Durable Medical Equipment (DME)

gainwell

What is Durable Medical Equipment?

- 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.

DME REIMBURSEMENT

- 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 7 practitioner's scope of practice and collaborative agreement procedures.
- 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.
- 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.
- 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.
- DOM does not process any DME/medical supply claims via POS. Pharmacies may be DME providers; however, for DOM to reimburse for DME/medical supplies, the pharmacy must enroll as a MS Medicaid DME provider. All DME items and/or medical supplies must be filed on a CMS-1500 claim form.
- https://medicaid.ms.gov/wp-content/uploads/2021/07/Title-23-Part-215-Home-Health-Services-7.1.21.pdf

Home Health/Hospice

Hospice

- Hospice Benefit is a State Plan service for terminally ill individuals at the end of their life cycle and having certification from a physician with a life expectancy of six (6) months or less. Hospice provides palliative treatment such as nursing care, medical social services, physician services, counseling short term patient care, medical appliances and supplies, drugs related to terminal condition, home health aide or homemaker, or non-restorative therapies.

- You can locate links to additional for in formation Hospice Forms https://medicaid.ms.gov/programs/hospice/

Non-Emergency Transportation (NET) Services

- Medicaid will provide transportation assistance to eligible persons for travel to medical appointments when there are no other means of getting to and/or from the appointment. The services must be medically necessary, covered by Medicaid, rendered by a Medicaid approved provider and the eligible person has not exceeded any service limits associated with the covered service.
- The Division of Medicaid contracts with a Broker to provide non-emergency transportation (NET) through a NET provider to Medicaid beneficiaries in appropriate vehicles, depending on the beneficiary's mobility status and personal capabilities on the date of service.
- For more information please see: Administrative Code https://medicaid.ms.gov/wp-content/uploads/2022/05/Title-23-Part-201-Transporation-Services.Entire.eff-5.1.22.pdf
- Fee For Service Medicaid NET transportation – Medical Transportation Management(MTM)
  - To schedule a ride – 1-866-331-6004
  - Your ride is late or a no show – 1-866-334-3794
  - To file a complaint – 1-866-436-0457

Waiver Services

1115 (a)

- Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services (HHS) to waive certain federal requirements and gives the Centers for Medicare and Medicaid Services (CMS) the authority to approve experimental, pilot, or demonstration projects. The purpose of these waivers is to demonstrate and evaluate policy approaches to better serve the Medicaid population. These projects must be likely to assist in promoting the objectives of the Medicaid program as determined by the Secretary.
- 1115(a) demonstrations must be "budget neutral," meaning that during the course of the waiver the Division of Medicaid expenditures cannot exceed what they would be without the waiver.

1915 (c)

- 1915 (c) waiver allows the Division of Medicaid to provide home and community-based services to beneficiaries who would otherwise need institutional care that is furnished in a hospital, Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)
- The Division of Medicaid has the following 1915(c) waivers:
  - Traumatic Brain Injury/Spiral Cord Injury (TBI/SCI) Waiver
  - Assisted Living (AL) Waiver
  - Intellectual Disabilities/Developmentally Disabled (ID/DD) Waiver
  - Independent Living (IL) Waiver
  - Elderly and Disabled (E&D) Waiver

1915(b)(4)

- Enables the Division of Medicaid to restrict the provider from whom Medicaid beneficiaries receive services as long as such restrictions do not substantially impair access to services of adequate quality where medically necessary. The Division of Medicaid's 1915(b)(4) waivers are specifically for selective contracting arrangements that are paid on a fee-for-service basis.
- Currently, the Division of Medicaid has 1915(b)(4) waivers to run concurrent with the 1915(c) waivers as follows:
  - Independent Living (IL) Waiver
- For more information and updates please visit: https://medicaid.ms.gov/programs/long-term-care-2/

Mental Health

- DOM Mental Health provides a way for people to get the mental health treatment they need in a variety of settings, depending on age and conditions. However, several of our programs are limited to children under age 21. Some services are not covered, while others may require a specific diagnosis to be covered. Additionally, some services require prior authorization for coverage. Geriatric psychiatric services are not covered. The Office of Mental Health is comprised of three divisions: Mental Health Programs, Special Mental Health Initiatives, and Mental Health Services.

