



MISSISSIPPI DIVISION OF  
**MEDICAID**

Administrative Code

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Title 23: Medicaid

Part 209

Durable Medical Equipment, Medical Appliances and Medical Supplies

## Table of Contents

|                                                                                                                                    |    |
|------------------------------------------------------------------------------------------------------------------------------------|----|
| <a href="#">Title 23: Medicaid</a>                                                                                                 | 1  |
| <a href="#">Table of Contents</a>                                                                                                  | 1  |
| <a href="#">Title 23: Division of Medicaid</a>                                                                                     | 1  |
| <a href="#">Part 209: Durable Medical Equipment and Medical Supplies</a>                                                           | 1  |
| <a href="#">Part 209 Chapter 1: Durable Medical Equipment</a>                                                                      | 1  |
| <a href="#">Rule 1.1: Provider Participation</a>                                                                                   | 1  |
| <a href="#">Rule 1.2: Provider Enrollment Requirements</a>                                                                         | 1  |
| <a href="#">Rule 1.3: Definitions</a>                                                                                              | 1  |
| <a href="#">Rule 1.4: Reimbursement</a>                                                                                            | 2  |
| <a href="#">Rule 1.5: DME Co-payments</a>                                                                                          | 7  |
| <a href="#">Rule 1.6: Items and Services Not Covered through the DME Program</a>                                                   | 8  |
| <a href="#">Rule 1.7: Dual Eligibles</a>                                                                                           | 9  |
| <a href="#">Rule 1.8: Duplication of Equipment</a>                                                                                 | 9  |
| <a href="#">Rule 1.9: Documentation</a>                                                                                            | 9  |
| <a href="#">Rule 1.10 Apnea Monitors</a>                                                                                           | 12 |
| <a href="#">Rule 1.11: Augmentative Communication Device</a>                                                                       | 14 |
| <a href="#">Rule 1.12: Bath Bench/Shower Chair</a>                                                                                 | 15 |
| <a href="#">Rule 1.13: Battery and Battery Charger</a>                                                                             | 16 |
| <a href="#">Rule 1.14: Bi-level Positive Airway Pressure Device (BIPAP) With or Without an In-Line Heated Humidifier</a>           | 16 |
| <a href="#">Rule 1.15: Breast Pump, Electric</a>                                                                                   | 18 |
| <a href="#">Rule 1.16: Cane</a>                                                                                                    | 19 |
| <a href="#">Rule 1.17: Combination Positive Expiratory Pressure, Airway Oscillation, and Intermittent Flow Acceleration Device</a> | 20 |
| <a href="#">Rule 1.18: Commode Chairs and Other Toileting Aids</a>                                                                 | 21 |

|                                                                                                                                                                |    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| <a href="#"><u>Rule 1.19: Compressors</u></a> .....                                                                                                            | 22 |
| <a href="#"><u>Rule 1.20: Continuous Positive Airway Pressure (CPAP) With or Without an In-Line Heated Humidifier</u></a> .....                                | 22 |
| <a href="#"><u>Rule 1.21: Crutches</u></a> .....                                                                                                               | 24 |
| <a href="#"><u>Rule 1.22: Diapers and Underpads</u></a> .....                                                                                                  | 25 |
| <a href="#"><u>Rule 1.23: Electromyography (EMG) Biofeedback Device</u></a> .....                                                                              | 26 |
| <a href="#"><u>Rule 1.24: Cochlear Implants and Implantable and Non-Implantable Auditory Osseointegrated Devices, Batteries and Battery Chargers</u></a> ..... | 26 |
| <a href="#"><u>Rule 1.25: Gait Trainer</u></a> .....                                                                                                           | 27 |
| <a href="#"><u>Rule 1.26: Glucose Monitor and Replacement Battery</u></a> .....                                                                                | 28 |
| <a href="#"><u>Rule 1.27: Hip Abductor Pillow/Wedge</u></a> .....                                                                                              | 30 |
| <a href="#"><u>Rule 1.28: Hospital Bed</u></a> .....                                                                                                           | 30 |
| <a href="#"><u>Rule 1.29: Hydraulic Lift with Seat or Sling</u></a> .....                                                                                      | 33 |
| <a href="#"><u>Rule 1.30: Infusion Pump, Enteral/Parenteral/External</u></a> .....                                                                             | 34 |
| <a href="#"><u>Rule 1.31: Insulin Pumps</u></a> .....                                                                                                          | 35 |
| <a href="#"><u>Rule 1.32: IV Poles</u></a> .....                                                                                                               | 36 |
| <a href="#"><u>Rule 1.33: Nebulizer</u></a> .....                                                                                                              | 36 |
| <a href="#"><u>Rule 1.34: Neuromuscular Electrical Stimulator (NMES)</u></a> .....                                                                             | 37 |
| <a href="#"><u>Rule 1.35: Oxygen and Oxygen Related Equipment</u></a> .....                                                                                    | 38 |
| <a href="#"><u>Rule 1.36: Pacemaker Monitor</u></a> .....                                                                                                      | 42 |
| <a href="#"><u>Rule 1.37: Pulse Oximeter</u></a> .....                                                                                                         | 42 |
| <a href="#"><u>Rule 1.38: Spacer/Aerosol-Holding Chamber</u></a> .....                                                                                         | 43 |
| <a href="#"><u>Rule 1.39: Suction Pump, Respiratory/Gastric</u></a> .....                                                                                      | 44 |
| <a href="#"><u>Rule 1.40: Traction Equipment</u></a> .....                                                                                                     | 45 |
| <a href="#"><u>Rule 1.41: Transcutaneous Electrical Nerve Stimulator (TENS)</u></a> .....                                                                      | 45 |
| <a href="#"><u>Rule 1.42: Transfer Board</u></a> .....                                                                                                         | 46 |
| <a href="#"><u>Rule 1.43: Trapeze Bar/Equipment</u></a> .....                                                                                                  | 47 |
| <a href="#"><u>Rule 1.44: Ventilator</u></a> .....                                                                                                             | 47 |

|                                                                                                        |    |
|--------------------------------------------------------------------------------------------------------|----|
| <a href="#"><u>Rule 1.45: Walker</u></a> .....                                                         | 48 |
| <a href="#"><u>Rule 1.46: Wedge Seat Insert, Custom</u></a> .....                                      | 50 |
| <a href="#"><u>Rule 1.47: Wheelchair</u></a> .....                                                     | 51 |
| <a href="#"><u>Rule 1.48: Wheelchair Accessories</u></a> .....                                         | 59 |
| <a href="#"><u>Rule 1.49: Wheelchair, Drivers and Seating, Custom</u></a> .....                        | 64 |
| <a href="#"><u>Rule 1.50: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)</u></a> ..... | 64 |
| <a href="#"><u>Rule 1.51: Humidifier/Vaporizer</u></a> .....                                           | 64 |
| <a href="#"><u>Rule 1.52: Pressure Reducing Support Surface</u></a> .....                              | 65 |
| <a href="#"><u>Part 209 Chapter 2: Medical Supplies</u></a> .....                                      | 67 |
| <a href="#"><u>Rule 2.1: Medical Supplies</u></a> .....                                                | 67 |
| <a href="#"><u>Rule 2.2: Covered Medical Supplies</u></a> .....                                        | 69 |
| <a href="#"><u>Rule 2.3: Non-Covered Medical Supplies</u></a> .....                                    | 77 |
| <a href="#"><u>Rule 2.4: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)</u></a> .....  | 77 |
| <a href="#"><u>Rule 2.5: Diabetic Supply Rebate Program</u></a> .....                                  | 85 |

## **Title 23: Division of Medicaid**

### **Part 209: Durable Medical Equipment and Medical Supplies**

#### **Part 209 Chapter 1: Durable Medical Equipment**

##### *Rule 1.1: Provider Participation*

In order to participate as a Durable Medical Equipment (DME) supplier in the Medicaid program, a provider must:

- A. 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 Medicaid.
- B. Meet all applicable requirements of law to conduct business in the State.
- C. Execute a participation agreement with Medicaid.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1861, Subpart E

##### *Rule 1.2: Provider Enrollment Requirements*

DME providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

- A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPES),
- B. Provide written confirmation from the IRS confirming the tax identification number and legal business name,
- C. Provide a copy of current Medicare certification for the servicing location. Explanation of Medicare Benefits (EOMB) is not acceptable, and
- D. Provide a copy of DME or pharmacy permit from MS State Board of Pharmacy for the servicing location.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

##### *Rule 1.3: Definitions*

The Division of Medicaid defines:

- A. Durable Medical Equipment (DME) and/or medical appliance as an item meeting all five (5) criteria below:

1. It can withstand repeated use,
  2. Is reusable or removable,
  3. Is primarily and customarily used to serve a medical purpose,
  4. Is generally not useful to a person in the absence of a disability, illness, or injury, and
  5. Is appropriate for use in any setting where the beneficiary's normal life activities take place other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made by the Division of Medicaid for inpatient services that include room and board.
- B. Prior authorization, as used in this chapter, is defined as prior authorization for a service or item based on medical necessity review by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity.
- C. An allowed non-physician practitioner is defined as a:
1. A nurse practitioner, clinical nurse specialist or certified nurse midwife working in collaborative/consultative relationship under established protocol or practice guidelines with a Mississippi licensed attending physician enrolled as a Mississippi Medicaid provider,
  2. A physician assistant under the supervision of the Mississippi licensed attending physician enrolled as a Mississippi Medicaid provider as required by the Mississippi Board of Medical Licensure.
- D. Home is defined as any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or any setting in which payment is or could be made by the Division of Medicaid for inpatient services that include room and board.
- E. The Division of Medicaid defines a trial period as the time required to assess the effectiveness of an item and beneficiary compliance.

Source: 42 U.S.C. § 1395x(n); 42 C.F.R. § 440.70; Miss. Code Ann. § 43-13-121.

History: Revised eff. 07/01/2021, Revised eff. 09/01/2018.

#### *ule 1.4: Reimbursement*

- A. The Division of Medicaid reimburses for durable medical equipment (DME) and/or medical appliances when ordered by a physician or through the use of a collaborative practice agreement between the non-physician practitioner and the physician, and within the

practitioner's scope of practice and collaborative agreement procedures. [Refer to Miss. Admin. Code Part 207 for DME coverage in a long-term care facility.]

- B. The Division of Medicaid requires prior authorization be submitted prior to or within thirty (30) days of delivery of the DME and/or medical appliance. The Division of Medicaid does not allow the beneficiary to be billed if the DME provider chooses to deliver the item/service prior to submitting a prior authorization request and approval is not given.
- C. All standard DME and/or medical appliance, excluding custom motorized/power wheelchair systems, must have a manufacturer's warranty of a minimum of one (1) year.
  - 1. If the provider supplies DME or a medical appliance that is not covered under a warranty, the provider is responsible for any repairs, replacement or maintenance that may be required within one (1) year.
  - 2. The warranty begins on the date of the delivery to the beneficiary.
  - 3. The DME provider must keep a copy of the warranty and repair information in the beneficiary's file.
  - 4. The Division of Medicaid reserves the right to request copies of the warranty and repair information for audit/review purposes when necessary.
  - 5. The Division of Medicaid investigates cases suggesting intentional damage, neglect, or misuse of the DME and/or medical appliance. If the provider suspects such damage of DME and/or medical appliance, the provider must report it immediately to the Division of Medicaid for investigation and notify the beneficiary that the cost for repairs/replacement may be the responsibility of the beneficiary if the Division of Medicaid determines intentional damage, neglect, or misuse of the DME and/or medical appliance.
  - 6. DME providers must provide a two (2) year warranty of the major components for custom motorized/power wheelchairs.
    - a) The main electronic controller, motors, gear boxes, and remote joystick must have a two (2) year warranty from the date of delivery.
    - b) Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects, if the surface does not remain intact due to normal wear.
    - c) Powered mobility bases must have a lifetime warranty on the frame against defects in material and workmanship for the lifetime of the beneficiary.
    - d) If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the provider is responsible for any repairs, replacement or maintenance that may be required within two (2) years.

- e) The warranty begins the date of delivery to the beneficiary.
- D. The Division of Medicaid reimburses rental of DME and/or medical appliance up to ten (10) months, or up to the purchase price, whichever is the lesser, unless specified as a “rental only” item in Miss. Admin. Code Part 209.
- 1. After rental benefits are paid for ten (10) months, the DME becomes the property of the beneficiary, unless otherwise authorized by the Division of Medicaid through specific coverage criteria.
  - 2. There cannot be sales tax on “rental only” items as there is no sale or purchase.
  - 3. A trial period for DME and/or medical appliance must be applied toward the ten (10) month rental.
    - a) The Division of Medicaid applies the rental fees paid for any trial period toward the maximum reimbursement for purchase.
    - b) The Division of Medicaid does not reimburse a rental trial period in addition to the full purchase price.
  - 4. The rental allowance includes the DME and/or medical appliance, delivery, freight and postage, set-up, all supplies necessary for operation of the DME and/or medical appliance, education of the patient and caregiver, all maintenance and repairs or replacement, labor including respiratory therapy visits, and servicing charges.
  - 5. Rental benefits beyond the ten (10) month period must be:
    - a) Prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity,
    - b) Medically necessary, and
    - c) Cost effective for the Division of Medicaid.
  - 6. The DME and/or medical appliance must be returned to the DME provider after it is no longer required, if the rental period is less than ten (10) months.
- E. The Division of Medicaid reimburses repairs, including labor and delivery, of DME and/or a medical appliance that is owned by the beneficiary not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.
- 1. DME providers providing custom wheelchairs, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8) a.m. and five (5) p.m. Monday through Friday. Each

technician must keep, on file, records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.

2. The Division of Medicaid requires prior authorization by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for the repair and must include an estimated cost of necessary repairs, including labor, and a statement from the physician stating that there is a continued need for the DME and/or medical appliance.
  3. Labor and delivery charges are included in the repair cost and are not reimbursed separately.
  4. The Division of Medicaid does not reimburse repair of a rental item.
  5. The Division of Medicaid does not reimburse repairs when it has been determined that the DME and/or medical appliance has been intentionally damaged, neglected, or misused by the beneficiary, caregiver or family.
  6. The Division of Medicaid reimburses, under extenuating circumstances as determined by the Division of Medicaid, UM/QIO, or designated entity rental of an item on a short-term basis while DME and/or medical appliance owned by the beneficiary is being repaired.
- F. The Division of Medicaid reimburses the replacement of DME and/or a medical appliance, without a trial period, under the following circumstances: The initial trial period may be waived for the replacement of an identical or existing piece of DME or medical appliance.
1. Wear and tear every five (5) years, unless there are extenuating circumstances.
  2. Theft when there is documentation from law enforcement of a theft.
  3. Fire when there is documentation from the fire department.
  4. Natural disaster when there is documentation from the appropriate authorities.
- G. The Division of Medicaid reimburses for the purchase of DME and/or medical appliance when it is determined by the Utilization Management/Quality Improvement Organization, the Division of Medicaid or designated entity to be more economical than renting and when the period of need is estimated by the physician to be ten (10) or more months.
- H. The Division of Medicaid reimburses DME and/or medical appliances at the lesser of the provider charge or the Division of Medicaid's allowable fee set as follows:
1. Purchased items are set at eighty percent (80%) of the Medicare fee.
  2. Rental items are set at ten percent (10%) of the Division of Medicaid's allowable fee.

3. Used DME and/or medical appliances and repairs are set at fifty percent (50%) of the Division of Medicaid's allowable fee.
- I. The Division of Medicaid manually prices items that do not have an assigned allowable fee.
1. The Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity performs the manual pricing of the item.
  2. When requesting manually priced items, the DME provider must indicate the name of the product, the product number, and the name of the manufacturer or distributor and must provide the required documentation for pricing.
  3. If there is no DMEPOS fee, the provider will be reimbursed a fee determined by the Division of Medicaid. The Division of Medicaid will utilize the lower of the Division of Medicaid's average/established fee or the average of the fees from other states, when available, or determine the fee from cost information from providers and/or manufacturers, survey information from national fee analyzers, or other relevant fee-related information. The fees will be updated as determined by the Division of Medicaid.
  4. If there is no DMEPOS fee or a fee determined by the Division of Medicaid, the provider will be reimbursed a fee calculated through the following manual pricing hierarchy:
    - a) Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%) or,
      - 1) It is expected that most items will have a retail price; therefore, providers should request MSRP pricing for all manually priced items unless there is absolutely no retail price.
      - 2) Other acceptable terms that represent MSRP include suggested list price, retail price, or price.
      - 3) The provider must submit clear, written, dated documentation from a manufacturer or distributor that specifically states the MSRP for the item. This documentation must be provided with an official manufacturer's or distributor's letterhead, price list, catalog page, or other forms that clearly show the MSRP.
      - 4) A manufacturer's or distributor's quote may be substituted for an MSRP if the manufacturer does not make an MSRP available. The quote must be in writing from the manufacturer or distributor and must be dated.
    - b) If there is no MSRP, then the provider's invoice received from a wholesaler or manufacturer plus twenty percent (20%).
      - 1) The provider must attach a copy of a current invoice indicating the cost to the provider for the item dispensed and a statement that there is no MSRP available for the item.

