MSRP on the documentation. If the MSRP is not clearly documented, the request may be denied.

   A manufacturer or distributor 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.

2. Cost-Based Pricing – Items that do not have a fee **or** MSRP may be priced at the provider's cost plus 20%. 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. If the provider purchases from the manufacturer, a manufacturer's invoice must be provided. If the provider purchases from a distributor (not directly from the manufacturer), the invoice from the distributor must be provided. Quotes, price lists, catalog pages, computer printouts, or any form of documentation other than an invoice are not acceptable for this pricing solution. The invoice must not be older than one year prior to the date of the request; exceptions to the one-year requirement may be approved only for unusual circumstances.

Billing

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

Items Supplied to Nursing Facility Residents

The DME provider 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. Oxygen cylinders and ventilators must be prior approved by the UM/QIO and must satisfy all medical criteria; ostomy supplies may be billed to the fiscal agent and do not require prior authorization.

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 provider 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 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 for items that require certification.

DME Provider Documentation

All professional and institutional providers participating in the Medicaid program are required to maintain records that will disclose services rendered and billed under the program and, upon request, make such records available to representatives of DOM or Office of Attorney General in substantiation of any or all claims. These records should be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

The beneficiary and/or the legal guardian, with medically appropriate assistance of the medical practitioner, will have an active role in the selection of the DME provider and must be informed of all equipment, services and charges to be billed to Medicaid.

All DME providers must comply with the documentation requirements and **all documentation must be clear, legible, and complete.**

DME licenses, permits, ownership information, and an employee roster of current and past employees must be produced immediately on request. The DME Surety Bond information should be accessible. Originals of purchase invoices for equipment and supplies should be made part of the records available upon request.

The item **must be ordered by the appropriate physician, nurse practitioner, or physician assistant**. It is expected that physicians, nurse practitioners, and physician assistants only order 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.

In order for DOM to fulfill its obligations to verify services to Medicaid beneficiaries and those paid for by Medicaid, DME providers must maintain auditable records that will substantiate the claim submitted to Medicaid. A provider file must be maintained on each beneficiary, kept in the provider office at the business location and must contain the following information:

- A copy of the completed Certificate of Medical Necessity and Plan of Care forms when required. This must include the date, diagnosis, type of equipment being requested and anticipated length of need. Frequency and specific orders must be specified for wound care, diabetic supplies, etc., in order to determine quantity.

- A copy of the original prescription from the ordering physician.

- The date and method of delivery of equipment to the patient.

- The delivery ticket or proof of receipt form for equipment or services, signed and dated by the beneficiary or responsible party, which describes the services/equipment provided at that time, and the cost of the service/equipment, signed and dated by the delivering employee of the DME provider.

- If delivered by a third party delivery service (Fed EX, UPS, US Mail, etc.), a copy of the delivery ticket describing the piece of equipment or supply with date and signature of the receiving party.

- Record of the manufacturer or brand, and quantity/units of the supply provided.

- Reason or description and date for each and every repair or maintenance procedure on equipment in the possession of the patient or returned to the DME company for repair or maintenance, and if out of the possession of the patient, the time period it was unavailable for his/her use and any arrangements made to accommodate the patient during the time period.

- Indicate if new or used, manufacturer's name, model number or name, serial number (if marked on the device), any optional attachments, enhancements, or improvements added by the manufacturer or DME provider which results in an increased charge amount that supports the justification for and proves the delivery of the complete equipment product as billed to and paid by Medicaid or Medicare.

- Records of any maintenance supplies delivered and/or used.

- For customized equipment or appliances, the name(s), business name and address, telephone number of the therapist or technician who determines the measurements necessary to modify, build, or complete the custom item.

- Copies of any specialized documents required, such as polysomnogram with CPAP/BiPAP, seating evaluations, measurements and fittings/adjustments for orthotics/prosthetics, etc.

- Copy of environmental assessment if needed for potential accommodation of equipment.

- Copies of any teaching, training, instruction given to patient/caregiver and response.