- Federally Qualified Health Centers and Rural Health Clinics provide mental health services in the community. Each person is allowed a medical visit and a separate mental health visit on the same day. All visits count against the service limits for adults. Children under the age of 21 may receive more visits, if medically necessary, with prior authorization.

- For fee schedule information please visit: https://medicaid.ms.gov/wp-content/uploads/2022/07/RHC-2022-Rates-Published-last-updated.pdf

- For additional information please visit: HTTPs://medicaid.ms.gov/programs/mental-health/mental-health-services/

Mental Health Provider Updates

- Intellectual Disabilities/Developmental Disabilities Waiver providers and those enrolling as Community Support Program providers should choose the Enrollment Type of Other with taxonomy code 251S00000X instead of choosing Group when submitting their initial enrollment application.

Hospital Services

Inpatient Services

- MS DOM considers a patient an inpatient if formally admitted as an inpatient with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight.
- Inpatient services are services that are ordinarily furnished by the hospital for the care and treatments of the beneficiary, solely during his/her stay in the hospital
- The three (3) day payment window rule refers to the requirement that all outpatient services provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital, within the three (3) days prior to an inpatient hospital admission that are related to the reason for the inpatient hospital stay must be included in the All Patient Refined Diagnosis Related Group (APR-DRG) payment for the inpatient stay