- 2) If the provider purchases from the manufacturer, a manufacturer's invoice must be provided.
  - 3) If the provider purchases from a distributor and not directly from the manufacturer, the invoice from the distributor must be provided.
  - 4) Quotes, price lists, catalog pages, computer printouts, or any form of documentation other than an invoice are not acceptable for this pricing solution.
  - 5) The invoice must not be older than one (1) year prior to the date of the request. Exceptions to the one (1) year requirement may be approved only for unusual circumstances.
- J. When it is determined by DOM, based on documentation, that the Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule (DMEPOS) fee is insufficient for the Mississippi Division of Medicaid population or could result in a potential access issue, then a fee will be calculated using market research from the area.
- K. [Reserved]
- L. DME, medical appliances, and medical supplies related to the terminal illness for those Division of Medicaid beneficiaries receiving benefits in the Hospice Program cannot be reimbursed through the DME and medical appliances program.
- M. The Division of Medicaid's fee schedule of DME is not comprehensive. The Division of Medicaid reimburses for items not listed on the DME fee schedule, on a case-by-case basis, when prior authorized as medically necessary by a UM/QIO, and the provider submits the following to the Division of Medicaid:
1. Paper claim, and
  2. Approved prior authorization.
- N. The following are not reimbursed by the Division of Medicaid under the DME program:
1. Additional charges for freight, postage and/or delivery and
  2. Cost of replacing items that were not delivered to the beneficiary due to loss, theft or incomplete delivery.
- O. The Division of Medicaid reimburses for the face-to-face encounter conducted by a physician or non-physician practitioner separately according to the appropriate fee schedule.
- P. Evaluations and/or assessments including environmental evaluations in order to provide DME and/or medical appliances are not separately reimbursable.

Source: U.S.C. § 1395(m); Miss. Code Ann. § 43-13-121.

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

Rule 1.5: [Reserved]

*Rule 1.6: Coverage Requests for Items and Services Not Listed as Covered through the DME Medical Appliance Program*

- A. The Division of Medicaid does not cover items or services through durable medical equipment (DME) and medical appliance program that do not meet:
  - 1. The definition of DME and/or medical appliances,
  - 2. Medical necessity or standard of care criteria,
  - 3. Healthcare Common Procedure Coding System (HCPCS) code descriptors that represent the product, or
  - 4. The approval of the appropriate government regulatory bodies.
- B. The Division of Medicaid covers medically necessary DME items that are not listed on the fee schedule on a case-by-case basis when:
  - 1. The provider submits documentation that meet the requirements listed in Rule 1.6.A.,
  - 2. The request for coverage is limited to one (1) beneficiary, and
  - 3. The request is not used to cover multiple items or multiple beneficiaries.
- C. Maintenance contracts and servicing fees are not covered under the DME and medical appliance program. For charges related to repair of DME and/or medical appliances, refer to Miss. Admin. Code Part 209, Rule 1.4.

Source: 42 U.S.C. § 1395m(a); Miss. Code Ann. § 43-13-121.

History: Revised eff. 07/01/2021; Revised eff. 09/01/2018.

- B. The Division of Medicaid covers medically necessary DME items that are not listed on the fee schedule on a case-by-case basis when:
  - 1. The provider submits documentation that meet the requirements listed in Rule 1.6.A.,

2. The request for coverage is limited to one (1) beneficiary, and
  3. The request is not used to cover multiple items or multiple beneficiaries.
- C. Maintenance contracts and servicing fees are not covered under the DME and medical appliance program. For charges related to repair of DME and/or medical appliances, refer to Miss. Admin. Code Part 209, Rule 1.4.

Source: 42 U.S.C. § 1395m(a); Miss. Code Ann. § 43-13-121.

History: Revised eff. 05/01/2021; Revised eff. 09/01/2018.

*Rule 1.7: Dual Eligibles*

Medicaid covers durable medical equipment not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. For dual eligible beneficiaries covered by both Medicare and Medicaid, Medicaid reimburses the Medicare deductible and co-insurance for those items on crossover claims.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1834

*Rule 1.8: Duplication of Equipment*

Medicaid covers the duplication of DME on an individual basis only. Medicaid covers the duplication of DME item(s) that are not portable, not mobile, or the size/weight of the item is such that daily or frequent transportation is not feasible.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1834

*Rule 1.9: Documentation*

- A. The Division of Medicaid requires that the beneficiary and/or the legal guardian, with medically appropriate assistance from the ordering physician, have freedom of choice to select the durable medical equipment (DME) provider and must be informed of all DME, medical appliances, services and charges to be billed to the Division of Medicaid.
- B. The following must be available to the Division of Medicaid at all times:
1. DME licenses,
  2. Permits,
  3. Ownership information,
  4. Employee roster of current and past employees,

5. DME Surety Bond information, and
  6. Original purchase invoices for DME, medical appliances and supplies.
- C. DME providers must maintain a record for each beneficiary that is located at the DME's office or can be accessed from the DME provider's office and must contain, at minimum, the following information:
1. Documentation by a physician which includes:
    - a) That a face-to-face encounter related to the primary reason the beneficiary requires DME and medical appliances occurred no more than six (6) months prior to the start of services,
    - b) The practitioner who conducted the encounter, and
    - c) The time and date of the encounter.
  2. If the face-to-face encounter is conducted by an allowed non-physician practitioner as defined in Miss. Admin Code Part 209, Rule 1.3:
    - a) The allowed non-physician practitioner performing the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician.
    - b) The clinical findings of the face-to-face encounter must be incorporated into a written or electronic document in the beneficiary's medical record.
  3. A copy of the completed Certificate of Medical Necessity and Plan of Care for each item when required by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, which must include:
    - a) Date of request,
    - b) Diagnosis of beneficiary,
    - c) Type(s) of DME and/or medical appliance, and
    - d) Anticipated length of need.
  4. A copy of the original prescription from the ordering physician for each item.
  5. The date of delivery, method of delivery, and proof of delivery (POD) for each DME item and/or medical appliance.

- a) For each item sent directly by the DME provider, the proof of delivery (POD) signed and dated by the DME provider's technician or representative for each item which must include:
  - 1) Beneficiary's name,
  - 2) Delivery address,
  - 3) Detailed description of the DME, medical appliances and/or services provided at that time and Healthcare Common Procedure Coding System (HCPCS) codes that identify the item being delivered,
  - 4) Quantity delivered,
  - 5) Date of delivery which must be the date the beneficiary received the item, and
  - 6) Signature of beneficiary or designated representative.
    - a) During a national or statewide emergency, a signature is not required.
    - b) During a national or statewide emergency, the provider must document the emergency and confirmation of delivery by an alternate means including, but not limited to:
      - (1) Telephone,
      - (2) Text message, or
      - (3) Other electronic communication.
- b) For each item sent via a shipping service, the POD must include:
  - 1) Beneficiary's name
  - 2) Delivery address,
  - 3) Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents or purchase order to the delivery service's record,
  - 4) Detailed description with HCPCS codes that identify the item being delivered,
  - 5) Quantity delivered,
  - 6) Date shipped,

- 7) Date of delivery,
  - 8) Evidence of delivery which must include a tracking log that identifies each individual package with a unique identification number and delivery address.
6. Record of the manufacturer or brand of each item, and quantity/units of each item supplied.
  7. Reason or description and date for each and every repair or maintenance procedure on DME and/or medical appliance in the possession of the beneficiary or returned to the DME company for repair or maintenance; and if out of the possession of the beneficiary, the time period it was unavailable for his/her use and any arrangements made to accommodate the beneficiary during the time period.
  8. A record for each item that indicates if the item is 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 DME and/or medical appliance product as billed to and paid by The Division of Medicaid or Medicare.
  9. Records of any maintenance supplies delivered and/or used.
  10. For customized DME and/or medical appliances, the name(s), business name and address, and telephone number of the therapist or technician who determines the measurements necessary to modify, build, or complete the custom item.
  11. Copies of any specialized documents including but not limited to:
    - a) An environmental assessment if needed for potential accommodation of DME and/or medical appliance.
    - b) Any teaching, training or instruction given to beneficiary/caregiver and response.
  12. Documentation that the beneficiary's need for the DME and/or medical appliance is reviewed annually by a Medicaid enrolled physician.
- D. The physician ordering the DME, medical appliance, or medical supply must maintain documentation relating to the medical necessity for each item.
1. The information must be recorded in the beneficiary's medical record or on the appropriate Medicaid Certificate of Medical Necessity.
  2. The physician must retain a copy of the completed Certificate of Medical Necessity in the file.

- E. Records must be documented and maintained in accordance with requirements set forth in Miss. Admin Code Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised eff. 08/01/2020, Revised eff. 09/01/2018.

*Rule 1.10 Apnea Monitors*

- A. Medicaid defines an apnea monitor as 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.
- B. Medicaid covers apnea monitors for all beneficiaries:
1. When prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity.
  2. For an initial three (3) month rental trial period, then recertification is required. The three (3) month rental trial period applies toward the maximum reimbursement for purchase.
  3. [Reserved]
  4. When the beneficiary is/had at least one (1) of the following:
    - a) An infant who has a diagnosis of apnea of prematurity.
    - b) A preterm infant with continued symptomatic apnea past thirty-six (36) weeks gestational age.
    - c) Been observed having or has a recorded episode of prolonged apnea within the last three (3) months that is documented by medical personnel and associated with bradycardia, reflux, cyanosis, or pallor. Medicaid defines prolonged apnea as cessation of breathing greater than twenty (20) seconds or bradycardia episodes less than sixty (60) beats per minute (bpm) for greater than five (5) seconds.
    - d) 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.
    - e) Had an event or events requiring vigorous stimulation or resuscitation within the past three (3) months.
    - f) A tracheotomy.
    - g) An infant with bronchopulmonary dysplasia who requires oxygen and displays medical instability.

- h) An adult or child has demonstrated symptomatic apnea due to neurological impairment, craniofacial malformation, central hyperventilation syndrome, or is secondary to gastrointestinal reflux
- C. Medicaid will cover diagnoses not included above on an individual basis with appropriate documentation.
- D. Medicaid does not cover apnea monitors for terminally ill beneficiaries or for those who have "do not resuscitate" orders.
- E. Medicaid covers apnea monitors for an initial three (3) month certification. After the three (3) month initial certification, apnea monitors may be recertified up to seven (7) additional months with a new prescription or letter of medical necessity.
  - 1. Medicaid will not reimburse for a three (3) month trial period then pay full purchase price.
  - 2. Medicaid does not cover supplies, such as a battery pack, safety lead wires, electrodes, electrode belts, event recording downloads, or remote alarms separately.
  - 3. Medicaid requires that apnea monitors must be returned to the DME provider after it is no longer required if the rental period is less than ten (10) months.

Source: 42 U.S.C § 1395m; Miss. Code Ann. §§ 43-13-121; 43-13-117(7).

History: Revised eff. 09/01/2018.

*Rule 1.11: Augmentative Communication Device (ACD)*

- A. The Division of Medicaid defines an augmentative, or alternative, communication device (ACD) as any type of system that allows beneficiaries with severe, expressive communication disorders, or speech-language impairments, to overcome the disabling effects of communication impairment by representation of vocabulary or ideas and expression of messages.
- B. The Division of Medicaid covers ACD's for all beneficiaries, when prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity for rental up to the purchase amount, or purchase as indicated when the following criteria is met:
  - 1. When ordered by a pediatrician, neurologist, or a physiatrist, a physician specializing in physical rehabilitation, and who has documented training in assessment for and prescription of ACD's.

2. Documentation that the beneficiary's ability to communicate using speech and/or writing is insufficient for communication purposes.
  3. Documentation clearly supports that the beneficiary is mentally, emotionally, and physically capable of operating/using an ACD.
  4. When the prescription includes specification for the ACD, component accessories, and all necessary therapies and/or training.
- C. The Division of Medicaid requires an evaluation and recommendation be performed by a speech-language pathologist (SLP) in conjunction with other health professionals as appropriate.
1. A written copy of the evaluation and recommendation must be submitted with the request for prior authorization. This evaluation must include at a minimum:
    - a) Communication status and limitations, abilities to meet communication needs through other means such as sign language, manual communication, and the like,
    - b) Current speech and language skills,
    - c) Prognosis for speech and/or written communication,
    - d) Cognitive readiness, interactional/behavioral and social abilities,
    - e) Capabilities and needs including intellectual, including educational, postural, physical, sensory, including visual and auditory, motor, and cognitive,
    - f) Motivation to communicate,
    - g) Environmental, including residential, vocational and educational, assessment,
    - h) Current seating or positioning equipment and any modification that would be required secondary to the ACD,
    - i) Integration of communication with other behavior,
    - j) Alternative ACD(s) considered with comparison of capabilities,
    - k) Other communication methods/devices tried,
    - l) Ability of recommended ACD to be implemented/integrated into environments,
    - m) Ability to meet projected communication needs, like growth potential, projected length of time the beneficiary will be able to use the proposed system,

- n) Anticipated changes, modifications, or upgrades with projected short and long-term time frames,
  - o) Anticipated prognosis with the specific device requested, and
  - p) Training plan including dates, names, addresses, and capabilities of available caregivers.
- D. The Division of Medicaid allows for a trial period of at least thirty (30) days, not to exceed ninety (90) days, to ensure that the beneficiary's needs are met by the proposed ACD and in the most cost-effective manner.
- E. The Division of Medicaid does not cover carrying cases separately.

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

History: Revised eff. 08/01/2018.

*Rule 1.12: Bath Bench or Shower Chair*

- A. The Division of Medicaid defines a bath bench or shower chair as durable medical equipment (DME) enabling a beneficiary to bathe or shower safely.
- B. The Division of Medicaid covers a bath bench or shower chair when:
1. [Reserved],
  2. Prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity,
  3. The ordering physician or allowed NPP documents the beneficiary has a medical condition that will not allow him/her to safely shower or bathe without use of the bath bench or shower chair,
  4. A physician or allowed NPP documents that the ordered bath bench or shower chair will allow the beneficiary to safely bathe or shower.

Source: 42 U.S.C. § 1395(m); Miss. Code Ann. §§ 43-13-121; 43-13-117(17).

History: Revised eff. 09/01/2018. Revised-01/01/2013.

*Rule 1.13: Battery and Battery Charger*

- A. The Division of Medicaid defines the following:
1. Battery is a device for generating electric current by chemical action.

2. Battery charger is a device that adds electrical energy to a battery.
- B. The Division of Medicaid covers a sealed battery and single mode battery charger for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for purchase only, when all of the following criteria is met:
  1. Batteries and battery chargers are associated with the purchase of equipment and are included in the maximum reimbursement for that equipment except for power wheelchair batteries [Refer to Miss. Admin. Code Part 209 Rule 1.47 and 1.48], and
  2. Replacement batteries, if coverage criteria is met.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 10/01/2020; Revised eff. 09/01/2018. Revised – 01/01/2013.

*Rule 1.14: Bi-level Positive Airway Pressure Device (BiPAP) With or Without an In-Line Heated Humidifier*

- A. Medicaid defines a bi-level positive airway pressure (BiPAP) device as 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.
- B. Medicaid covers a BiPAP for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental for an initial three (3) months trial period if one (1) or more of the following is met:
  1. The beneficiary was unable to tolerate the necessary CPAP pressures,
  2. The beneficiary has frequent central apneas that do not resolve with administration of CPAP, or
  3. The beneficiary's baseline hypoxemia in cases involving chronic lung disease or hypoventilation syndromes is not corrected with administration of CPAP.
- C. 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 covered.

