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The Division of Medicaid covers medical supplies, equipment, and appliances prescribed by a physician and prior authorized as specified by the Division of Medicaid. Medical supplies, equipment, and appliances may be provided regardless of whether a beneficiary is receiving services from a home health agency.

For the initial ordering of certain medical equipment the prescribing physician or allowed non-physician practitioner must document that a face-to-face encounter occurred no more than six (6) months prior to the start of services. The face-to-face encounter must be related to the primary reason the beneficiary requires the medical equipment. An allowed non-physician practitioner that performs the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

Medical supplies, equipment, and appliances are covered if they:

1. Are relevant to the beneficiary's plan of care,
2. Are medically necessary,
3. Primarily serve a medical purpose,
4. Have therapeutic or diagnostic characteristics enabling a beneficiary to effectively carry out a physician's prescribed treatment for illness, injury, or disease, and
5. Are appropriate for use in the non-institutional setting where the beneficiary's normal life activities take place, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities (ICF/IID) unless the ICF/IID is not required to provide the home health service; or any setting in which payment is or could be made under Medicaid for inpatient service that include room and board.

The beneficiary's need for medical supplies, equipment and appliances must be reviewed by the beneficiary's physician annually.

Medical equipment and appliances must be provided through qualified DME providers. Medical supplies may be provided through a qualified home health agency or DME provider.

Certain diabetic equipment and supplies may be provided by Mississippi Medicaid enrolled pharmacies.

The Division of Medicaid covers all medically necessary services for Early, Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries without regard to service limitation and with prior authorization.

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VIII. Durable Medical Equipment

A The payment for the purchase of new Durable Medical Equipment (DME) is the lesser of the provider's usual and customary charge or a fee from the statewide uniform fee schedule effective as of October 1, 2022 and updated July 1 of each year thereafter and effective for services provided on or after those dates. The Mississippi statewide uniform fee schedule will be calculated using eighty percent (80%) of the Medicare rural rate, if available, or the non-rural rate if there is no rural rate, on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1 of each year·.

If there is no DMEPOS fee, the provider will be reimbursed a fee determined by the Division of Medicaid, as needed, based on 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.

B. 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:

1. Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%), or

2. If there is no MSRP, then the provider's invoice received from a wholesaler or manufacturer plus twenty percent (20%).

C. The payment for rental of DME is made from a Mississippi statewide uniform fee schedule based on ten percent (10%) of eighty percent (80%) of the Medicare DMEPOS in effect January 1 of that year or Mississippi Medicaid established fee as described in letter A or B not to exceed ten (10) months. After rental benefits are paid for ten (10) months, the DME becomes the property of the Mississippi Medicaid beneficiary unless otherwise authorized by the Division of Medicaid through specific coverage criteria.

D. The payment for purchase of used DME is made from a Mississippi statewide uniform fee schedule based on fifty percent (50%) of eighty percent (80%) of the Medicare DMEPOS in effect January 1 of that year or Mississippi Medicaid established fee as described in letter A or B.

E. The payment for repair of DME is the cost of the repair, not to exceed fifty percent (50%) of eighty percent (80%) of the Medicare DMEPOS in effect January 1 of that year or Mississippi Medicaid established fee as described in letter A or B.

F. Any durable medical equipment not listed on the fee schedule may be requested for coverage by submitting documentation to the Division of Medicaid's UM/QIO who will determine medical necessity on a case-by-case basis.

G. Certain diabetic equipment will be reimbursed according to Attachment 4.19-B, Pages 12a. through 12a.1.1 when provided by a Mississippi Medicaid enrolled Pharmacy.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

DME for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) beneficiaries, if medically necessary, which exceed the limitations and scope for Medicaid beneficiaries, as covered in this Plan, are reimbursed according to the methodology in the above paragraphs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of DME. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

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