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, 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. The Plan of Care form and the generic Certificate of Medical Necessity (CMN) form is included in this policy. Specific CMN forms are in the following policy sections for specific items provided through the DME program. 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~~ www.medicaid.ms.gov 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.