The Division of Medicaid, the fiscal agent, and/or the Utilization Management Quality Improvement Organization (UM/QIO), reserve the right to obtain copies of hospital/physician and other records to support the medial necessity for the specific type of service billed to Medicaid.

Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

DOM, the fiscal agent, and /or the UM/QIO have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the DME provider.

If a DME provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to the Mississippi Medicaid program any money received from the program for such non-substantiated services. If a refund is not received within 30 days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the DME provider.

A DME provider who knowingly or willfully makes or causes to be made false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and shall automatically disqualify the DME provider as a provider of Medicaid Services.

Physician/Nurse Practitioner/Physician Assistant Documentation

The physician, nurse practitioner, or physician assistant ordering the item/service must maintain documentation relating to the medical necessity for this item. The information may be recorded in the patient's medical record or on the appropriate Certificate of Medical Necessity form required by the Division of Medicaid. The physician, nurse practitioner, or physician assistant must retain a copy of the completed Certificate of Medical Necessity form in the file.

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 3 through 20 years of age

___ 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 Diapers:

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.

Diapers

Diapers are covered for beneficiaries ages 3 through 20 years old who have an underlying medical condition that prevents control of the bowels or bladder. There must be documentation of the patient's diagnosis that is related to the cause or is causing the incontinence of the bowels and bladder.

Diapers are approved at a quantity of six (6) per day. In extenuating circumstances where there is full documentation that justifies the medical necessity for more than six per day, individual consideration will be given to the specific request. Diapers are not covered in conjunction with coverage of blue pads.

Providers may only dispense a one month supply at a time and may not ship diapers or any other supply items on a regular basis regardless of need.

Providers must dispense size, waist and weight appropriate diapers based on the child's current weight. Should the DME provider need to change the size of the diaper due to a change in the child's size, the DME provider must submit a new Plan of Care.

For those cases where there is full documentation justifying the need for the diapers for beneficiaries whose medical condition is not expected to improve, recertification will only be required every twelve (12) months.

Underpads

Underpads are covered for beneficiaries ages three (3) through twenty (20) years old who have a medical condition which causes incontinence of bowel and bladder. Underpads are limited to a quantity of six (6) per 24-hour period. In extenuating circumstances where there is full documentation that justifies the medical necessity for more than six (6) per 24-hour period, individual consideration will be given to the specific request.

Underpads must be dispensed with appropriate documentation only at beneficiary request and cannot be shipped on an automatic basis.

Underpads may not be provided for a beneficiary for incontinent care if they are receiving diapers.

For beneficiaries whose medical condition is not expected to improve, recertification will only be required every twelve (12) months when there is full documentation justifying the need.

MISSISSIPPI DIVISION OF MEDICAID
MEDICAL SUPPLY CERTIFICATE OF MEDICAL NECESSITY & PLAN OF CARE

This form is required for all medical supplies billed to Mississippi Medicaid (except diapers and underpads – see Section 10.32). This form must be completed and signed by the ordering physician, nurse practitioner, or physician assistant every 12 months. Medical supplies provided without a current signed prescription and/or Medical Supply CMN/POC form are not covered.

Beneficiary Name :	Beneficiary Medicaid ID #:
DME Provider Name:	DME Provider Medicaid #:
Prescribing Provider Name:	Prescribing Provider Medicaid # or MS License #:
	Prescribing Provider Phone #:
Beneficiary Diagnoses/ICD-9 Diagnosis Codes: *Diagnoses must relate to and justify the need for the prescribed medical supplies.*	

Prescribed Medical Supplies

Description	HCPCS Code	Provider Charge, MSRP, or Invoice Cost	Deliver Date	Dates of Need		Quantity (#) Delivered
				From	Thru	

DME PROVIDER ATTESTATION, SIGNATURE, AND DATE:

I certify that those items listed on this form are those exact items ordered and certified as medically necessary by the ordering physician/nurse practitioner/physician assistant whose signature appears on this form, and that these exact items will be delivered to the beneficiary listed on this form. A DME provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

SIGNATURE OF DME PROVIDER _____ DATE _____

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ATTESTATION, SIGNATURE, AND DATE:

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed medical supplies listed on this form, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified on this form. I certify that medical necessity information listed on this form is true, accurate, and complete to the best of my knowledge. I certify that I have reviewed the items listed on this form and that I deem them medically necessary for the patient listed on this form. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.