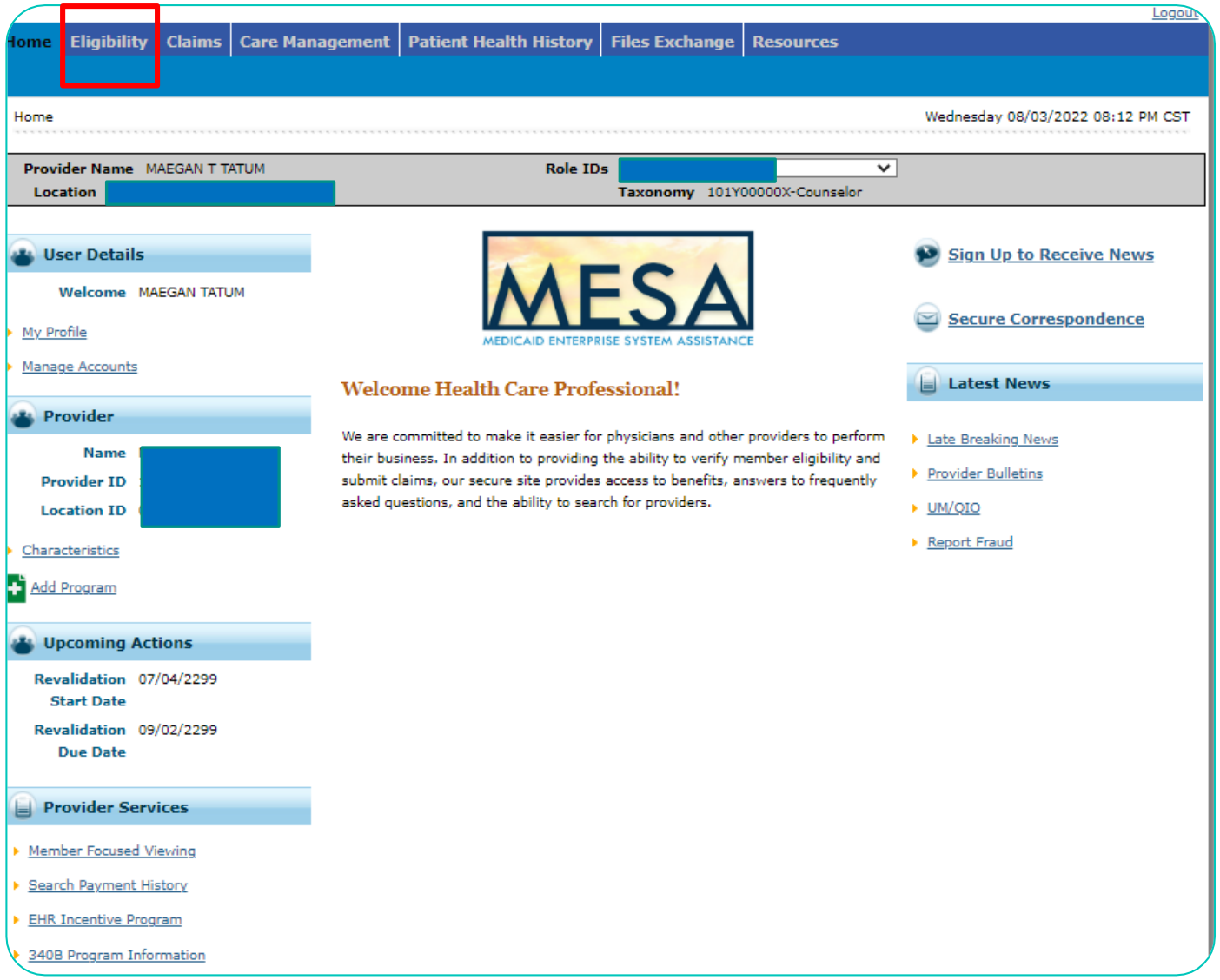
Newborn Enrollment

Division of Medicaid Administrative Code

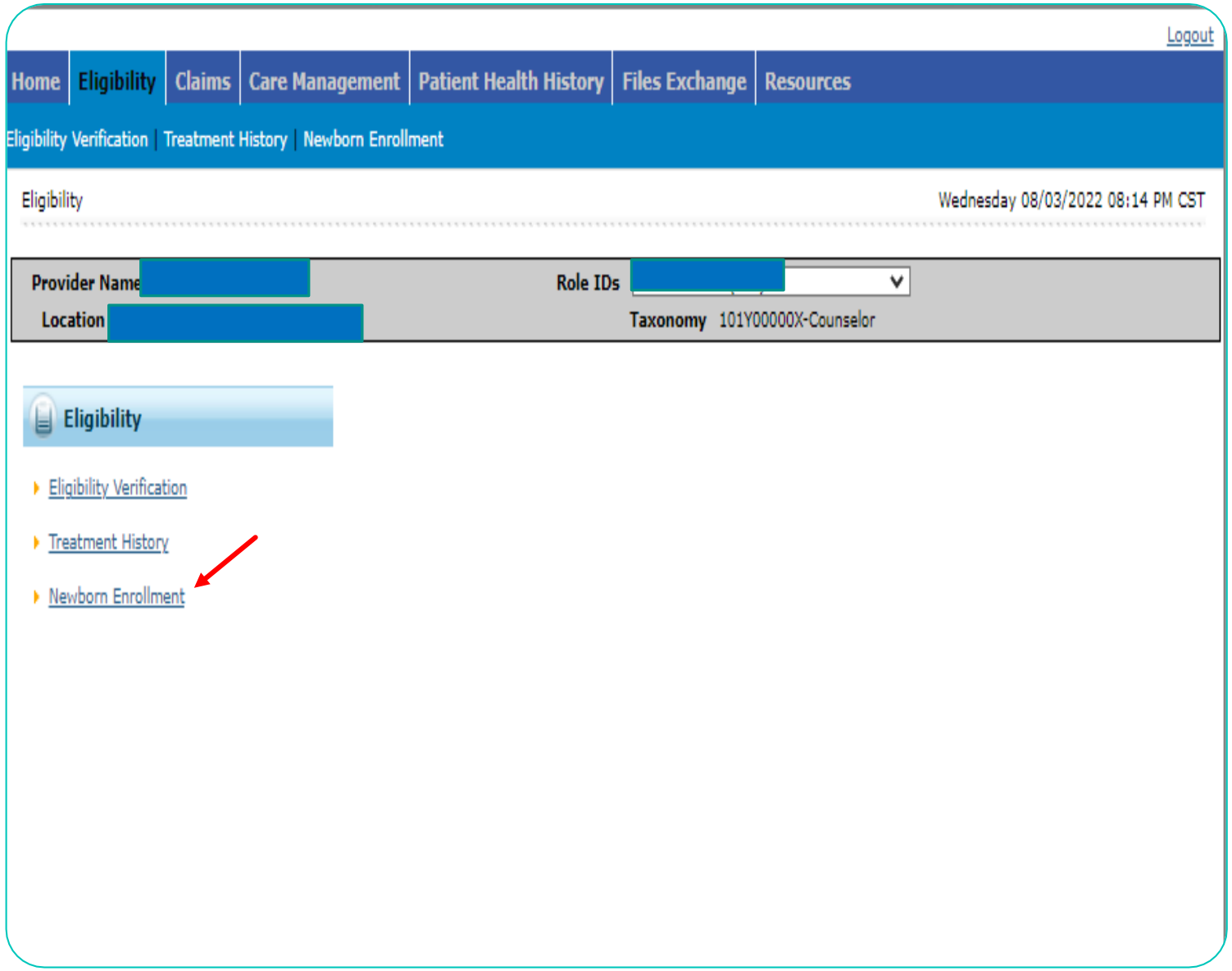
Title 23: Division of Medicaid

Part 202: Hospital Services, Chapter 1: Inpatient Services

- Well newborn services provided in the hospital must be billed separately from the mother's hospital claim.
  - a) The hospital must notify the Division of Medicaid within five (5) calendar days of a newborn's birth via the Newborn Enrollment Form located on the Division of Medicaid's website.
  - b) The Division of Medicaid will notify the provider within five (5) business days of the newborn's permanent Medicaid identification (ID) number