- D. Medicaid covers appropriate supplies for BiPAP units if owned by the beneficiary at maximum amounts expected to be medically necessary. Medicaid covers for amounts exceeding the maximum amount if there is documented justification and on individual bases.
- E. After an initial three (3) month trial period, the BiPAP may be recertified up to seven (7) additional months with a BiPAP Compliance Medicaid Certificate of Medical Necessity completed by the ordering physician.
  - 1. If the equipment was not effective or if the beneficiary was non-compliant, the equipment may be returned to the vendor.
  - 2. The rental fees paid for the three (3) month trial period must apply toward the maximum reimbursement for purchase.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.15: Breast Pumps*

- A. The Division of Medicaid defines a breast pump as a device used to extract breast milk from a lactating mother.
- B. The Division of Medicaid covers the following types of breast pumps for nursing mother beneficiaries when medically necessary, prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity.
  - 1. The Division of Medicaid defines a manual breast pump as a single-user device manually operated to express breast milk from a lactating mother and is covered for purchase when:
    - a) Used to promote lactation when natural breastfeeding has been insufficient in maintaining adequate nutritional needs of the infant, or
    - b) Used to provide lactation support when natural breastfeeding is not possible.
  - 2. The Division of Medicaid defines an electric breast pump as an electronic device used to express breast milk from a lactating mother and is covered for rental up to purchase amount, or for purchase when one (1) of the following is met:
    - a) The infant:
      - 1) Is preterm or term and requires hospitalization longer than the mother,
      - 2) Has a cleft palate or cleft lip,

- 3) Has cranial-facial abnormalities,
  - 4) Is unable to suck adequately,
  - 5) Has Failure to Thrive,
  - 6) Has a low birth weight, or
  - 7) Has other medical conditions that interfere with breastfeeding.
- b) The mother:
- 1) Has a breast abscess,
  - 2) Has mastitis,
  - 3) Is hospitalized due to illness or surgery on short term basis,
  - 4) Is unable to effectively use a manual pump to promote or maintain lactation due to a medical condition or physical limitation,
  - 5) Is undergoing treatment with short-term medications which requires the pumping and discarding of breast milk, or
  - 6) Has other medical conditions that interfere with breastfeeding.

C. All prior authorization requests must:

1. Be in the mother beneficiary's name,
2. Include the mother beneficiary's Medicaid ID number, and
3. Include an estimate of how many weeks or months the mother will require the electric breast pump.

Source: 42 U.S.C. §§ 1395m, 1396d; 42 CFR §§ 440.60, 440.166, 440.210, 440.220; PHSA § 2713; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/01/2018. Revised eff. 05/01/2014.

*Rule 1.16: Cane*

- A. Medicaid defines a cane as an assistive device held in the hand and used for support during ambulation. This includes canes of all materials, single, quad or three pronged, adjustable or fixed.

- B. Medicaid covers canes for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for rental up to purchase amount or purchase when indicated and all the following criteria met:
1. [Reserved]; and
  2. When condition or injury causing impaired ambulation and when there is a potential for ambulation.
- C. Tips, handgrips, adjustment features or other accessory items are inclusive in the rental or purchase of the cane.
- D. Straight, single post canes may be either fixed or height adjustable. Medicaid covers straight canes for the following indications:
1. To relieve stress on a joint in post-surgery beneficiaries.
  2. To aid beneficiaries with decreased balance due to vestibular, neurological, or orthopedic conditions.
- E. Three prong or quad canes may be either fixed or height adjustable. Medicaid covers these canes for the following indications:
1. For beneficiaries who require an added base of support (BOS) provided with the cane for stance and ambulation.
  2. For beneficiaries who have achieved increased ambulation skills and no longer require a walker but still need an assistive device with a wider BOS than a straight cane will offer.
- F. All canes issued to children should be height adjustable to provide for growth.
- G. Some beneficiaries may require two (2) canes for greater stability.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.17: Combination Positive Expiratory Pressure, Airway Oscillation, and Intermittent Flow Acceleration Device*

- A. The Division of Medicaid defines a combination positive expiratory pressure, airway oscillation, and intermittent flow acceleration device as a unit for mobilizing respiratory tract secretions in a beneficiary with chronic lung conditions such as, but not limited to:

1. Chronic obstructive lung disease,
  2. Chronic bronchitis,
  3. Cystic fibrosis, or
  4. Emphysema.
- B. The Division of Medicaid covers this device for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for purchase when the beneficiary has one (1) of the following diagnosis:
1. A chronic lung condition where mobilization of respiratory secretions is hindered,
  2. Cystic fibrosis,
  3. Bronchiectasis,
  4. Chronic bronchitis/COPD, and
  5. Atelectasis, or
  6. Any other disease process in which secretion mobilization is needed.
- C. Beneficiary teaching must be documented along with the beneficiary's ability to properly use and clean the device.
- D. The item may not be appropriate for children less than six (6) years of age.
1. For the item to be considered for children under age six (6), the ordering physician or allowed NPP conducting the face-to-face encounter must document that the child is able to use the device correctly.
  2. Individual consideration will be given for children under age six (6).

Source: 42 U.S.C. § 1395(m); Miss. Code Ann. §§ 43-13-117(7) and (17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.18: Commode Chairs and Other Toileting Aids*

- A. The Division of Medicaid defines commode chairs as toileting aids used to assist beneficiaries who are not able to use regular toilet facilities due to their physical condition.

- B. The Division of Medicaid covers commode chairs and raised toilet seats for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase when indicated and all the following criteria met:
1. [Reserved]
  2. When the beneficiary's physical condition is such that the beneficiary is unable to use regular toilet facilities.
  3. A commode chair with detachable arms, if used to facilitate transferring the beneficiary or if the beneficiary has a body configuration that requires extra commode width.
  4. A heavy duty or extra wide commode chair, with or without detachable arms, if the beneficiary's body measurements are greater than the measurements specified by the manufacturer for the DME or the beneficiary's weight is three hundred (300) pounds or greater. Documentation must be maintained for weight and measurements.
  5. A raised toilet seat if the beneficiary has a medical condition such as being convalescent from hip surgery which prevents the beneficiary from using a regular commode without a raised seat.
  6. A raised toilet seat if the beneficiary does not have a bedside commode capable of fitting over the toilet.

Source: 42 U.S.C. § 1395(m); Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.19: Compressors*

- A. Medicaid defines compressors as machines that compress air into storage tanks for use by air driven equipment.
- B. Medicaid covers for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for rental up to the purchase amount or purchase.
- C. Medicaid covers compressors for separate reimbursement when used in conjunction with a ventilator, nebulizer, or other types of humidification equipment that is not self-contained or cylinder driven.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.20: Continuous Positive Airway Pressure (CPAP) With or Without an In-Line Heated Humidifier*

- A. The Division of Medicaid defines continuous positive airway pressure (CPAP) with or without an in-line heated humidifier as a non-invasive provision of air pressure through nasal administration and a flow generator system to prevent collapse of the oropharyngeal walls during sleep. For the Division of Medicaid's purposes, apneas and hypopneas physiologically represent the same compromise, will be considered as equivalents, and will be referred to as "respiratory events."
- B. The Division of Medicaid covers the rental of a CPAP during the three (3) month trial period for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, when the following criteria is met:
  - 1. [Reserved],
  - 2. When one (1) of the following is met:
    - a) The beneficiary experiences fifteen (15) or more respiratory events per hour, or between five (5) and fourteen (14) respiratory events per hour with documentation of the following symptoms:
      - 1) Excessive daytime sleepiness,
      - 2) Impaired cognition,
      - 3) Mood disorders or insomnia, or
      - 4) Documented hypertension, ischemic heart disease, or history of stroke.
    - b) The beneficiary is a prepubescent child and the polysomnogram demonstrates an average of one (1) or more respiratory events per hour.
    - c) The beneficiary is a child who has documented measurements of increased end-tidal carbon dioxide (CO<sub>2</sub>) values that confirm the presence of obstructive sleep apnea.
    - d) The beneficiary has a diagnosis of upper airway resistance syndrome with the presence of at least ten (10) respiratory related electroencephalogram (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.
- C. The Division of Medicaid will review, for determination of coverage for a CPAP, with appropriate documentation, the following medical conditions:

1. Persistent hypoxemia of oxygen saturation (SaO<sub>2</sub>) less than ninety percent (90%) during sleep even in the absence of obstructive sleep apnea,
  2. Central sleep apnea,
  3. Chronic alveolar hypoventilation syndrome,
  4. Intrinsic lung disease,
  5. Neuromuscular disease.
- D. After the initial three (3) month trial period, the CPAP may be recertified up to seven (7) additional months with a CPAP Compliance Certificate of Medical Necessity completed by the ordering physician.
1. If the equipment was not effective or, if the beneficiary was non-compliant, the equipment must be returned to the vendor.
  2. The rental fees paid for the three (3) month trial period will apply toward the maximum reimbursement for purchase.
  3. After ten (10) consecutive months of rental, including the trial period, the CPAP is owned by the beneficiary.
- E. The Division of Medicaid reimburses the DME supplier for the supplies listed below:
1. Full face mask used with a positive airway pressure device,
  2. Face mask interface, replacement for full face mask,
  3. Replacement pillows for nasal application device,
  4. Replacement cushion for nasal mask interface,
  5. Nasal interface, either a mask or cannula type, used with positive airway pressure device with or without head strip,
  6. Headgear used with positive airway pressure device,
  7. Chin strap used with positive airway pressure device,
  8. Tubing used with positive airway pressure device,
  9. Disposable Filter, used with positive airway pressure device,

10. Non-Disposable Filter, used with positive airway pressure device,
11. Oral interface used with positive airway pressure device,
12. Combination oral/nasal CPAP mask,
13. Replacement oral cushion for oral/nasal mask,
14. Replacement nasal pillows for oral/nasal mask, and
15. Humidifier water chamber.

F. Division of Medicaid does not cover for more than the usual maximum replacement amount unless documentation is submitted that justifies a larger quantity in the individual case.

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

History: Revised eff. 07/01/2021; Revised eff. 09/01/2018.

*Rule 1.21: Crutches*

A. Medicaid defines crutches as assistive devices used for support during ambulation.

1. Crutches may provide underarm or forearm support.
2. Crutches may be made of wood or metal, fixed or adjustable in height and must be supplied with tips.

B. Medicaid covers crutches for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity.

1. Medicaid covers underarm crutches when the following criteria are met:
  - a) Post-op or post injury to reduce or alleviate weight bearing through the lower extremities.
  - b) Progression to ambulation without an assistive device.
2. Medicaid defines forearm crutches as crutches that decrease energy consumption during ambulation and provide increased support through the upper extremities.
  - a) Forearm crutches can be made of various materials, adjustable or fixed, and must be dispensed as a pair complete with handgrips.
  - b) Medicaid covers forearm crutches when the following criteria is met:

- 1) For those who will be long-term crutch users;
  - 2) For use with beneficiaries whose balance does not require the base of support (BOS) provided by a walker; and
  - 3) For beneficiaries who need the assistance provided by the crutch to increase their independence in the community. Beneficiaries may use a reciprocating, swing through, or swing to type of gait.
- C. Medicaid covers customized crutches with prior authorization by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity.
- D. Attachments to crutches are indicated when one (1) or both upper extremities are compromised due to surgical intervention, decreased range of motion, or contracture. The beneficiary may also need the attachment to provide a greater area of support.
- E. Platform attachments are indicated when one (1) or both upper extremities have decreased range of motion at the elbow, shoulder, or wrist and allow the beneficiary to grasp and hold onto the crutch.
- F. Tips, hand grips, adjustment features, and other accessory items not specifically listed as covered are inclusive in the rental or purchase of the crutches and Medicaid does not reimburse these as separate items.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.22: Diapers and Underpads*

Refer to Part 209, Chapter 2: Medical Supplies, Rule 2.2.AA.

History: Revised eff. 05/01/2021; Revised eff. 01/01/2013.

*Rule 1.23: Electromyography (EMG) Biofeedback Device*

- A. Medicaid defines an electromyography (EMG) biofeedback device as a device that uses recording equipment to detect, amplify and display a physiological response.
1. EMG uses surface electrodes that are attached to the skin over a specific muscle or group of muscles.
  2. The EMG has an amplifier that is used to record the small electrical signals that are produced by contraction of the muscle fibers. These signals are amplified and converted into auditory and/or visual signals for display.

3. Biofeedback instruction can teach a patient to learn to modify or reinforce voluntary control of specific responses.
- B. Medicaid covers for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for rental up to three (3) months, then requires recertification when one (1) or more of the following treatments are prescribed:
1. The beneficiary is in a prescribed therapeutic exercise program,
  2. The beneficiary has musculoskeletal pain,
  3. The beneficiary has musculoskeletal stress related injuries, or
  4. The beneficiary is on a pre-chronic pain and headache program.
- C. After the three (3) month rental period, the device may be recertified when documentation demonstrates desired outcomes are being achieved. The DME provider must thoroughly document that the beneficiary is capable of using and understanding the mechanism of biofeedback.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.24: Cochlear Implants and Implantable and Non-Implantable Auditory Osseointegrated Devices, Batteries and Battery Chargers*

- A. The Division of Medicaid covers repairs and external replacement parts for cochlear implant devices when medically necessary, prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designee, and ordered by an audiologist, otologist, otolaryngologist or other physician specialty who has documented training in assessment for and prescription of cochlear implant devices.
- B. The Division of Medicaid covers repairs and external replacement parts of an implantable auditory osseointegrated device (AOD) when medically necessary, prior authorized by a UM/QIO, the Division of Medicaid, or designee and ordered by an audiologist, otologist, otolaryngologist or other physician specialty who has documented training in assessment for and the prescription of AODs.
- C. The Division of Medicaid covers repairs and replacement parts of non-implantable AODs when medically necessary, prior authorized by a UM/QIO, the Division of Medicaid, or designee and ordered by an audiologist, otologist, otolaryngologist or other physician specialty who has documented training in assessment for and the prescription of AODs.

- D. The Division of Medicaid covers batteries and battery chargers for cochlear implants and implantable and non-implantable AODs when medically necessary, prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designee, and ordered by an audiologist, otologist, otolaryngologist or other physician specialty who has documented training in assessment for and the prescription of AODs.
- E. The manufacturer must provide a minimum one (1) year warranty for all items. [Refer to Part 209, Rule 1.4.]

Source: 42 USC §§ 1395m, 1395x; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2015.

*Rule 1.25: Gait Trainer*

- A. The Division of Medicaid defines a gait trainer as a device similar to a walker and consists of a wide based steel frame with four (4) casters/wheels and may include a seat or support accessories. The user has difficulty with balance and control of the trunk, has an unsteady gait and is uncoordinated in ambulation.
- B. The Division of Medicaid covers for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to three (3) months, then requires recertification when ordered by a physician who specializes in physical medicine, orthopedics, or neurology and the following criteria is met:
  - 1. The beneficiary has a condition which causes unsteady gait and difficulty with ambulation,
  - 2. The beneficiary has been evaluated by a physical therapist (PT) or occupational therapist (OT) not employed by the DME supplier,
  - 3. The PT/OT evaluation report must be submitted with the request for prior approval and must document medical necessity and indicates the approximate length of time the beneficiary will need the gait trainer,
  - 4. The beneficiary's functional level is such that he/she is trainable in use of a gait trainer,
  - 5. The beneficiary has the potential to be ambulatory and is involved in therapy to regain or strengthen ambulatory function,
  - 6. There is enough space in the beneficiary's home for the beneficiary to utilize gait trainer, and
  - 7. There are no medical contraindications to use of the gait trainer.

Source: 42 U.S.C. § 1395(m); Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.26: Glucose Monitoring Devices*

A. The Division of Medicaid defines glucose monitoring devices as durable medical equipment (DME) for home use to measure glucose levels which includes a:

1. Blood glucose monitor (BGM) defined as a portable battery-operated meter used to determine the beneficiary's blood glucose level by exposing a reagent strip to a small blood sample resulting in the strip's colorimetric reaction to glucose concentrations, and
2. Continuous glucose monitoring (CGM) defined as DME used to detect trends and patterns in the beneficiary's glucose levels in the interstitial or intracellular fluid. There are two types of CGMs:
  - a) An adjunctive CGM requires the user verify their glucose levels or trends displayed on a CGM with a BGM prior to making treatment decisions. The glucose levels are recorded by an external recorder that stores the data until it is downloaded for review or sent via a transmitter to an external monitor for beneficiary interaction.
  - b) A non-adjunctive CGM can be used to make treatment decisions without the need for a stand-alone BGM to confirm testing results. These readings are intended to take the place of the information obtained from beneficiary self-monitoring of blood glucose via a BGM.