SIGNATURE OF PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT _____ DATE _____

GENERAL POLICIES FOR COVERAGE OF MEDICAL SUPPLIES

1. Medical supplies are covered when they are
    a. Medically necessary for the treatment of a medical condition;
    b. Dispensed in quantities that meet a beneficiary's medical needs without excessive utilization;
    c. Considered standard of care for treatment of the beneficiary's medical condition; and
    d. Provided according to Mississippi Medicaid policy criteria detailed in this manual.

2. Certification or prior authorization is not required for covered medical supplies (except for diapers and underpads as described in Section 10.07). DME providers and pharmacy DME providers may submit claims without Treatment Authorization Numbers (TAN's) for medical supplies that do not require certification for dates of service beginning January 1, 2009.

3. All medical supplies, including those required for operation of DME, must be prescribed by a licensed, qualified physician, nurse practitioner, or physician assistant.
    a. A Medical Supply Certificate of Medical Necessity/Plan of Care (CMN/POC) form must be completed by the DME provider.
    b. The Medical Supply CMN/POC form must be signed by the ordering physician, nurse practitioner, or physician assistant within thirty (30) days of item delivery. The Medical Supply CMN/POC form can be used as the physician prescription.
    c. The Medical Supply CMN/POC form is to be kept by the DME provider in the beneficiary's medical record and is subject to review by the Division of Medicaid or Office of the Attorney General.
    d. A copy of the Medical Supply CMN/POC form is to be provided to the ordering physician, nurse practitioner, or physician assistant for their medical records.

4. The DME provider is responsible for compliance with all Medicaid policies, including use of the appropriate HCPCS code for the billed item(s); dispensing of the appropriate medically necessary quantities of supplies; ensuring accurate billing; and maintenance of all documentation to show policy compliance.

5. Medical supplies may only be dispensed in quantities to meet the beneficiary's needs for one calendar month. The beneficiary must request the supplies each month. Supplies cannot be shipped on an automatic basis.

6. A prescription and/or Medical Supply CMN/POC form must be completed and signed by the ordering physician, nurse practitioner, or physician assistant every twelve (12) months. The prescription and/or Medical Supply CMN/POC form is considered current up to twelve (12) months from the date it was signed by the physician, nurse practitioner, or physician assistant. Medical supplies will be considered non-covered if there is no current prescription and/or Medical Supply CMN/POC form.

MEDICAL 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	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/Under pads	>3 and <21 years	See Section 10.32, Diapers and Underpads, for criteria coverage. **Requires Certification.**
BIPAP/CPAP Supplies	None	See policy on BI/PAP/CPAP for coverage criteria.
Breast Pump Supplies (patient- owned electric breast pump only)	None	Beneficiary must meet criteria for Electric Breast Pumps. 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 section 10.32 Diapers and Underpads for coverage criteria. **Requires Certification.**

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Dressing Supplies • 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 <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. 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.
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.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Humidifiers • Distilled water, 1000 ml	None	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.
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.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
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, 10ml, 20 ml, 30 ml, and 50 ml bottles, 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.
Nebulizer Supplies • Administration set, disposable, non-filtered • Administration set, non disposable, non-filtered • 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.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
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.
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	None	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.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
Sling	<21 years	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 • Cannister, disposable, limit one per month • Gloves, any type • Gastric suction tube	None None	Beneficiary must meet criteria for 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 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.

SUPPLIES	AGE RESTRICTION	CRITERIA FOR COVERAGE
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 2ml, 2.5ml, 3ml, 5ml, 10ml, 20ml, 30ml, and 50 ml bottle, ampule, or vial. • Trach ties • Trach cleaning brush • Heat/Moisturizer Exchange System (HME) • Trach shower protector Tracheostomy/ laryngectomy tube plug/stop • Tracheostoma filter • Gauze	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
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.