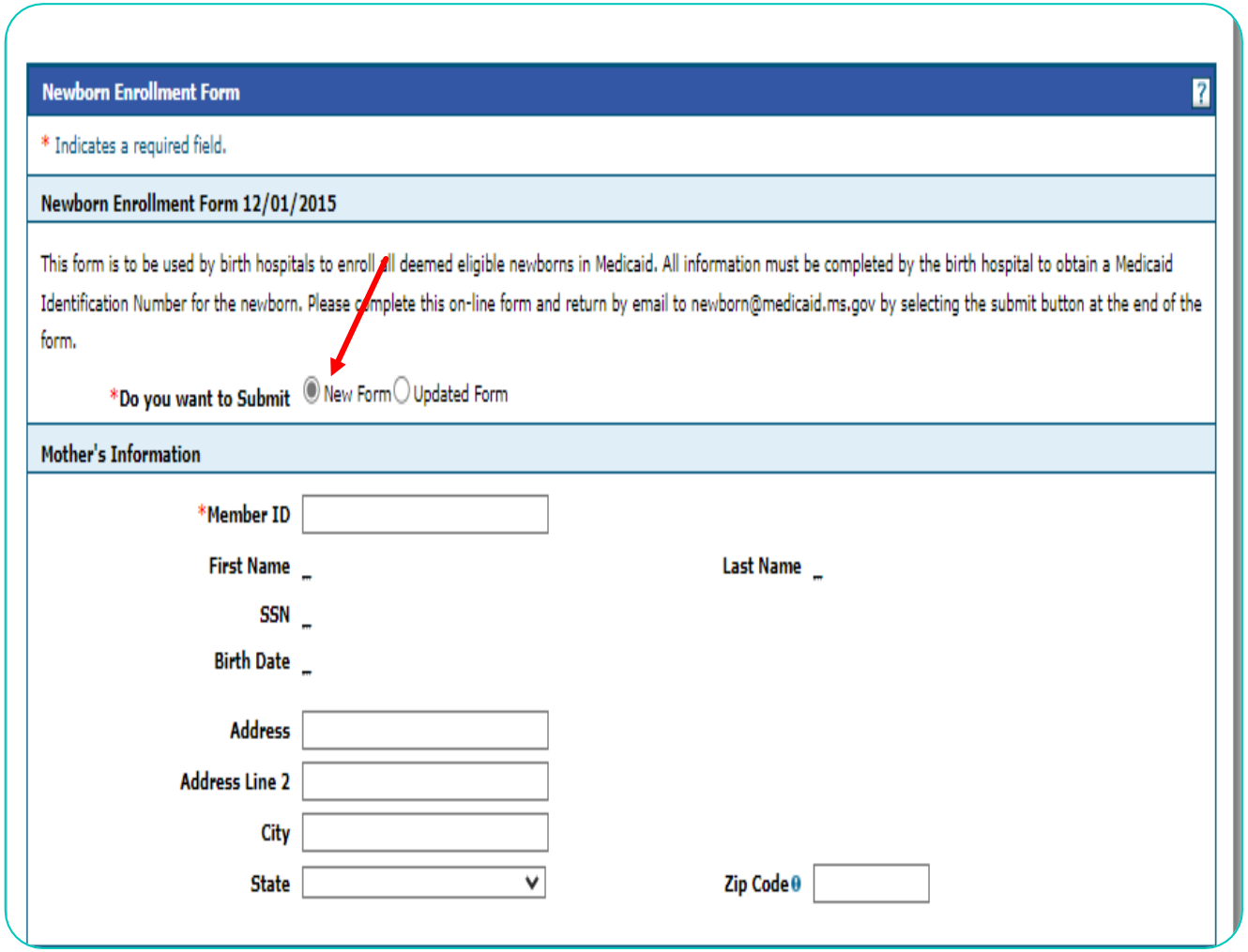


- Log into the portal and select the Eligibility tab.



- On the Eligibility page, click the Newborn Enrollment link.

- Select the New Form button to indicate this is a new enrollment.