B. The Division of Medicaid covers a BGM for rental up to amount of purchase, or purchase when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity and ordered by a physician when all the following are criteria are met [Refer to Miss. Admin. Code Part 209, Chapter 2: Medical Supplies, Rule 2.2.C.1 for Blood Glucose Monitor (BGM) and Rule 2.2.C.2 for Continuous Glucose Monitor (CGM)]:

1. The beneficiary has one (1) of the following diagnoses:
  - a) Type I diabetes mellitus,
  - b) Type II diabetes mellitus, or
    - 1) With a documented history of blood glucose fluctuating outside the normal range as specified by the physician,
    - 2) Requiring oral diabetes medication, and

- 3) Requiring a prescribed specialized diet.
- c) Gestational diabetes mellitus requiring treatment.
2. The medical record contains documentation that the beneficiary or caregiver is able to demonstrate the ability to accurately perform the blood glucose testing and accurately report the results.
3. The blood glucose monitor is specifically designed for home use rather than clinical use.
- C. The Division of Medicaid covers a minimally invasive CGM for rental up to amount of purchase, or purchase when indicated, when approved by the Federal Drug Administration (FDA) as a medical device for home use, medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, ordered by the physician who is actively managing the beneficiary's diabetes and the beneficiary meets all of the criteria outlined in Miss. Admin. Code, Part 225, Rule 4.3.
- D. The CGM device must be a Food and Drug Administration (FDA) approved medical device and be capable of accurately measuring and transmitting beneficiary blood data. Refer to Miss. Admin. Code Part 225, Chapter 4: Continuous Glucose Monitoring Services.

Source: 42 U.S.C. §§1395m, 1395x(n); Miss. Code Ann. §§ 43-13-117, 43-13-121, 83-9-353.

History: Revised eff. 10/01/2023; Revised eff. 07/01/2021; Revised eff. 09/01/2018. Revised eff. 07/01/2015; Revised eff. 01/01/2013.

*Rule 1.27: Hip Abductor Pillow/Wedge*

- A. Medicaid defines a hip abductor pillow wedge as a foam triangular shaped device placed between the beneficiary's thighs and secured with straps. The device maintains constant abduction.
- B. Medicaid covers hip abductor pillow wedges for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for purchase only, when ordered by a physician and one (1) of the following apply:
  1. A diagnosis which has resulted in a condition that requires maintaining the beneficiary's hips and thighs in abduction,
  2. Subluxing or dislocating hip(s),
  3. A diagnosis of an unstable hip,
  4. Following the reduction of a dislocated hip,

5. Following hip replacement (hemi or total),
6. Following hip arthroplasty or hip fracture surgery,
7. Following adductor tenotomy or abductor advancement surgery, or
8. Wheelchair patients who must maintain a degree of hip abduction.

Source: U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.28: Hospital Beds*

A. The Division of Medicaid defines a hospital bed as a medical device with:

1. An articulating frame allowing adjustment of the head and foot of the bed,
2. A headboard,
3. A footboard,
4. A mattress, and
5. Side rails.

B. The Division of Medicaid covers hospital beds when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity and ordered by a physician for purchase or rental up to the purchase amount.

1. The Division of Medicaid defines a manual fixed-height hospital bed as one with manual head and leg elevation adjustments but no height adjustment and is covered when a beneficiary meets one (1) of the following:
  - a) Requires positioning of the body in ways not feasible with a non-hospital bed in order to alleviate pain,
  - b) Requires the head of the bed to be elevated thirty (30) degrees or more due to a medical condition including, but not limited to, congestive heart failure, chronic pulmonary disease, or risk of aspiration,
  - c) Has failed to achieve the desired clinical outcome, with pillows or wedges,
  - d) Requires equipment that can only be attached to a hospital bed,

- e) Has a disease, injury, or condition causing paralysis, immobility, or severe malaise and weakness requiring the performance of bathing, bodily functions, and other treatment or care while in bed, or
  - f) Is semi-comatose or comatose.
- 2. The Division of Medicaid defines a manual variable-height hospital bed as one with manual height, head and leg elevation adjustments and is covered when a beneficiary:
  - a) Meets one (1) of the criteria listed in Miss. Admin. Code Part 209, Rule 1.28.B.1., and
  - b) Requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.
- 3. The Division of Medicaid defines a semi-electric hospital bed as one with manual height adjustment and with electric head and leg elevation adjustments and is covered when a beneficiary:
  - a) Meets one (1) of the criteria in Miss. Admin. Code Part 209, Rule 1.28.B.1.a) through e) and B.2.b),
  - b) Is able to operate the hospital bed controls, and
  - c) Lives alone or with assistance of a caregiver, but without continuous twenty-four (24) hours per day caregiver support.
- 4. The Division of Medicaid defines bariatric hospital beds as heavy duty extra-wide and extra-heavy duty extra wide hospital beds used for beneficiaries whose weight and/or body measurements exceed the manufacturer's limit for size or weight of a standard hospital bed and is covered when:
  - a) The beneficiary meets one (1) of the criteria listed in Miss. Admin. Code Part 209, Rule 1.28.B.1., and
  - b) Documentation includes current weight and body measurements that exceed the manufacturer's limit for size and weight of a standard hospital bed which is obtained within thirty (30) days of request.
- C. The Division of Medicaid covers total electric hospital beds when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity and when the following criteria are met:
  - 1. An orthopedist, neurologist, physiatrist, or a physician with expertise in treating beneficiaries with disabilities and/or special needs orders the hospital bed and documents

the following:

- a) Medical necessity detailing the clinical rationale for the hospital bed,
  - b) The number of hours and times of the day the beneficiary is expected to be in the hospital bed, and
  - c) The reason a lower cost hospital bed does not meet the needs of the beneficiary.
2. A Mississippi licensed occupational or physical therapist conducts an on-site evaluation of the location where the hospital bed is to be used includes certification of the following:
    - a) The hospital bed is for the exclusive use of the beneficiary,
    - b) The hospital bed can be installed without structural or electrical modifications to the environment, and
    - c) The beneficiary and/or caregiver are trained in the use, cleaning and care of the hospital bed.
  3. The hospital bed has a full two (2) year warranty.
  4. The beneficiary has not received a total electric hospital bed within the last five (5) years.

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

History: Revised eff. 07/01/2019. Revised eff. 09/01/2018. Revised eff. 05/01/2014.

*Rule 1.29: Hydraulic Lift with Seat or Sling*

- A. The Division of Medicaid defines a patient hydraulic lift as a device used to transfer a beneficiary between a bed, a chair, wheelchair or portable commode chair but not solely for use in the bathroom.
- B. The Division of Medicaid covers hydraulic lifts for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase when ordered by a physician and all the following criteria is met:
  1. Documentation that the beneficiary's condition is such that periodic position adjustment is necessary to effect improvement or to arrest or retard deterioration in his/her condition,
  2. The beneficiary is bed or chair confined, and
  3. There is an available caregiver in the home trained in the safe operation of the hydraulic lift.

- C. The Division of Medicaid covers the seat or sling in the initial purchase price or the monthly rental price.
- D. The Division of Medicaid covers an electric lift mechanism when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity and when the following criteria are met:
  - 1. An orthopedist, neurologist, physiatrist, or a physician with expertise in treating beneficiaries with disabilities and/or special needs orders the lift and documents the following:
    - a) Medical necessity detailing the clinical rationale for the DME, and
    - b) The reason a manual lift does not meet the needs of the beneficiary.
  - 2. A Mississippi licensed occupational or physical therapist conducts an on-site evaluation of the location where the bed is to be used includes certification of the following:
    - a) The lift is for the exclusive use of the beneficiary,
    - b) The lift can be installed without structural or electrical modifications to the environment, and
    - c) The beneficiary and/or caregiver are trained in the use, cleaning and upkeep of the lift.
  - 3. The lift has a full two (2)-year warranty.
  - 4. The beneficiary has not received an electric lift mechanism within the last five (5) years.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. § 43-13-117(17), 43-13-121.

History: Revised eff. 07/01/2019. Revised eff. 09/01/2018.

*Rule 1.30: Infusion Pump, Enteral/Parenteral/External*

- A. Medicaid defines an enteral pump as a device used to deliver nutritional requirements to the stomach or small bowel via a tube, including nasogastric, gastrostomy, jejunostomy and PEG tubes.
- B. Medicaid covers enteral pumps for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or for purchase when ordered by a physician and if the following criteria is met:

1. The beneficiary is tube fed, and
  2. The enteral feedings are the sole source of nutrition.
- C. Medicaid defines a parenteral pump as a device used to deliver nutritional requirements intravenously. Intravenous nutrition is also referred to as Total Parenteral Nutrition (TPN) or hyperalimentation therapy.
- D. Medicaid covers parenteral pumps if prior authorized, for rental up to purchase amount, or for purchase if indicated for all beneficiaries when ordered by a physician for beneficiaries who cannot absorb nutrients by the gastrointestinal tract.
- E. Medicaid defines an ambulatory infusion pump as a small portable electrical device that is used to deliver parenteral medication. It is designed to be carried by or worn by the beneficiary.
- F. Medicaid defines a stationary infusion pump as an electrical device which serves the same purpose as an ambulatory pump, but is larger and typically mounted on a pole.
- G. Medicaid covers ambulatory and stationary pumps when prior authorized, for rental up to purchase amount, or purchase if indicated when ordered by a physician for home use when the following criteria is met:
1. Parenteral administration of the medication in the home is reasonable and medically necessary; and
  2. An infusion pump is necessary to safely administer the medication.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.31: Insulin Pumps*

- A. Medicaid defines an insulin pump as a small battery-driven pump that delivers insulin subcutaneously. The pump can be programmed to deliver varying doses of insulin in accordance with changes in need for insulin during different conditions such as eating, exercise, sleep, or at a specific time of day.
- B. Medicaid covers insulin pumps for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase when ordered by an endocrinologist or other physician experienced in the treatment of diabetes and in the management of the insulin pump therapy and when one (1) or more of the following criteria is met:

1. The beneficiary has insulin dependent diabetes where control has been difficult to achieve, or
  2. The beneficiary has fluctuating blood sugars and is on three (3) or more injections per twenty four (24) hours, or
  3. The beneficiary is receiving treatment of secondary diabetic complications that require closer blood glucose control.
- C. Medicaid requires the prescribing provider, with experience in the use of the pump and in a position to monitor the clinical course of the beneficiary, to document that the beneficiary and/or caregiver demonstrates:
1. Motivation to control the diabetes and to comply with the pump regiment,
  2. The ability to learn how to use the pump effectively and the ability to comply with the regimen of the pump care, and
  3. A commitment to comply with diet, exercise, medications, and frequent self-monitoring of blood glucose.
- D. The prescribing provider and supplier of the pump must also ensure that the beneficiary and/or caregiver are fully educated about the beneficiary's diabetic condition and use of the insulin pump.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.32: IV Poles*

- A. Medicaid defines an IV pole as a device to suspend fluid to be administered by gravity or pump.
- B. Medicaid covers IV poles for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase when ordered by physician when the beneficiary is receiving enteral or parenteral fluids or IV medications and the beneficiary is not using an ambulatory infusion pump.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.33: Nebulizer*

- A. Medicaid defines a nebulizer as an apparatus for producing a fine spray or mist primarily for use in administering drugs by inhalation.
  - 1. This may be accomplished by rapidly passing air through a liquid or by vibrating a liquid at a high frequency so that the particles produced are extremely small.
  - 2. Medicaid expects that the practitioner will have considered the use of a metered dose inhaler with and without a reservoir or spacer device, if age appropriate, and has determined that, for medical reasons, it was not sufficient for the administration of needed inhalation drugs.
- B. Medicaid covers nebulizers for all beneficiaries for rental up to purchase amount, or purchase when indicated and ordered by a physician as follows:
  - 1. A nebulizer is covered for rental only when a beneficiary has an acute condition, such as pneumonia or acute bronchitis, which is expected to resolve in a short time.
  - 2. A nebulizer is covered for purchase when a beneficiary has a chronic condition that is not expected to resolve in a short time or is expected to recur frequently. Medical conditions that may be chronic or long term, but are not limited to:
    - a) Asthma,
    - b) Bronchopulmonary dysplasia,
    - c) Chronic bronchitis,
    - d) Chronic obstructive pulmonary disease,
    - e) Congenital heart anomaly,
    - f) Cystic fibrosis,
    - g) Diaphragmatic hernia, and
    - h) Respiratory distress syndrome.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17); 43-13-121.

History: Revised eff. 06/01/2021, Revised eff. 09/01/2018.

*Rule 1.34: Neuromuscular Electrical Stimulator (NMES)*

- A. Medicaid defines a neuromuscular electrical stimulator (NMES) as a device that transmits an electrical impulse to the skin over selected muscle groups by way of electrodes to treat disuse atrophy where the nerve supply to the muscle is intact.

- B. Medicaid covers for all beneficiaries when prior authorized, for rental only, when ordered by an orthopedist, neurologist or physiatrist, a physician specialized in physical rehabilitation, and when there is a documented diagnosis of disuse atrophy and the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves and one (1) of the following apply:
1. The beneficiary has or has had casting or splinting of a limb.
  2. The beneficiary has a contracture(s) due to scarring of soft tissue as in burn lesions.
  3. The beneficiary has had hip replacement surgery, until orthotic training begins.
  4. The beneficiary requires one (1) of the following:
    - a) Relaxation of muscle spasms,
    - b) Prevention or retardation of disuse atrophy,
    - c) Re-education of muscle,
    - d) Increasing of local blood circulation, or
    - e) Maintenance or increasing of range of motion.
- C. The beneficiary and/or caregiver must be able to demonstrate proper use and care of equipment.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

*Rule 1.35: Oxygen and Oxygen Related Equipment*

- A. The Division of Medicaid covers oxygen and oxygen related equipment that allows for the safe delivery of oxygen as durable medical equipment (DME) and includes:
1. Stationary gaseous oxygen systems which include container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask and tubing,
  2. Stationary liquid oxygen systems, which include container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask and tubing,
  3. Portable gaseous or liquid oxygen systems, which include portable container, regulator, flow meter, humidifier, cannula or mask and tubing,
  4. Oxygen concentrators, both stationary and portable, which include a humidifier, cannula or mask and tubing, or

5. Oxygen contents, liquid or gaseous.
  6. Portable gaseous oxygen systems, which include home compressor used to fill portable oxygen cylinders, portable containers, regulator, flow meter, humidifier, cannula or mask and tubing.
- B. The Division of Medicaid covers oxygen and oxygen related equipment for all beneficiaries when prior authorized by the Division of Medicaid or designee, for rental only when the following criteria are met:
1. The attending physician or consulting practitioner has examined the beneficiary and determined that he or she has one (1) of the following conditions that might be expected to improve with oxygen therapy:
    - a) A severe lung disease including, but not limited to:
      - 1) Chronic obstructive pulmonary disease (COPD),
      - 2) Diffuse interstitial lung disease,
      - 3) Cystic fibrosis,
      - 4) Bronchiectasis, or
      - 5) Widespread pulmonary neoplasm.
    - b) Hypoxia-related symptoms or findings including, but not limited to:
      - 1) Pulmonary hypertension,
      - 2) Recurring congestive heart failure (CHF) due to cor pulmonale, or
      - 3) Erythrocytosis.
  2. When ordered by the attending physician and prior authorized by the Division of Medicaid or designee:
    - a) Prior to the initiation of oxygen therapy, and
    - b) Annually thereafter.
  3. The order specifies the diagnosis necessitating oxygen therapy, oxygen flow rate, frequency, and duration of use, and estimates the period of need for oxygen and type of oxygen delivery system to be used.

