

State of Mississippi

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## VIII. Durable Medical Equipment

A. The payment for purchase of new Durable Medical Equipment (DME) is made from a statewide uniform fee schedule which is updated July 1 of each year and is effective for services provided on or after that date based on one of the following:

The lesser of the provider's usual and customary charge; or

1. Eighty percent (80%) of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1 of each year; or
2. A fee will be calculated using market research from the area when it is determined, based on documentation, that the DMEPOS fees are insufficient for the Mississippi Medicaid population or could result in a potential access issue; or
3. If no DMEPOS fee is available and a fee cannot be calculated the item will be manually priced.
  - a. Manually priced items are priced at the Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%).
  - b. Items that do not have a fee or MSRP may be priced at the provider's cost plus twenty percent (20%).

B. The payment for rental of DME is made from a statewide uniform fee schedule based on ten percent (10%) of the purchase allowance for new DME 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.

C. The payment for purchase of used DME is made from a statewide uniform fee schedule not to exceed fifty percent (50%) of the new DME purchase allowance.

D. The payment for repair of DME cannot to exceed fifty percent (50%) of the cost of the new DME purchase allowance.

E. The payment for other individual consideration items must receive prior authorization of the Utilization Management/Quality Improvement Organization (UM/QIO) and/or the Division of Medicaid and shall be limited to the amount authorized.

All terms of the Division's Durable Medical Equipment Reimbursement and Coverage Criteria are applicable.

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.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The federal match will be paid based on the reduced amount.

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## State of Mississippi

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### Medical Supplies

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A. The payment for purchase of Medical Supplies is made from a statewide uniform fee schedule which is updated July 1 of each year and is effective for services provided on or after that date based on one of the following:

The lesser of the provider's usual and customary charge; or

1. Eighty percent (80%) of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1 of each year; or
2. A fee will be calculated using market research from the area when it is determined, based on documentation, that the DMEPOS fees are insufficient for the Mississippi Medicaid population or could result in a potential access issue; or
3. If no DMEPOS fee is available and a fee cannot be calculated the item will be manually priced.
  - a. Manually priced items are priced at the Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%).
  - b. Items that do not have a fee or MSRP may be priced at the provider's cost plus twenty percent (20%).

B. The payment for other individual consideration items must receive prior authorization of the Utilization Management/Quality Improvement Organization (UM/QIO) and/or the Division of Medicaid and shall be limited to the amount authorized.

All terms of the Division's Medical Supplies Reimbursement and Coverage Criteria are applicable.

Medical Supplies for 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.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The federal match will be paid based on the reduced amount.