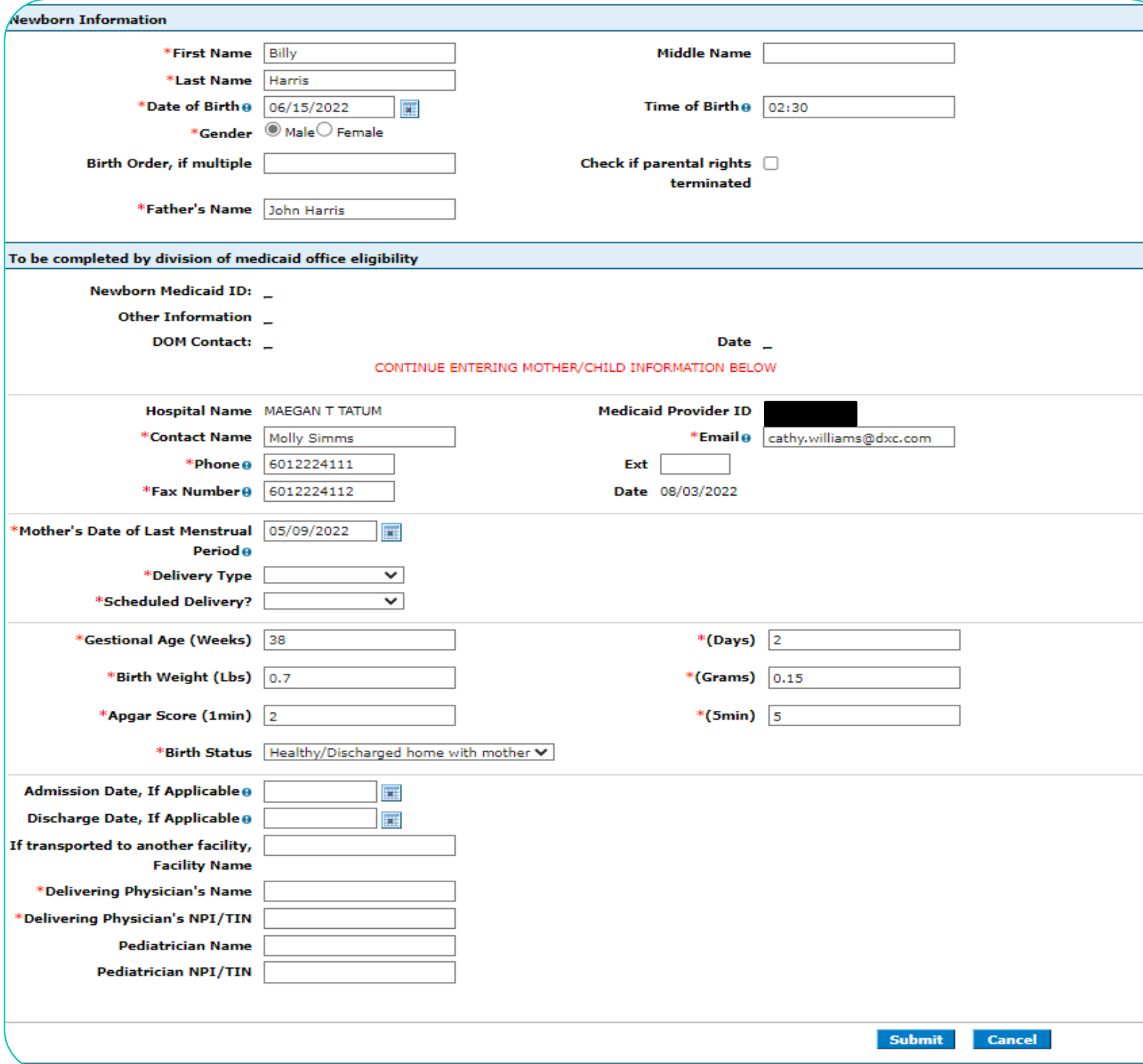


Enter the mother's member ID in the Member ID field and tab to the next field. The system populates the member's information.

Enter the newborn's information along with father's name.

Enter all the data related to the infant, including the delivering physician's name and National Provider Identifier (NPI) or Tax Identification Number (TIN).

When you're finished, click Submit.



Newborn Information

*First Name: Billy
Middle Name:
*Last Name: Harris
*Date of Birth: 06/15/2022
Time of Birth: 02:30
*Gender: Male / Female
Birth Order, if multiple:
Check if parental rights terminated:
*Father's Name: John Harris

To be completed by division of medicaid office eligibility

Newborn Medicaid ID: --
Other Information: --
DOM Contact: --
Date: --

CONTINUE ENTERING MOTHER/CHILD INFORMATION BELOW

Hospital Name: MAEGAN T TATUM
Medicaid Provider ID: [redacted]
*Contact Name: Molly Simms
*Email: cathy.williams@dxc.com
*Phone: 6012224111
Ext:
*Fax Number: 6012224112
Date: 08/03/2022