4. The attending physician or consulting practitioner tried or considered alternative treatments and they were deemed clinically ineffective.
5. The qualifying blood gas study value was obtained under these conditions:
  - a) During an inpatient stay closest to, but no earlier than, two (2) days prior to the hospital discharge date, with oxygen therapy beginning immediately following the discharge,
  - b) During an outpatient encounter, within thirty (30) days of the date of the initial certification while the beneficiary is in a chronic stable state, which is when the beneficiary is not in a period of acute illness or an exacerbation of his or her underlying disease, or
  - c) If there is documentation in the medical record that it is detrimental to the life of the beneficiary to obtain oxygen levels on room air then Miss. Admin. Code Title 23, Part 209, Rule 1.35. B.6. is not required.
6. The beneficiary's blood gas study, either by an oximetry test or arterial blood gas (ABG), values meet either the following Group I or Group II criteria.
  - a) Group I criteria:
    - 1) The beneficiary when tested on room air while at rest and awake had an:
      - (a) Arterial oxygen (O<sub>2</sub>) saturation at or below eighty-eight percent (88%), or
      - (b) Arterial partial oxygen pressure (PO<sub>2</sub>) at or below fifty-five (55) millimeters (mm) of mercury (Hg).
    - 2) The beneficiary when tested during exercise and, if during the day while at rest, arterial PO<sub>2</sub> is at or above fifty-six (56) mm Hg or an arterial oxygen saturation is at or above eighty-nine percent (89%):
      - (a) Arterial PO<sub>2</sub> is at or below fifty-five (55) mm Hg or an arterial oxygen saturation is at or below eighty-eight (88%), and
      - (b) There is documented improvement of hypoxemia during exercise with oxygen.
    - 3) The beneficiary when tested during sleep, if the arterial PO<sub>2</sub> is at or above fifty-six (56) mm Hg or an arterial oxygen saturation is at or above eighty-nine (89%) while awake, additional testing must show:

- (a) Arterial PO<sub>2</sub> is at or below fifty-five (55) mm Hg or an arterial oxygen saturation is at or below eighty-eight percent (88%) for at least five (5) minutes, which do not have to be continuous, or
- (b) A decrease in arterial PO<sub>2</sub> of more than ten (10) mm Hg or a decrease in arterial oxygen saturation greater than five percent (5%) and for at least five (5) minutes, which do not have to be continuous, and has signs and symptoms reasonably attributable to hypoxemia including, but not limited to:
  - (1) Cor pulmonale,
  - (2) “P” pulmonale on electrocardiogram (ECG),
  - (3) Documented pulmonary hypertension, or
  - (4) Erythrocytosis reasonably attributable to hypoxemia.

b) Group II criteria:

- 1) The beneficiary when tested on room air at rest while awake had an:
  - (a) Arterial oxygen saturation of eighty-nine percent (89%) at rest and awake, or
  - (b) Arterial PO<sub>2</sub> of fifty-six (56) to fifty-nine (59) mm Hg, and
    - (1) There is dependent edema caused by congestive heart failure, or
    - (2) There is documentation supportive of pulmonary hypertension or cor pulmonale determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or “P” pulmonale on ECG, with P wave greater than three (3) mm in standard leads II, III, or AVF, or
    - (3) There is erythrocytosis with a hematocrit greater than fifty-six percent (56%).
- 2) The beneficiary when tested during exercise had an:
  - (a) Arterial oxygen saturation of eighty-nine percent (89%), or
  - (b) Arterial PO<sub>2</sub> of fifty-six (56) to fifty-nine (59) mm Hg, and
    - (1) Dependent edema suggesting congestive heart failure,
    - (2) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or “P”

pulmonale on ECG, P wave greater than three (3) mm in standard leads II, III, or AVF, or

(3) Erythrocythemia with a hematocrit greater than fifty-six percent (56%).

3) The beneficiary when tested during sleep for at least five (5) minutes, which do not have to be continuous, had an:

(a) Arterial oxygen saturation of eighty-nine percent (89%), or

(b) Arterial PO<sub>2</sub> of fifty-six (56) to fifty-nine (59) mm Hg, and

(1) Dependent edema suggesting congestive heart failure,

(2) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or “P” pulmonale on EKG, P wave greater than 3 mm in standard leads II, III, or AVF, or

(3) Erythrocythemia with a hematocrit greater than fifty-six percent (56%).

C. The Division of Medicaid does not cover oxygen and oxygen related equipment:

1. For the following conditions including, but not limited to:

a) Angina pectoris in the absence of hypoxemia.

b) Dyspnea without cor pulmonale or evidence of hypoxia.

c) Severe peripheral vascular disease resulting in clinically evident desaturation in one (1) or more extremities. There is no evidence that increased PO<sub>2</sub> will improve the oxygenation of tissues with impaired circulation.

d) Terminal illnesses that do not affect the respiratory system.

2. When the order is for when necessary (PRN) use only.

D. The Division of Medicaid reimburses for the rental of oxygen and oxygen related equipment, supplies and related services as follows:

1. For stationary oxygen systems, the DME provider:

a) Is allowed to bill a monthly rental fee which includes, but is not limited to, the following:

1) Regulators and flow meters,

- 2) Tubing,
  - 3) Cannulas or mask,
  - 4) Humidifier,
  - 5) Nebulizer,
  - 6) Oxygen contents,
  - 7) Backup oxygen equipment,
  - 8) Maintenance,
  - 9) Repairs, and
  - 10) Delivery.
- b) Is allowed to bill for stationary oxygen contents when the provider includes:
- 1) The appropriate Healthcare Common Procedure Coding System (HCPCS) code indicating the prescribed flow rate is one (1) to (4) liters per minute (LPM), or
  - 2) The appropriate HCPCS code and modifier indicating if the prescribed flow rate is:
    - (a) Less than one (1) liter per minute (LPM), or
    - (b) Greater than four (4) LPM.
- c) Is not allowed to bill:
- 1) For medical supplies separately for the delivery of oxygen, or
  - 2) For backup oxygen equipment.
- d) Is not allowed to bill for a monthly rental if the beneficiary requires less than one (1) month of rental of oxygen, but must bill the daily rate for only those days the beneficiary required oxygen.
2. For portable oxygen systems, the rental is continuous and the DME provider:
- a) Is allowed to bill:

- 1) Monthly for the portable oxygen system which includes, but is not limited to the following:
  - (a) Regulators and flow meters,
  - (b) Tubing,
  - (c) Cannulas or masks,
  - (d) Humidifiers,
  - (e) Portable container, and/or
  - (f) Supply reservoir.
- 2) For portable oxygen contents as medically necessary when the provider includes:
  - (a) The appropriate HCPCS code indicating the prescribed flow rate is less than (4) liters per minute (LPM), or
  - (b) The appropriate HCPCS code and modifier indicating if the prescribed flow rate is greater than four (4) LPM.
- b) Is not allowed to bill portable oxygen contents exceeding one (1) unit per month.
  - 1) A unit is defined as the quantity of oxygen the beneficiary uses per month.
  - 2) The Division of Medicaid's reimbursement is the same regardless of the quantity of oxygen dispensed.
3. The Division of Medicaid does not reimburse for:
  - a) The rental of a portable home compressor and the rental of portable oxygen equipment, including contents, at the same time, or
  - b) Portable oxygen contents based on the modifier indicating the oxygen flow rate.
- E. The DME provider must document the following information in the beneficiary's record after each visit:
  1. Date of service,
  2. Documentation of maintenance and/or repair, operation and safety of the oxygen equipment,
  3. Determination of oxygen output,

4. Changing of filters, and
5. Proper functioning of the backup system.

Source: 42 U.S.C. § 1395m; 42 C.F.R. § 440.70; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2018. Revised eff. 09/01/2018.

*Rule 1.36: Pacemaker Monitor*

- A. Medicaid defines a pacemaker monitor as a self-contained device used in the evaluation of a pacemaker by trans-telephonic monitoring of the transmission of the generator's pulse rate.
  1. By means of special equipment, the sound tone of the patient's pacemaker is transmitted over the telephone to a receiving system at a pacemaker clinic.
  2. The sounds are converted into an electronic signal and permanently recorded on an ECG strip.
- B. Medicaid covers pacemaker monitors for all beneficiaries with prior authorization by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase when indicated when ordered by a physician and all the following criteria is met:
  1. The beneficiary has a pacemaker implanted for a cardiac arrhythmia.
  2. The beneficiary/caregiver is capable of performing the pacemaker monitoring function.
  3. The beneficiary has access to a telephone for transmission.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.37: Pulse Oximeter*

- A. Medicaid defines pulse oximeter as a photoelectric apparatus for determining the amount of oxygen in the blood. This is usually done by measuring the amount of light transmitted through a translucent part of the skin.
- B. Medicaid covers pulse oximeters for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase if indicated when ordered by a physician and one (1) of the following criteria is met for a non-recording pulse oximeter:

1. The beneficiary has a documented serious respiratory diagnosis and requires short-term oximetry to rule out hypoxemia and/or determine the need for supplemental oxygen.
2. The beneficiary is dependent on a ventilator with supplemental oxygen.
3. The beneficiary has a tracheostomy and requires monitoring of O<sub>2</sub> saturation as determined by the practitioner.
4. The beneficiary requires supplemental oxygen and has unstable saturations.
5. The beneficiary is on supplemental oxygen and weaning is in process.

C. Medicaid covers a recording pulse oximeter when all the following criteria is met:

1. The beneficiary's condition meets one (1) of the criteria for a non-recording oximeter, and
2. The recording oximeter is being ordered by the practitioner to monitor the beneficiary during a specific event such as a weaning attempt from oxygen or ventilator, feeding times for an infant, or other times for which the physician needs documentation of the patient's blood oxygen saturation.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.38: Spacer/Aerosol-Holding Chamber*

A. Medicaid defines a spacer/aerosol-holding chamber as a cylinder shaped device usually four (4) to eight (8) inches long with a one (1) way valve.

1. The device is attached to a metered dose inhaler (MDI).
2. Use of the spacer/aerosol-holding chamber slows the delivery of medication from the pressurized MDI and decreases the amount of medication deposited in the mouth and throat.

B. Medicaid covers spacer/aerosol-holding chambers for all beneficiaries for purchase when ordered by a physician and all the following criteria is met:

1. The beneficiary is unable to coordinate spraying the metered dose inhaler and inhaling.
2. The beneficiary has a medical diagnosis of asthma, chronic bronchitis or emphysema.
3. The beneficiary must have a metered dose inhaler.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 06/01/2021, Revised eff. 09/01/2018.

*Rule 1.39: Suction Pump, Respiratory/Gastric*

- A. Medicaid defines a mobile or stationary home model suction pump as 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.
- B. Medicaid covers stationary home model suction pump for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase when indicated when ordered by a physician and if the beneficiary is unable to clear the airway of secretions by coughing secondary to, but not limited to, one (1) of the following:
  - 1. Cancer or surgery of the throat,
  - 2. Paralysis of the swallowing muscles,
  - 3. Tracheostomy, or
  - 4. Comatose or semicomatose condition.
- C. 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. Medicaid covers a mobile unit if all of the following apply:
  - 1. Prescribed because the beneficiary is subject to secretions that require suctioning during travel.
  - 2. The beneficiary is not being transported by an ambulance.
  - 3. There is sufficient documentation to justify the medical necessity for both stationary and portable units.
- D. Medicaid requires those using the suction apparatus must be sufficiently trained to adequately, appropriately and safely use the device.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.40: Traction Equipment*

- A. Medicaid defines traction equipment as encompassing a variety of equipment used to apply a pulling force to a part of the body. It may be used to minimize muscle spasms, to reduce, align, and immobilize fractures, to lessen deformity or to increase space between opposing surfaces within a joint.
- B. Medicaid covers traction equipment for all beneficiaries when prior authorized, for rental up to three (3) months, then requires recertification when all the following criteria is met:
  - 1. When ordered by an orthopedic physician, neurosurgeon, neurologist or a physiatrist, a physician who specializes in physical rehabilitation.
  - 2. The beneficiary has a cervical or pelvic orthopedic impairment verified by radiographic documentation or has a documented history of chronic pain from an orthopedic impairment that has been unrelieved by other treatment modalities.
- C. Medicaid requires all traction equipment must be of a type appropriate for use in the beneficiary's home.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

*Rule 1.41: Transcutaneous Electrical Nerve Stimulator (TENS)*

- A. Medicaid defines a transcutaneous electrical nerve stimulator (TENS) as a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins.
- B. Medicaid covers TENS for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase when indicated when ordered by a physician and one (1) of the following criteria is met:
  - 1. The TENS unit is being used for acute post-operative pain, the beneficiary is within thirty (30) days post-op, other treatment modalities have failed and the patient is being treated at home rather than an inpatient hospital. Approval is limited to thirty (30) days rental.
  - 2. The beneficiary has intractable chronic pain of at least three (3) months duration from date of onset and a history of failed response to other treatment modalities. A thirty (30) to sixty (60) day trial period is required.
- C. Medicaid covers for a conductive garment to be used with a TENS unit when ordered by the practitioner only if one (1) of the following apply:

1. The beneficiary cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
  2. The beneficiary cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
  3. The beneficiary has a documented medical condition, such as a skin condition, that precludes the application of conventional electrodes, adhesive tapes, and lead wires.
  4. The beneficiary requires electrical stimulation beneath a cast to treat chronic intractable pain.
- D. Medicaid requires for purchase to be considered, the practitioner must provide a copy of the re-evaluation performed at the end of the trial period and documentation that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time.
- E. If a four (4) lead TENS unit is ordered, the practitioner must document why two (2) leads are insufficient to meet the patient's needs.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.42: Transfer Board*

- A. Medicaid defines a transfer board as a wooden or plastic device used to transfer individuals from one (1) surface to another. It may be used by caregivers to assist with bed mobility of a dependent patient.
- B. Medicaid covers transfer boards for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase when indicated when ordered by a physician and one (1) of the following criteria is met:
1. The patient has decreased to absent lower extremity function and the board can be used by the patient or caregivers for successful transfer.
  2. The patient is obese and unable to transfer without lifting.
  3. It is required by the caregiver to assist with the bed mobility of the patient.
  4. The caregiver is unable to lift the patient for transfer.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.43: Trapeze Bar/Equipment*

Medicaid covers trapeze bars/equipment for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase when indicated and when ordered by a physician and one of the following criteria is met:

- A. A trapeze bar or freestanding trapeze equipment when a beneficiary has truncal or lower extremity weakness and needs this device in order to rise to sit, change body position, or get in and/or out of bed.
- B. An attached trapeze bar when it is either an integral part of or used on a hospital bed, and it has been determined that both the hospital bed and the trapeze bar are medically necessary.
- C. A freestanding trapeze only when used with a non-hospital bed. The beneficiary must not be renting or own a hospital bed.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.44: Ventilator*

- A. Medicaid defines a ventilator as a mechanical device used for artificial ventilation of the lungs.
- B. Medicaid covers ventilators for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental only, and ordered by a physician and one (1) of the following criteria is met:
  - 1. The beneficiary is unable to maintain spontaneous respiration.
  - 2. The beneficiary is unable to maintain safe levels of arterial carbon dioxide or oxygen with spontaneous breathing.
  - 3. The beneficiary has a medical condition that requires mechanically assisted ventilation that is appropriate for home use, without continuous technical or professional supervision.
- C. Medicaid covers the rental allowance which includes:

1. The equipment,
2. Delivery,
3. Freight and postage,
4. Set-up,
5. All supplies necessary for operation of the equipment,
6. Education of the patient and caregiver,
7. All maintenance and repairs or replacement,
8. Labor including respiratory therapy visits, and
9. Servicing charges.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.45: Walker*

- A. Medicaid defines a walker as an assistive device used to provide a wide base of support (BOS) for ambulation and stance.
  1. It may be rigid or folding, rolling or a pickup type, and/or fixed or height adjustable.
  2. The walker may have accessories to provide increased support.
- B. Medicaid covers walkers for all beneficiaries when prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, for rental up to purchase amount, or purchase when indicated and must be ordered by a physician.
  1. For a rigid or folding walker the following criteria must also be satisfied:
    - a) The beneficiary has a medical condition which causes impaired ambulation, but there is potential for the beneficiary to ambulate, and
    - b) There is a need for greater stability and security than can be provided by canes or crutches.

2. For a rigid pickup walker the same criteria apply, but the following specific criteria must also be met:
  - a) The beneficiary must be able to maintain balance while picking up the walker and moving it forward.
  - b) The beneficiary or caregiver must have means to transport a rigid walker.
  - c) Rigid walkers must provide a stable base of support:
  - d) For beneficiaries with impaired lower extremity weight-bearing ability such as spinal cord injury, cerebral palsy, congestive heart failure, stroke, post-operative conditions.
  - e) For beneficiaries with impaired balance during ambulation.
  - f) For ambulation training in newly braced children, adults in rehabilitation, and other diagnoses as medically necessary.
3. For wheeled walkers the same criteria applies but must meet also the following specific criteria:
  - a) The beneficiary must be able to maintain balance during ambulation with the rolling motion. It may be two (2) or four (4) wheeled.
  - b) Wheeled walkers are appropriate for beneficiaries who have difficulty using a rigid walker.
4. For folding walkers that are fixed, with or without wheels or seat, the same criteria from Rule 1.45 B. 1-3 above applies. Medicaid covers folding walkers that are push or pull types with two (2) or four (4) wheels.
5. For heavy duty walkers, multiple braking system, variable wheel resistance walkers the same criteria applies from Rule 1.45 B. 1-3 above, but must also meet the following criteria:
  - a) For larger or obese beneficiaries, or beneficiaries, who are unable to use a standard walker due to severe neurological disorders or restricted use of one (1) hand,
  - b) Beneficiaries whose gait patterns apply excessive force on the walker, and
  - c) Beneficiaries at risk of falling.
6. For attachments to walkers the same criteria applies from Rule 1.45 B. 1-3 above but must also meet the following:

- a) When one (1) or both upper extremities are compromised due to surgical intervention, decreased range of motion, or contracture,
- b) Provide a greater area of support,
- c) When the beneficiary has decreased mobility and requires rest periods,
- d) Seating attachments when beneficiaries who need rest periods during ambulation to conserve energy and maintain their endurance, and
- e) Platform attachments for beneficiaries when one (1) or both upper extremities have decreased range of motion at the elbow, shoulder, or wrist that allows the beneficiary to grasp and hold onto the walker.

C. Medicaid covers for hand brakes when medically necessary.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117(17), 43-13-121.

History: Revised eff. 09/01/2018.

*Rule 1.46: Wedge Seat Insert, Custom*

- A. Medicaid defines a custom wedge seat insert as an item that is made of various materials and is inserted into a seating system. It is used either for positioning or pressure reduction and has been uniquely constructed or substantially modified for a specific beneficiary.
- B. Medicaid covers custom wedge seat inserts for all beneficiaries with prior authorization for purchase only, when ordered by pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist, a physician specializing in physical rehabilitation, and has a stable seating device or a mobility device such as a buggy/stroller, stable seating device, or wheelchair to allow use of the item and is needed to:
  - 1. Decrease posterior pelvic tilt, or
  - 2. Assist with proper positioning for stable seating.
- C. Medicaid requires that the assessment or evaluation must be performed by a physical therapist or occupational therapist not employed by the DME supplier or manufacturer.
- D. If the beneficiary has an existing wheelchair custom seating system or a custom wheelchair seat that provides similar benefits, Medicaid does not cover this.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

*Rule 1.47: Wheelchairs*

- A. The Division of Medicaid defines a wheelchair as a seating system that is designed to increase the mobility of beneficiaries who would otherwise be restricted by inability to ambulate or transfer from one place to another.
- B. The Division of Medicaid covers wheelchairs for all beneficiaries when ordered by the appropriate medical professional, is medically necessary and prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for rental up to purchase amount or for purchase as follows:
  - 1. The provider must fully assess the beneficiary's needs and must ensure that the prescribed wheelchair is adequate to meet those needs, including measuring to ascertain proper height, width and weight and providing an automatic or special locking mechanism for those who are unable to apply manual brakes to prevent falls.
  - 2. The beneficiary, family or caregiver and supplying vendor must be present for the wheelchair assessment. It is also recommended that each of these people be present at the delivery of the wheelchair.
  - 3. At a minimum, all wheelchairs must include a seat, back, armrests (may be desk or full length, fixed or removable), leg rest (may be fixed, swing away detachable, or elevating), footplates, safety belts, anti-tipping device, wheels, and an appropriate type of wheel-locking mechanism, manual or automatic.
  - 4. A standard wheelchair is covered when the beneficiary's condition is such that without the use of a wheelchair, he/she would be otherwise bed or chair confined.
  - 5. An amputee wheelchair is covered if the beneficiary has had an amputation of one (1) or both lower extremities.
  - 6. Hemi-wheelchairs are covered with appropriate documentation and medical necessity justification.
  - 7. A tilt-in-space wheelchair is one that maintains the congruency of the seat to back angle while tilting the patient in space.
- C. Standard manual wheelchairs with added accessories do not qualify as custom wheelchairs. Standard manual wheelchairs must be ordered by a physician.
  - 1. A heavy duty standard manual wheelchair:
    - a) Is covered if the beneficiary meets the criteria for a standard manual wheelchair and meets one of the following criteria:
      - 1) Weighs more than two hundred fifty (250) pounds, or
      - 2) Body measurements do not conform to a standard manual wheelchair, or

- 3) Has severe spasticity.
- b) Documentation must include:
  - 1) Specific weight or measurements that cause the beneficiary to require this type chair, or
  - 2) The specific condition causing the beneficiary to be unable to function with a standard manual wheelchair.
2. An extra heavy duty standard manual wheelchair:
  - a) Is covered if the beneficiary meets the criteria for a standard manual wheelchair and meets one of the following criteria:
    - 1) Weighs more than three hundred (300) pounds, or
    - 2) Body measurements do not conform to a standard or heavy duty wheelchair.
  - b) Documentation must include:
    - 1) Specific weight and measurements causing the beneficiary to be unable to function with a standard manual or heavy duty wheelchair, and
    - 2) Specific measurements causing the beneficiary to be unable to function with a standard manual or heavy duty wheelchair.
3. A high strength lightweight manual wheelchair is covered with appropriate documentation and medical necessity justification.
4. A lightweight manual wheelchair:
  - a) Is covered if a beneficiary meets all of the following criteria:
    - 1) Meets the criteria for a standard manual wheelchair,
    - 2) Cannot self-propel in a standard manual wheelchair using arms and/or legs, and
    - 3) Is able to and does self-propel in a lightweight manual wheelchair.
  - b) Documentation must reflect the specific cause or condition that hinders the beneficiary from being able to function with a standard manual wheelchair.
5. An ultra-light manual wheelchair is covered with the appropriate documentation of medical necessity.

6. The Division of Medicaid defines a custom manual wheelchair as one uniquely constructed or substantially modified for a specific beneficiary. Custom manual wheelchairs must be ordered by a physician experienced in evaluating specialized needs for the purpose of prescribing custom manual wheelchairs after a face-to-face examination of the beneficiary.
- D. Standard motorized/power wheelchairs with added accessories do not qualify as an individualized beneficiary specific custom motorized/power wheelchair. The Division of Medicaid covers standard motorized/power wheelchairs when all the following criteria are met:
1. Ordered by a physician experienced in evaluating specialized needs for the purpose of prescribing motorized/power wheelchairs after a face-to-face examination of the beneficiary.
  2. Medically necessary with comprehensive documentation including, but not limited to:
    - a) That a manual wheelchair cannot meet the beneficiary's needs,
    - b) The beneficiary requires the motorized/power wheelchair for six (6) months or longer.
    - c) The beneficiary must:
      - 1) Be bed/chair confined and have documented severe abnormal upper extremity dysfunction or weakness.
      - 2) Expect to have physical improvements or the reduction of the possibility of further physical deterioration, from the use of a motorized/power wheelchair or be for the necessary treatment of a medical condition.
      - 3) Have a poor prognosis for being able to self-propel a functional distance in the future.
      - 4) Not exceed the weight capacity of the motorized/power wheelchair being requested.
      - 5) Have sufficient eye/hand perceptual capabilities to operate the prescribed motorized/power wheelchair safely.
      - 6) Have sufficient cognitive skills to understand directions, such as left, right, front, and back, and be able to maneuver the motorized/power wheelchair in these directions independently.

- 7) Be independently able to move away from potentially dangerous or harmful situations when seated in the motorized/power wheelchair.
  - 8) Demonstrate the ability to start, stop, and guide the prescribed motorized/power wheelchair within a reasonably confined area.
  - 9) Be in an environment conducive to the use of the prescribed motorized/power wheelchair.
    - (a) The environment should have sufficient floor surfaces and sufficient door, hallway, and room dimensions for the prescribed motorized/power wheelchair unit to turn and enter/exit, as well as necessary ramps to enter/exit the residence.
    - (b) The environmental evaluation must be documented and signed by the beneficiary/caregiver and supplier for the prescribed motorized/power wheelchair.
    - (c) If the residential environment cannot accommodate the prescribed motorized/power wheelchair, the wheelchair is not covered.
  - 10) Or the caregiver must be capable of maintaining the motorized/power wheelchair or be capable of having the motorized/power wheelchair repaired and maintained.
  - 11) Have appropriate covered transportation for the prescribed motorized/power wheelchair.
3. The ordering practitioner must document:
- a) The face-to-face examination in a detailed narrative note in the beneficiary's chart and must clearly indicate that the reason for the visit was a mobility examination.
  - b) Whether or not the beneficiary currently possesses a motorized/power wheelchair not previously purchased by the Medicaid program.
  - c) And provide a certificate of medical necessity with comprehensive documentation that describes the medical reason(s) why a motorized/power wheelchair is medically necessary such that no other type of wheelchair can be utilized including, but not limited to:
    - 1) The diagnosis/co-morbidities and conditions relating to the need for a motorized/power wheelchair.
    - 2) Description and history of limitation/functional deficits.
    - 3) Description of physical and cognitive abilities to utilize DME.

- 4) History of previous interventions/past use of mobility devices.
  - 5) Description of existing DME, age and specifically why it is not meeting the beneficiary's needs.
  - 6) Explanation as to why a less costly mobility device is unable to meet the beneficiary's needs.
  - 7) Description of the beneficiary's ability to safely tolerate/utilize the prescribed motorized/power wheelchair.
  - 8) The type of chair and each individual attachment required by the beneficiary.
4. An initial evaluation documented by a physical therapist (PT) or occupational therapist (OT), not employed by the DME supplier or the manufacturer, within three (3) months of the written prescription date to determine individualized needs of the beneficiary which includes whether the beneficiary currently possesses a motorized/power wheelchair not previously purchased by the Medicaid program.
  5. An agreement documented by both the prescribing physician and the PT or OT performing the initial evaluation that the motorized/power wheelchair being ordered is appropriate to meet the needs of the beneficiary.
  6. A subsequent evaluation documented after the delivery of the motorized/power wheelchair by a PT or OT, not employed by the DME provider or the manufacturer, to determine if the motorized/power wheelchair is appropriate for the resident's needs. The DME provider cannot bill the Division of Medicaid until the PT/OT documentation verifies on the subsequent evaluation that the motorized/power wheelchair is appropriate for the resident's needs.
  7. Documentation during the PT/OT initial and subsequent evaluations must include appropriate seating accommodation for beneficiary's height and weight, specifically addressing anticipated growth and weight gain or loss.
  8. The DME provider must fully assess the beneficiary's needs and ensure that the motorized/power wheelchair is adequate to meet those needs.
- E. The Division of Medicaid defines an individualized, beneficiary specific custom motorized/power wheelchair as one that has been uniquely constructed or substantially modified for a specific beneficiary. Individualized, beneficiary specific custom motorized/power wheelchairs must meet the following criteria:
1. Be ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist.
  2. Meet all the requirements in Miss. Admin. Code Part 209, Rule 1.47.D.2– 8.

3. Coverage for a customized electronic interphase device, specialty and/or alternative controls require documentation of an extensive evaluation of each customized feature required for physical status and specification of medical benefit of each customized feature to establish that the beneficiary is unable to manage a motorized/power wheelchair without the assistance of said device.
    - a) For a joystick, hand or foot operated, device the beneficiary must demonstrate safe operation of the motorized/power wheelchair with extremity using a joystick. The beneficiary can manipulate the joystick with fingers, hand, arm, or foot.
    - b) For a chin control device, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the chin control device. The beneficiary must have a medical condition which prevents the use of their hands/arms but is able to move their chin and safely operate the chair in all circumstances.
    - c) For a head control device, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the head control device. The beneficiary must have a medical condition which prevents the use of their hands/arms but is able to move their head freely with control of their head and can safely operate the chair in all circumstances.
  4. For an extremity control device, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the extremity control device. The beneficiary must have a medical condition which prevents or limits fine motor skills during the use of their extremities but is able to move their hands/arms/legs to safely operate the chair in all circumstances.
  5. For a sip and puff feature, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the sip and puff control. The beneficiary cannot move their body at all and cannot operate any other driver except this one.
- F. Standard and custom motorized/power wheelchairs are limited to one (1) per beneficiary every five (5) years based on medical necessity. Reimbursement:
1. Is made only for one (1) wheelchair at a time.
  2. Includes all labor charges involved in the assembly of the wheelchair,
  3. Includes all covered additions, accessories and modifications which providers must bill:
    - a) An appropriate procedure or service HCPCS code when available in unbundled HCPCS codes, and/or
    - b) A bundled HCPCS code for unlisted, custom or miscellaneous DME where there is no

- listed code or combination of HCPCS codes that adequately describes the item provided.
4. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.
  5. Is made only after the PT or OT subsequent evaluation is completed.
- G. Standard and custom motorized/power wheelchairs are not covered if the use of the standard and custom motorized/power wheelchair primarily benefits the beneficiary in their pursuit of leisure or recreational activities. Motorized/power wheelchairs are not covered for the convenience of the caregiver, ambulatory beneficiaries and non-compliant beneficiaries.
- H. The Division of Medicaid does not cover home, environment, and vehicle adaptations, equipment and modifications for motorized/power wheelchair accessibility.
- I. The DME provider providing standard and/or custom motorized/power wheelchairs to beneficiaries must have at least one (1) employee with Assistive Technology Professional (ATP) certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) who specializes in wheelchairs and who must be registered with the National Registry of Rehab Technology Suppliers (NRRTS).
1. The NRRTS and RESNA certified personnel must have direct, in-person, face-to-face interaction and involvement in the motorized/power wheelchair selection for the beneficiary.
  2. RESNA certifications must be updated every two (2) years.
  3. NRRTS certifications must be updated annually.
  4. If the certifications are found not to be current, the prior authorization request for the motorized/power wheelchair will be denied.
- J. DME providers must provide a two (2) year warranty of the major components for custom motorized/power wheelchairs. [Refer to Part 209, Chapter 1, Rule 1.4.]
1. If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the DME provider is responsible for any repairs, replacement or maintenance that may be required within two (2) years.
  2. The warranty begins the date of delivery to the beneficiary.
  3. A powered mobility base must have a lifetime warranty on the frame against defects in material and workmanship for the lifetime of the beneficiary.

4. The main electronic controller, motors, gear boxes, and remote joystick must have a two (2) year warranty from the date of delivery.
  5. Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects or if the surface does not remain intact due to normal wear.
- K. DME suppliers providing custom manual and/or motorized/power wheelchairs, customized electronic interphase devices, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8:00) a.m. and five (5:00) p.m. Monday through Friday. Each technician must keep on file records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.
- L. The Division of Medicaid covers repairs, including labor and delivery, of DME that is owned by the beneficiary not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.
1. Major repairs and/or replacement of parts require prior authorization from the UM/QIO and must include an estimated cost of the necessary repairs, including labor, and a documentation from the practitioner there is a continued need for the custom manual and/or motorized/power wheelchair.
  2. An explanation of time involved for repairs and/or replacement of parts must be submitted to the UM/QIO.
  3. Manufacturer time guides must be followed for repairs and/or replacement of parts.
  4. The Division of Medicaid defines repair time as point of service and does not include travel time to point of service.
  5. No payment is made for repairs or replacement if it is determined that intentional abuse, or misuse, of the wheelchair or components has occurred, which includes damage incurred due to inappropriate covered transportation for the prescribed motorized/power wheelchair.
  6. Reimbursement will be made for up to one (1) month for a rental of a wheelchair while the beneficiary's wheelchair is being repaired.
- M. The Division of Medicaid covers a travel wheelchair when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity and when the following criteria are met:
1. The travel wheelchair is not intended for extended daily use, or as a substitute or long-term replacement for other types of wheelchairs,

2. The beneficiary does not exceed the weight capacity of the travel wheelchair, and
3. The travel wheelchair is for the exclusive use of the beneficiary.