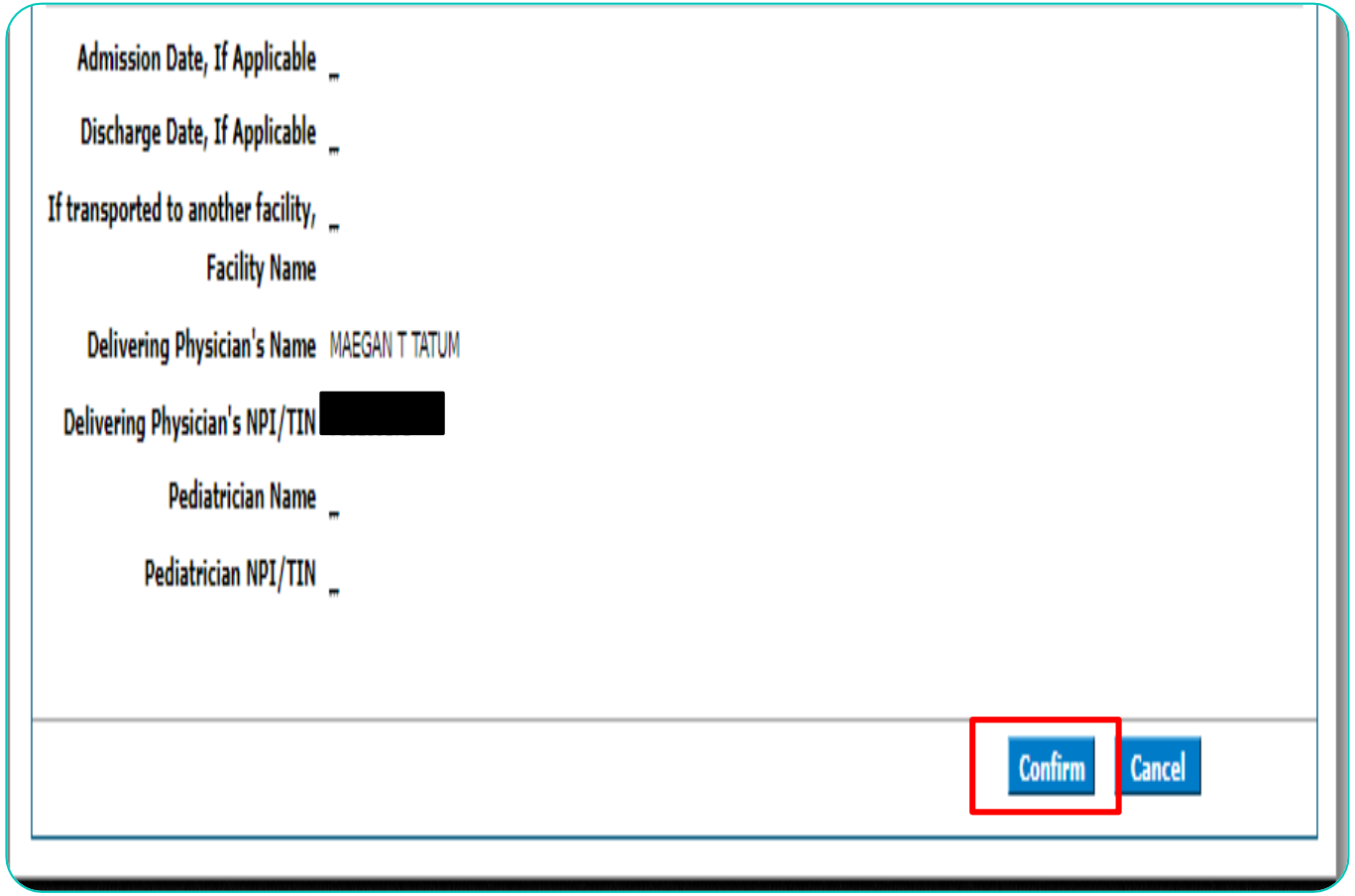
*Mother's Date of Last Menstrual Period: 05/09/2022
*Delivery Type:
*Scheduled Delivery?:

*Gestional Age (Weeks): 38
*(Days): 2
*Birth Weight (Lbs): 0.7
*(Grams): 0.15
*Apgar Score (1min): 2
*(5min): 5
*Birth Status: Healthy/Discharged home with mother