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

History: Revised eff. 07/01/2021; Revised eff. 10/01/2020. Revised eff. 09/01/2018. Revised eff. 01/02/2015. Revised eff. 01/01/2013.

*Rule 1.48: Wheelchair Accessories*

A. Medicaid covers manual and motorized/power wheelchair accessories and options for all beneficiaries when ordered by a physician is medically necessary and prior authorized and for purchase only as follows:

1. Medical necessity is met and adequate documentation of the beneficiary's condition and needs are provided.
2. The beneficiary must already have a wheelchair that meets coverage criteria and the beneficiary's condition must be such that, without the use of a wheelchair, he/she would otherwise be bed or chair confined.
3. The amputee adapter, pair, is covered for a beneficiary with an amputation of one (1) or both lower extremities. This device mounted on the wheelchair to bring the center of gravity forward on the chair to prevent tipping over.
4. A detachable armrest is covered to allow the beneficiary to perform side transfers independently or with assistance.
5. A swing away armrest is covered to allow the beneficiary to perform side transfers independently or with assistance.
6. A mobile arm support is covered for a beneficiary to assist with ADL's or to provide support to position and/or increase function to a weak or diseased upper extremity.
7. An arm trough is covered to support beneficiaries with spasticity or decreased strength or tone in an upper extremity.
8. The anti-roll back device is covered when the beneficiary has little or no assistance and meets the criteria for a manual chair.
9. A fully reclining back is covered when one (1) of the following applies:
  - a) The beneficiary is quadriplegic.
  - b) The beneficiary has a fixed hip angle that prevents sitting at a ninety-degree angle.

- c) The beneficiary has trunk or lower extremity casting/bracing that requires the reclining back for positioning.
  - d) The beneficiary needs to rest in a recumbent position two (2) or more times during the day and transfer between bed and chair is difficult.
10. Reinforced back and seat upholstery is covered when one (1) of the following applies:
- a) The beneficiary is morbidly obese and requires a more stable base.
  - b) The beneficiary requires the extra reinforcement due to excessive movement disorders.
11. A solid back insert, planar back, single density foam, attached with straps is covered when one (1) of the following applies:
- a) The beneficiary is using a sling seating system when the back is slung and requires increased support.
  - b) The beneficiary requires allowance for growth in a sling system up to one and one half inches (1½”) in growing room to the thigh area. The removable back is used until the beneficiary grows and then it is removed to allow for additional growth. This allows the therapist to order a standard wheelchair with growth potential for the beneficiary.
12. A calf pad is covered if the criteria for elevating leg rests are met.
13. A cylinder tank carrier is covered for beneficiaries with constant or intermittent oxygen needs.
14. High mount, flip up footrests are covered when the beneficiary has a lower leg, knee to foot, measurement that prevents them from using the manufactured mounting.
15. A footrest, lower extension tubes, each is covered when one (1) of the following applies:
- a) The beneficiary is growing and will need the adjustability of lowering the footrests for growth.
  - b) The beneficiary has a leg length difference and needs the footrest to be mounted at different heights.
16. Footplate, adjustable angle, is covered when one (1) of the following applies:
- a) The beneficiary has a fixed dorsiflexion or plantar flexion contracture.

- b) The beneficiary has the tendency to develop pressure problems on the plantar surface of the foot.
17. Heel loops, are covered when one (1) of the following applies:
- a) The beneficiary is seated in a tilt-in-space wheelchair.
  - b) The beneficiary has poor lower extremity muscular function and needs the support of the heel loop to keep the foot in place on the footrest.
  - c) The beneficiary needs the added support of a heel loop to assist in positioning of the lower extremities. This would be used for mild positioning only.
  - d) The heel loop with ankle strap is covered when one (1) of the following applies:
    - 1) The beneficiary cannot control the movement of his/her lower extremities to position the foot and ankle.
    - 2) The beneficiary is seated in a tilt-in-space wheelchair.
    - 3) The beneficiary cannot maintain adequate positioning of the foot and ankle without an ankle strap.
    - 4) The beneficiary has large feet or moves his/her feet excessively.
18. A hook on headrest extension, used to provide support for the head and neck, is covered if one (1) of the following applies:
- a) The beneficiary has decreased to poor head/neck control and is seated in a sling seating system.
  - b) The beneficiary requires the use of a headrest for safety during transportation.
  - c) The beneficiary has frequent seizures and the headrest is used for support during or after the seizure.
  - d) The beneficiary has a reclining back wheelchair and requires support for the head and neck.
19. An IV hanger is covered for those beneficiaries who require continuous/intermittent IV's or tube feedings.
20. A leg strap is covered when one (1) of the following applies:
- a) The beneficiary is seated in a tilt-in-space wheelchair and the strap is needed to prevent the lower extremity(ies) from falling backwards into the wheelchair.

- b) The beneficiary has increased or excessive extensor tone in the lower extremities and the strap is needed in front of the lower extremities to prevent them from extending forward.
  - c) The beneficiary has muscle spasms of the lower extremities and requires the strap to help keep the feet positioned on the footplates.
21. The leg strap, H style, is covered if one (1) of the following applies:
- a) The beneficiary requires the added reinforcement not supplied by the single leg strap.
  - b) The beneficiary has movement disorders and requires the added reinforcement of the H strap configuration.
22. Low pressure and positioning equalization pads, including one inch (1") to four inch (4") cushions for wheelchairs, are covered when one (1) or more of the following applies:
- a) The beneficiary has a history of pressure sores or decubitus ulcers.
  - b) The beneficiary has a pelvic obliquity.
  - c) The beneficiary is very thin and is subject to pressure problems secondary to decreased adipose tissue at the bony prominences.
  - d) The beneficiary cannot move his/her trunk and/or lower extremities due to a spinal cord injury whether from birth or through an accident.
  - e) The beneficiary has decreased or no sensation in the trunk and/or lower extremities.
23. A one (1) arm drive attachment is covered when both of the following apply:
- a) The beneficiary has functional use of only one (1) upper extremity.
  - b) There is sufficient cognition, dexterity and endurance to use this item.
24. Shoe holders are covered when the beneficiary requires the added support of a hard surface to position the foot.
25. The safety belt/pelvic strap that is in addition to the standard safety belt is covered when medically necessary to help maintain a neutral position of the pelvis when seated in the wheelchair or for those beneficiaries with an increased extensor tone.
26. The toe loop is covered when the beneficiary requires the cover of the forefoot to keep the foot positioned on the footplate.

27. A wheelchair tray is covered when medically necessary to assist with positioning of the trunk and upper extremities.
28. The wheel lock extension pair is covered when one (1) of the following applies:
  - a) The beneficiary does not have functional use of one (1) upper extremity. This allows the beneficiary to reach and lock both wheels independently without falling from the wheelchair.
  - b) The beneficiary has decreased strength and needs the extra height of the locks to achieve a greater lever arm for independent use of the wheel locks.

B. Non-covered accessories:

1. The following items are included in the base rate of the wheelchair for all beneficiaries and are not reimbursed separately:
  - a) Arms of the wheelchair,
  - b) Footrests, also known as footplates,
  - c) Large size footplates on a heavy duty wheelchair for beneficiaries who meet the criteria for that type chair,
  - d) Leg rests,
  - e) Elevating leg rests,
  - f) Standard safety belts,
  - g) The manual wheel lock assembly,
  - h) The automatic wheel lock assembly, a device fitted to the wheelchair which automatically locks the wheels when fifty percent (50%) or more of the beneficiary's body weight shifts forward. When one (1) of the following criteria exists, these locks are considered an essential part of the wheelchair and are included in the base rate of the wheelchair.
    - 1) The beneficiary has significant upper extremity disability or weakness and he/she cannot operate manual locks.
    - 2) The beneficiary does not have the cognitive awareness to consistently use manual locks.

2. Crutch and cane holders mounted to the back post of the wheelchair used to transport the cane or crutch of the beneficiary while in the wheelchair are considered not medically necessary and are not covered.

C. Any other accessory medically necessary is considered for coverage on an individual basis with appropriate documentation.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. § 43-13-117(17), 43-13-121.

History: Revised eff. 10/01/2020; Revised eff. 09/01/2018; Revised – 01/01/2013.

*Rule 1.49: Wheelchairs, Drivers and Seating, Custom*

Refer to Part 209, Chapter 1, Rule 1.47 Wheelchairs

History: Revised – 01/01/2013

*Rule 1.50: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

*Rule 1.51: Humidifier/Vaporizer*

A. Medicaid defines a humidifier, heated or non-heated, as a device used to increase the moisture content of the air.

B. Medicaid covers humidifiers for all beneficiaries when ordered by a physician, medically necessary and prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for rental up to the purchase amount or for purchase.

C. Room Humidifiers and Vaporizers

1. Medicaid defines a room humidifier as a mechanical device used to increase the moisture content of the air in a room with a cool mist. Medicaid defines a steam vaporizer as a mechanical device that creates moisture in the air by heating the water into a hot mist. Medicaid defines a warm mist humidifier as a type of steam vaporizer that cools the moist steam before it is released into the room.
2. Room humidifiers and vaporizers are covered for beneficiaries 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. The diagnosis may include, but are not limited to:

- a) Chronic bronchitis,
  - b) Asthmatic bronchitis,
  - c) Chronic Asthma,
  - d) Bronchopulmonary dysplasia, or
  - e) Chronic airway obstruction.
3. Documentation must be provided that the patient or caregiver is able to use and care for the equipment.
  4. Humidifiers are not covered for acute upper respiratory infections, a chronic cough or colds unrelated to another diagnosis.
- D. Medicaid defines a heat and moisture exchanger (HME), or an artificial nose, as a passive acting humidifier that collects expired heat and moisture and returns it during the following inspiration. The HME is covered when the beneficiary has:
1. An existing tracheostomy, and
  2. Documentation that supplemental, direct humidification is required for the beneficiary's tracheostomy.
- E. High-Flow or Water Reservoir Humidifiers
1. High-Flow, water reservoir, heated or non-heated humidifiers include, but are not limited to pass-over, wick, and bubble types. High-flow and water reservoir humidifiers are used to provide supplemental heat and humidity and are covered as follows:
    - a) The use of high-flow, water reservoir humidifiers to increase moisture to the airway of a beneficiary with a tracheostomy is covered when the beneficiary has an existing tracheostomy and documentation is present that the beneficiary requires supplemental, direct humidification to the tracheostomy.
    - b) A high-flow, water reservoir humidifier is covered for C-PAP and Bi-PAP devices if criteria for coverage of the C-PAP or BI-PAP device are satisfied and documentation is present that the beneficiary requires supplemental humidification.
    - c) A high-flow, water reservoir humidifier is covered in conjunction with ventilators if criteria for coverage of the ventilator are satisfied and documentation is present that the beneficiary requires supplemental humidification.
  2. Humidifiers are included in the rental or purchase price of that equipment when used in

conjunction with oxygen or IPPB treatments.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 09/01/2018. 01/01/2013.

*Rule 1.52: Pressure Reducing Support Surface*

- A. Medicaid defines pressure reducing support surfaces as surfaces designed for beneficiaries with limited or no mobility who are bed confined most or all of the day and prone to developing pressure ulcers.
- B. Medicaid covers pressure reducing support surfaces for all eligible beneficiaries when ordered by a physician, medically necessary and prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for rental up to purchase amount or purchase.
- C. Beneficiaries requiring pressure reducing support surfaces must have a care plan, established by the beneficiary's physician or home care nurse, documented in the beneficiary's medical record, which includes all of the following:
  - 1. Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers.
  - 2. Regular assessment by a nurse, physician, or other licensed health care practitioner.
  - 3. Appropriate turning and positioning.
  - 4. Appropriate wound care for a stage II, III or IV ulcer.
  - 5. Appropriate management of moisture/incontinence.
  - 6. Nutritional assessment and intervention consistent with the overall plan of care.
- D. Medicaid defines a pressure pad for a mattress as a non-powered pressure reducing mattress overlay designed to be placed on top of a standard hospital or home mattress which includes a gel mattress overlay, an air mattress overlay, a water mattress overlay and a foam mattress overlay with a waterproof cover.
  - 1. Medicaid covers a pressure pad when one (1) or more of the following apply:
    - a) The beneficiary is completely immobile and cannot make changes in body position without assistance.
    - b) The beneficiary has limited mobility and cannot independently make changes in body position significant enough to alleviate pressure.

- c) The beneficiary has any stage of a pressure ulcer on the trunk or pelvis.
  - d) The beneficiary is essentially bedbound with an impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status.
2. A replacement pad for use with a medically necessary power alternating pressure device owned by the beneficiary is covered if the beneficiary meets one (1) or more of the criteria in Rule 1.52, D.1.a-d.
  3. A foam overlay or mattress, such as an egg crate without a waterproof cover, is not considered durable and is not covered under the DME program.

#### E. Powered Pressure Reducing Overlays and Mattresses

1. Medicaid defines a powered pressure reducing overlay as a low air loss, powered flotation device without low air loss, or alternating pressure with an air pump or blower providing either sequential inflation or deflation of the air cells or a low interface pressure throughout the overlay designed to reduce friction and shear and are to be placed on top of a standard hospital or home mattress.
2. Medicaid defines a powered pressure reducing mattress as a mattress with alternating pressure, low air loss, or powered flotation without low air loss. An air pump or blower provides both sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress. The surface is designed to reduce friction and shear and can be placed directly on a hospital bed frame.
3. Powered pressure reducing overlays and mattresses are covered when one (1) or more of the following applies:
  - a) The beneficiary has multiple stage II pressure ulcers, defined as partial thickness skin loss involving epidermis and/or dermis, on the trunk or pelvis.
  - b) The beneficiary has been on a comprehensive ulcer treatment program and the ulcers have worsened or remained the same for one (1) month.
  - c) Large or multiple stage III pressure ulcers, defined as full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia, or stage IV pressure ulcers, defined as full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures, on the trunk or pelvis.
  - d) Myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the previous sixty (60) days.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 09/01/2018. 01/01/2013.

## **Part 209 Chapter 2: Medical Supplies**

### *Rule 2.1: General Provider Information*

- A. The Division of Medicaid defines medical supplies as medically necessary health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.
- B. All medical supplies, including those required for operation of DME, must be prescribed by a licensed, qualified physician.
  - 1. A Medical Supply Certificate of Medical Necessity (CMN) form must be completed by the DME provider.
  - 2. The Medical Supply CMN form must be signed by the ordering physician within thirty (30) days of the date of delivery which can be used as the physician prescription.
  - 3. The Medical Supply CMN form must be retained by the DME provider in the beneficiary's medical record and is subject to review by the Division of Medicaid
  - 4. The DME provider must provide a copy of the Medical Supply CMN form to the ordering physician, nurse practitioner, or physician assistant for their records.
- C. The DME provider is responsible for compliance with all the Division of Medicaid rules, including, but not limited to:
  - 1. Use of the appropriate procedure code for the billed item(s),
  - 2. Dispensing of the appropriate medically necessary quantities of supplies,
  - 3. Ensuring accurate billing, and
  - 4. Maintaining all documentation to show compliance with Miss. Admin. Code Part 209.
- D. The provider must only dispense medical supplies in quantities to meet the beneficiary's needs for thirty (30) days.
  - 1. The beneficiary must request the supplies each month.
  - 2. Supplies cannot be shipped on an automatic basis.
  - 3. Supplies provided on a reoccurring basis may be delivered no more than ten (10) calendar days prior to the expected end of the current supply.

- E. A prescription and/or Medical Supply CMN form must be completed and signed by the ordering physician every twelve (12) months.
1. The prescription and/or Medical Supply CMN form is considered current up to twelve (12) months from the date it was signed by the physician.
  2. Medical supplies will be considered non-covered if there is no current prescription and/or Medical Supply CMN form in the beneficiary's medical record.
- F. When medical supplies are delivered to a beneficiary's home the provider must document:
- 1) Beneficiary's name,
  - 2) Delivery address,
  - 3) Detailed description of the medical supplies provided at that time and Healthcare Common Procedure Coding System (HCPCS) codes that identify the item being delivered,
  - 4) Quantity delivered,
  - 5) Date of delivery which must be the date the beneficiary received the item, and
  - 6) Signature of beneficiary or designated representative.
    - a) During a national or statewide emergency, a signature is not required.
    - b) During a national or statewide emergency, the provider must document the emergency and confirmation of delivery by an alternate means including, but not limited to:
      - (1) Telephone,
      - (2) Text message, or
      - (3) Other electronic communication.