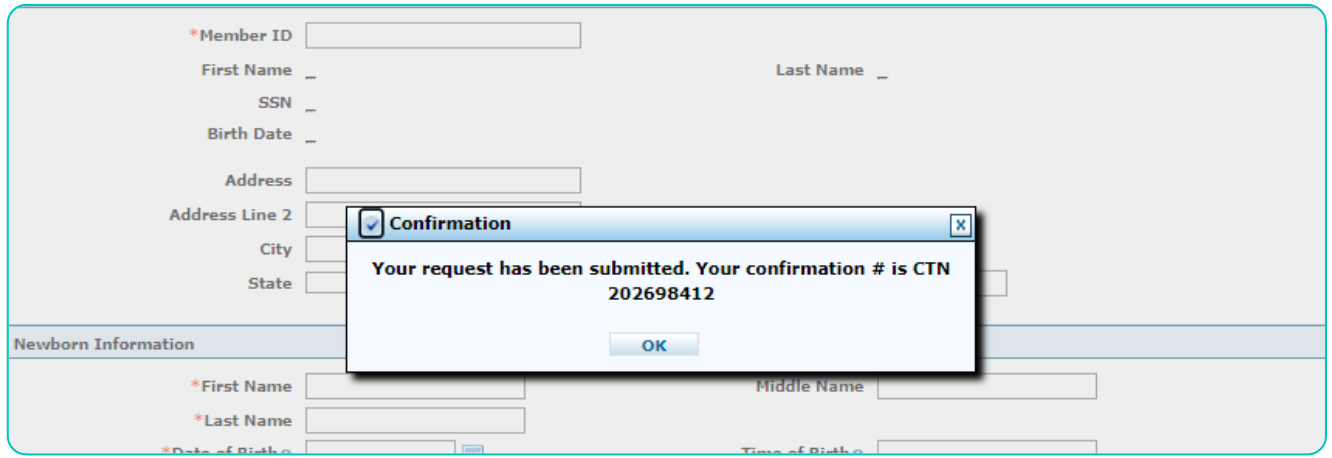
Admission Date, If Applicable:
Discharge Date, If Applicable:
If transported to another facility, Facility Name:
*Delivering Physician's Name:
*Delivering Physician's NPI/TIN:
Pediatrician Name:
Pediatrician NPI/TIN:

Submit Cancel

Review the application before submitting it. If you see an error, click Cancel and start again. If everything is correct, click Confirm



- You will receive a CTN number for future reference.
- The CTN will be sent to DOM for review and processing.
- Once processed, communication will be sent to the provider.



Vision Services

- Vision service is an optional benefit under the state's Medicaid program and financial assistance is provided as follows:
  A. Eyeglasses for all Medicaid beneficiaries who have had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses are medically indicated within six (6) months of the surgery and is in accordance with rules established by Medicaid, **OR**
  B. One (1) pair of eyeglasses every five (5) years and in accordance with rules established by Medicaid. In either instance, the eyeglasses must be prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the beneficiary selects. C.
  C. Eye exams for all eligible beneficiaries are covered.

Vision Services Cont'd.

- Medicaid covers vision services under a statewide uniform fixed fee schedule for the professional services of the optometrist or ophthalmologist plus actual acquisition cost for eyeglass frames and lenses. The provider of eyeglasses must bill the actual acquisition cost (AAC) for the frames and lenses. Medicaid will cover the frames and lenses based on the lower of AAC or the maximum fee as determined by Medicaid. Effective as of July 1, 2021 all rates and/or fees for items and services will remain the same as those in effect for State Fiscal Year (SFY) 2021.
- Medicaid does not permit providers of optometric services to charge a beneficiary an additional amount for services or supplies, like frames, above the fee established. The provider cannot dispense a more expensive frame than is covered under the Medicaid program and collect the difference from the beneficiary
- A beneficiary may purchase non-covered services, like scratch resistant lens coating. Providers cannot bill Medicaid and hold the eyeglasses or contacts until Medicaid pays the provider. Providers may not bill Medicaid for replacement costs associated with provider error or poor workmanship.

Dental Services

- The Division of Medicaid is authorized to furnish:
  - A. Dental care that is an adjunct to treatment of an acute medical or surgical condition,
  - B. Services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone, AND
  - C. Emergency dental extractions and treatment related thereto. Medicaid defines a dental emergency as a condition that requires treatment and that causes pain and/or infection of the dental apparatus and/or contiguous structures.

Dental Covered/Non-covered Services

- Covered Services include:
  - Limited oral evaluation, problem-focused,
  - Radiographs
  - Gingivectomy and/or gingivoplasty for Dilantin therapy only,
  - Oral surgery
  - Extractions
  - Alveoloplasty

Dental Covered/Non-covered Services Cont'd.

- Non-Covered Services Include but not limited to, the following:
  - Comprehensive oral evaluation,
  - Preventative services
  - Amalgams, composites, and crowns,
  - Endodontics
  - Dentures
  - Orthodontia
- B. The Division of Medicaid does not cover for scheduling/rescheduling for any dental or oral surgical procedure in any treatment setting.
- Additional information regarding dental services can be found at: https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-204.pdf