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

History: Revised eff. 06/01/2025. Revised eff. 08/01/2020, Revised eff. 09/01/2018. Revised eff. 07/01/2015.

### *Rule 2.2: Covered Medical Supplies*

The Division of Medicaid covers the following medical supplies when they are medically necessary and considered standard care for the treatment of a beneficiary's medical condition and dispensed in quantities that meet a beneficiary's medical needs without excessive utilization, including, but not limited to: [Refer to Miss. Admin. Code Part 207 for coverage of medical supplies in a long-term care facility.]

- A. Alcohol preps, swabs, wipes and bottle are covered for quantity or number of pints appropriate for the plan of care for all beneficiaries for injection site cleanings, for self-administration, or care giver administration of intramuscular or subcutaneous injections ordered by a practitioner.
- B. Apnea monitor supplies for beneficiaries who have an apnea monitor.
  - 1. Electrodes,
  - 2. Lead wires, and
  - 3. Battery pack.
- C. Diabetic supplies for all beneficiaries who meet the criteria for:
  - 1. Blood glucose monitors (BGM):
    - a) Test strips,
    - b) Lancets,
    - c) Insulin syringes,
    - d) Control solutions,
    - e) Replacement battery,
    - f) Spring lancet device,
    - g) Autoclix lancets (spring), and
    - h) Urine test or reagent strips.
  - 2. Continuous glucose monitoring (CGM):

- a) CGM supply allowance covers supplies as a bundle which includes disposable sensors and transmitter. Supplies billed separately will not be covered.
  - b) DME receiver to display glucose data,
    - 1) A DME receiver is covered if used alone or in conjunction with a non-DME device including, but not limited to: a watch, smartphone, tablet, laptop computer.
    - 2) Non-DME devices will not be covered.
    - 3) If a DME receiver is never used, the supply allowance will not be covered.
  - c) Replacement batteries.
- D. Dressing supplies for all beneficiaries.
- 1. 4x4 non-sterile gauze pads,
  - 2. 4x4 sterile gauze pads, including drain sponges,
  - 3. Tape,
  - 4. Sterile normal saline solution, 1000 ml, and
  - 5. Gloves, sterile and non-sterile.
- E. Biofeedback/Electromyography (EMG) supplies for all beneficiaries who meet criteria for biofeedback/EMG.
- 1. Lead wires, and
  - 2. Electrodes.
- F. Enteral Feeding supplies for all beneficiaries who meet criteria for enteral feeding pump.
- 1. 4x4 non-sterile gauze,
  - 2. 4x4 sterile gauze, including drain sponges,
  - 3. Tape,
  - 4. Sterile solution, 1000ml,
  - 5. Gloves, sterile and non-sterile,
  - 6. Feeding bag(s),

7. Feeding syringe, and
8. Sterile water, 1000ml.

G. Elbow and heel protectors for all beneficiaries when one (1) of the following criteria is met:

1. The beneficiary is bed/chair confined and has a history of decubitus ulcers on a heel or elbow.
2. The patient is bed/chair confined and currently has a decubitus ulcer on a heel or elbow.
3. The beneficiary exhibits signs of redness or discomfort at bony prominences or other areas of potential breakdown

H. Hydrogen peroxide for all beneficiaries who have a tracheostomy and a wound.

I. Insulin pen needles or pre-filled insulin syringe needles for all beneficiaries receiving a pre-filled insulin injection device through the pharmacy program. Needles are covered through the medical supply program only if one (1) of the following criteria is met:

1. The patient has very poor eyesight and is unable to read the markings on a standard insulin syringe.
2. The patient has a condition of the hands that will not allow them to manipulate a vial and syringe to draw up their insulin.

J. Insulin pump supplies for all beneficiaries who meet criteria for insulin pump.

1. Cartridges,
2. Infusion sets with cannula,
3. Skin cleanser,
4. Skin prep,
5. Alcohol prep,
6. Adhesive remover,
7. Replacement batteries, and
8. Gloves, sterile.

K. Intravenous (IV) Pump, also referred to as an Infusion Pump, and supplies for all beneficiaries who meet criteria for an IV pump.

1. Cassette appropriate for pump type, and
2. Replacement batteries.

L. IV Supplies for all beneficiaries who meet criteria for an IV pump or an IV pole.

1. Central line supplies,
2. Administration set,
3. Tubing and clamp,
4. Extension set,
5. IV start kit,
6. Butterfly needles, all sizes,
7. IV catheters, all sizes,
8. Non-coring needles,
9. 2x2 gauze, sterile,
10. Tape, all types,
11. Syringe, any size without needles,
12. Syringe, any type with needle,
13. INT,
14. Flush kit,
15. Iodine prep,
16. Alcohol preps,
17. Dial-a-flow,
18. Sterile normal saline for injection - 2ml, 2.5ml, 3ml, 5ml, 10ml, 20ml, 30ml, and 50ml supplied in bottles, ampules or vials, and

19. Gloves, sterile.

M. Nebulizer supplies for all beneficiaries when criteria for nebulizer are met.

1. Administration set, disposable, non-filtered,
2. Administration set, non-disposable, non-filtered,
3. Administration set, filtered,
4. Aerosol mask, and
5. Tubing.

N. Neuromuscular Electrical Stimulator (NMES) supplies for all beneficiaries who meet criteria for neuromuscular electrical stimulator.

1. Electrodes, and
2. Lead wires.

O. Ostomy supplies for all beneficiaries who have a surgically established opening, or stoma to divert urine, feces, or illegal contents outside the body.

P. Oxygen and oxygen related supplies are covered for all beneficiaries who meet criteria for oxygen therapy.

1. E cylinders, including delivery,
2. H or K Cylinders, including delivery,
3. Tubing,
4. Face masks,
5. Nasal cannulas, and
6. Regulators.

Q. Pulse oximeter supplies, which include an oxygen probe, are covered for all beneficiaries who meet criteria for pulse oximeter monitoring.

R. A sling for all beneficiaries who have an injury or diagnosis which requires support or immobilization of an upper extremity to control pain, restrict motion, prevent further deformity, or protect the limb following trauma or surgery. The request for coverage must be

supported by the beneficiary's diagnosis, the goals for use of the sling, and the expected duration of use.

S. Suction pump supplies (respiratory or gastric) for all beneficiaries who meet criteria for a suction pump.

1. Respiratory suction supplies include:

- a) Catheter kit, sterile,
- b) Suction catheter, 8-15 FR,
- c) Yankauer type respiratory suction,
- d) Respiratory suction tubing,
- e) Canister, disposable, and
- f) Gloves, any type.

2. Gastric suction supplies include:

- a) Gastric suction catheter kit,
- b) Gastric suction catheter, 8-15 FR,
- c) Gastric suction whistle tip, with valve,
- d) Gastric suction tubing,
- e) Canister, disposable,
- f) Gloves, any type, and
- g) Gastric suction tube.

T. Supplies for maintenance of drug infusion catheter, per week, for all beneficiaries who meet criteria for an IV pump.

- 1. Catheter insertion devices,
- 2. Dressing for catheter site,
- 3. Flush solutions not directly related to drug infusion,
- 4. Cannulas,

5. Needles,
  6. Infusion supplies, excluding the insulin reservoir, and
  7. Gloves, sterile.
- U. Supplies for external drug infusion pump, per cassette or bag, for all beneficiaries who meet criteria for an IV pump.
1. Cassettes,
  2. Bags,
  3. Diluting solution,
  4. Tubing,
  5. Other administration supplies,
  6. Port charges, not used for syringe-type reservoir,
  7. Gloves, sterile.
- V. Syringes and needles are covered for self-administration of intramuscular and/or subcutaneous injectable medication for all beneficiaries that are performing the administration of injections in any non-institutional setting where the beneficiary's normal life activities take place.
- W. Transcutaneous Electrical Nerve Stimulator (TENS) supplies for all beneficiaries who meet criteria for Transcutaneous Electric Nerve Stimulator.
1. Electrodes, and
  2. Lead wires.
- X. Tracheostomy supplies for all beneficiaries who have a tracheostomy with documentation of the specific respiratory condition.
1. Trach mask or collar,
  2. Trach or laryngectomy tube,
  3. Trach, inner cannula,
  4. Replacement tracheal suction catheter, any type,

5. Trach care kit, for new trach,
6. Trach care kit, for established trach,
7. Suction catheter kit, sterile,
8. Sterile water, 1000 ml,
9. Sterile normal saline for instillation, supplied in 2ml, 2.5ml, 3ml, 5ml, 10ml, 20ml, 30ml, and 50 ml bottle, ampule, or vial.
10. Trach ties,
11. Trach cleaning brush,
12. Heat and Moisture Exchangers (HME),
13. Trach shower protector,
14. Tracheostomy/laryngectomy, tube plug/stop,
15. Tracheostoma filter,
16. Gauze, and
17. Gloves, sterile.

#### Y. Urinary catheters

1. Urinary catheters are covered for all beneficiaries when one (1) of the following criteria is met:
  - a) Beneficiary must have an acute condition which requires intermittent catheterization for measuring residual, instilling medication, or other medically necessary indication,
  - b) Beneficiary has an acute condition which requires the short-term use of an indwelling catheter,
  - c) Beneficiary has a chronic condition which incontinence is exacerbating pressure sores that will not heal,
  - d) Beneficiary has a condition that requires accurate measurement of intake and output on a short-term basis, or
  - e) Beneficiary has urinary retention that cannot be relieved by medication.

2. Supplies include:

- a) Insertion tray,
- b) Irrigation tray, with bulb or piston syringe,
- c) Irrigation syringe, bulb or piston,
- d) Sterile solution for irrigation,
- e) Female external collection device,
- f) Indwelling catheter, foley, two-way,
- g) Indwelling catheter, three-way,
- h) Male external catheter, with or without adhesive,
- i) Intermittent catheter, straight tip,
- j) Bedside drainage bag,
- k) Leg bag with or without strap,
- l) Gloves, sterile.

- 3. The Division of Medicaid requires the beneficiary and/or caregiver to be capable of performing the catheterization procedure and report results and have been instructed in the procedure and properly demonstrated the ability to perform the procedure.
- 4. The Division of Medicaid covers condom catheters for beneficiaries with paraplegia, neurogenic bladder, or other medically necessary indications when requested with appropriate documentation.

Z. The Division of Medicaid covers supplies for manual and electric breast pumps.

AA. Incontinence Garments and Supplies

- 1. The Division of Medicaid covers the following disposable incontinence garments and supplies:
  - a) Diapers,
  - b) Pull-ons,

- c) Underpads,
  - d) Non-sterile gloves,
  - e) Non-medicated skin protectant, and
  - f) Personal sanitary wipes.
2. The Division of Medicaid covers up to six (6) units of incontinence garments per day for beneficiaries aged three (3) and above only when certified as medically necessary. Prior authorization is required for quantities in excess of the limit.
- a) One (1) unit is equal to one (1) diaper or one (1) pull-on or one (1) underpad.
  - b) The six (6) units can consist of any combination of diapers, pull-ons and/or underpads.
3. The Division of Medicaid covers incontinence supplies for beneficiaries aged three (3) and above when medically necessary.
- a) Incontinence supplies include:
    - 1) Up to four hundred (400) Personal sanitary wipes per month,
    - 2) Up to two hundred (200) pair of non-sterile gloves per month, and
    - 3) Up to two (2) units of non-medicated skin protectant per month.
  - b) Prior authorization is required for quantities in excess of the specified limit.
3. A beneficiary must have a diagnosis of incontinence or must meet one (1) of the following criteria due to a documented medical condition in order for the incontinence garments and supplies to be considered medically necessary:
- a) Inability to utilize regular toilet facilities.
  - b) Inability to physically turn self or reposition self.
  - c) Inability to transfer self from bed to chair or wheelchair without assistance.
4. The physician must order all incontinence garments and supplies and maintain documentation of the medical necessity and diagnosis of incontinence in the beneficiary's medical record.

5. The durable medical equipment (DME) provider must maintain in the beneficiary's record a current certificate of medical necessity (CMN), signed by the ordering physician and must include:
  - a) An initial physician's order,
  - b) The beneficiary's diagnosis along with associated diagnoses and code(s),
  - c) The anticipated frequency and duration of need,
  - d) The requested quantity per month,
  - e) A detailed description of the item(s) including the type, size and corresponding Healthcare Common Procedure Coding System (HCPCS) code for each,
  - f) The ordering physician's signature and date of signature. Signature stamps, date stamps, or the signature of anyone other than the ordering physician is not acceptable.
6. The DME provider must have a current physician's order and CMN to initiate or continue the provision of incontinence garments and supplies to a beneficiary.
  - a) The CMN must be renewed every six (6) months.
  - b) For those cases where there is documentation justifying the need for incontinence garments and supplies for beneficiaries whose medical condition is chronic, recertification is only required every twelve (12) months.
7. The DME provider must maintain documentation of proof of delivery of incontinence garments and supplies including:
  - a) Beneficiary's name,
  - b) Date of delivery which must be the date the beneficiary received the item; including the dates of service the delivered quantity is expected to last,
  - c) Delivery address,
  - d) Detailed description of incontinence garments delivered,
  - e) Quantity delivered, and
  - f) The signature of the beneficiary, caregiver, or family member who received the supplies.
    - 1) During a national or statewide emergency, a signature is not required.

- 2) During a national or statewide emergency, the provider must document the emergency and confirmation of delivery by an alternate means including, but not limited to:
  - (a) Telephone,
  - (b) Text message, or
  - (c) Other electronic communication.
8. DME providers:
  - a) Are allowed to deliver incontinence garments and supplies in quantities expected to last no more than one (1) month.
  - b) Are not allowed to dispense items to a beneficiary who already has at least a one (1) month's supply on hand.
  - c) Must make contact, either orally or in writing, with each beneficiary and/or their legal representative or guardian to confirm the current need before delivering additional incontinence garments or supplies.
  - d) Must keep documentation of the monthly contact on file.
9. DME providers must supply size, waist, and weight appropriate incontinence garments based on the beneficiary's current measurements.
10. The DME provider must submit a new CMN form signed and dated by the ordering physician detailing changes and medical necessity to the Division of Medicaid or designee if DME provider needs to amend the initial order for incontinence garments being delivered due to a change in the beneficiary's size or underlying medical condition.
11. DME providers must maintain documentation of measurements and medical conditions in the beneficiary's record which supports reimbursement for the specific size of incontinence garments.

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

History: Revised eff. 01/01/2025; Revised to correspond with MS SPA 22-0027 (effective 10/01/2022) effective 01/01/2023; Revised eff. 10/01/2021; Revised eff. 07/01/2021; Revised eff. 08/01/2020, Revised eff. 10/01/2019; Revised eff. 07/01/2019; Revised eff. 09/01/2018. Added Miss. Admin. Code Part 209, Rule 2.2.C.2. eff. 07/01/2015; Revised Miss. Admin. Code Part 209, Rule 2.2.O eff. 01/02/2015; Added Miss. Admin. Code Part 209, Rule 2.2.Z., eff. 05/01/2014; Revised eff. 01/01/2013.

*Rule 2.3: Non-Covered Medical Supplies*

Oral Hygiene supplies that include tooth brushes, dental floss, toothpaste, toothettes, lemon glycerin swabs and other non-specific oral hygiene items.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Removed Miss. Admin. Code Part 209, Rule 2.3.B., eff. 05/01/2014.

*Rule 2.4: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

*Rule 2.5: Diabetic Supply Rebate Program*

A. The Division of Medicaid may operate a diabetic supply rebate program in coordination with the Sovereign States Drug Consortium.

1. Diabetic supplies included in the rebate program are listed on the Preferred Diabetic Supply List located on the Division of Medicaid's website.
2. Providers, including coordinated care organizations, are prohibited from collecting any manufacturer rebates on items included on the Preferred Diabetic Supply List.

B. Diabetic supplies included in the Preferred Diabetic Supply List provided by a pharmacy may be billed on a pharmacy claim.

C. Diabetic supplies billed through pharmacies must comply with the coverage requirements for medical supplies as applicable.

Source: Miss. Code Ann § 43-13-121.

History: Revised eff. 05/01/2025. New rule eff. 01/01/2025 to correspond with MS SPA 24-0014 (effective 7/1/2024).