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**PERMANENT ADMINISTRATIVE RULES**

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
Sandy Cafourek	dmap.rules@state.or.us
Rules Coordinator	Email Address
500 Summer St. NE, Salem, OR 97301	503-945-6430
Address	Telephone
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**RULE CAPTION**

Rebasing Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Reimbursement Levels  
Not more than 15 words

**RULEMAKING ACTION**

**ADOPT:**

AMEND: 410-122-0186

REPEAL: 410-122-0186 (T)

**RENUMBER:**

**AMEND & RENUMBER:**

Stat. Auth.: ORS 413.042 & 414.065

**Other Auth.:**

Stats. Implemented: ORS 414.065

**RULE SUMMARY**

The Division has temporarily amended OAR 410-122-0186 to allow a change in payment methodology based on a percentage of a more current version of Medicare fee schedule (2012). Payments were calculated as a percentage of 2010 Medicare

fee schedule and vary depending on category of service. The new percentages keep rates essentially the same to maintain budget neutrality.

*Rhonda Buser*

Rhonda Buser

7-9-14

Authorized Signer

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## 410-122-0186

### Payment Methodology

(1) The Division of Medical Assistance Programs (Division) utilizes a payment methodology for covered durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that is generally based on the 2012 Medicare fee schedule.

(a) The Division fee schedule amount is 82.6 percent of the 2012 Medicare Fee Schedule for items covered by Medicare and the Division except for:

(A) Ostomy supplies fee schedule amounts are 93.3 percent of the 2012 Medicare Fee Schedule (See Table 122-0186-1 for list of codes subject to this pricing); and

(B) Prosthetic and Orthotic fee schedule amounts (L-codes) are 82.6 percent of the 2012 Medicare Fee Schedule; and

(C) Complex rehabilitation items and services, other than power wheelchairs, fee schedule amounts are 88 percent of the 2012 Medicare Fee Schedule (See Table 122-0186-2 for a list of codes subject to this pricing); and

(D) Group 1 power wheelchairs (K0813-K0816) and Group 2 power wheelchairs with no added power option (K0820-K0829) fee schedule amounts are 55 percent of the 2012 Medicare Fee Schedule; and

(E) Group 3 power wheelchairs (K0835-K0864) fee schedule amounts are 58.7 percent of the 2012 Medicare Fee Schedule;

(b) For items that are not covered by Medicare but covered by the Division, the fee schedule amount shall be 99 percent of DMAP's published rate effective July 31, 2011.

(c) For new codes added by the Center for Medicare and Medicaid Services (CMS), payment shall be based on the most current Medicare fee schedule and shall follow the same payment methodology as stated in (1)(a)(A-E). New codes that do not appear on the current Medicare fee schedule shall be manually priced as indicated in (4)(a-c) of this rule.

(2) Payment is calculated using the lesser of the following:

(a) The Division fee schedule amount using the above methodology in (1)(a) and (b); or

(b) The manufacturer's suggested retail price (MSRP); or

(c) The actual charge submitted.

(3) The Division reimburses for the lowest level of service that meets medical appropriateness. See OAR 410-120-1280 Billing and 410-120-1340 Payment.

(4) The Division shall reimburse miscellaneous codes E1399 (durable medical equipment, miscellaneous) and K0108 (wheelchair component or accessory, not otherwise specified), and any code that requires manual pricing using the lesser of the following:

(a) Seventy-five percent (75) of Manufacturer's Suggested Retail Price (MSRP) verifiable with quote, invoice, or bill from the manufacturer that clearly states the amount indicated is MSRP; or

(b) If MSRP is not available then reimbursement shall be acquisition cost plus 20 percent, verifiable with quote, invoice, or bill from the manufacturer that clearly states the amount indicated is acquisition cost; or

(c) Actual charge submitted by the provider.

(5) Reimbursement on miscellaneous codes E1399 and K0108 shall be capped at \$3,200.

(6) Prior authorization (PA) is required for miscellaneous codes E1399, K0108, and A4649 (surgical supply; miscellaneous) when the cost is greater than \$150, and the DMEPOS provider shall submit the following documentation:

(a) A copy of the items from (4)(a) and (b) that will be used to bill; and,

(b) Name of the manufacturer, description of the item, including product name and model name and number, serial number when applicable, and technical specifications;

(c) A picture of the item upon request by the Division.

(7) The DMEPOS provider shall submit verification for items billed with miscellaneous codes A4649, E1399, and K0108 when no specific Healthcare Common Procedure Coding System (HCPCS) code is available. Providers are allowed to submit verification from an organization such as the Medicare Pricing, Data Analysis and Coding (PDAC) contractor.

(8) The Division may review items that exceed the maximum allowable or cap on a case-by-case basis and may request the provider submit the following documentation for reimbursement:

(a) Documentation which supports that the client meets all of the coverage criteria for the less costly alternative; and,

(b) A comprehensive evaluation by a licensed clinician (who is not an employee of or otherwise paid by a provider) that clearly explains why the less costly alternative is not sufficient to meet the client's medical needs, and;

(c) The expected hours of usage per day, and;

(d) The expected outcome or change in the client's condition.

(9) For codes A4649, E1399, and K0108 when the cost is \$150 or less per each unit:

(a) Only items that have received an official product review coding decision from an organization such as PDAC with codes A4649, E1399, or K0108 shall be billed to the Division. These products may be listed in the PDAC Durable Medical Equipment Coding System Guide (DMECS) DMEPOS Product Classification Lists;

(b) Subject to service limitations of the Division's rules;

(c) PA is not required;

(d) The amount billed to the Division shall not exceed 75 percent of Manufacturer's Suggested Retail Price (MSRP). The provider is required to retain documentation of the quote, invoice, or bill to allow the Division to verify through audit procedures.

(10) For rented equipment, the equipment is considered paid for and owned by the client when the Division fee schedule allowable is met or the actual charge from the provider is met, whichever is lowest. The provider shall transfer title of the equipment to the client.

(11) Table 122-1086-1: Ostomy Codes, Table 122-0186-2: Complex Rehabilitation Codes

Statutory Authority: ORS 413.042 and 414.065

Statutes Implemented: 414.065

**Table 122-0186-1: Ostomy Codes**

Medicare covered codes	
A4361	A4397
A4372	A5051
A4378	A5062
A4383	A5081
A4390	A4369
A4395	A4376
A4402	A4381
A5054	A4388
A5072	A4393
A4362	A4398
A4373	A5052
A4379	A5063
A4384	A5093
A4391	A4371
A4396	A4377
A4404	A4382
A5055	A4389
A5073	A4394
A4367	A4399
A4375	A4435
A4380	A4456
A4385	A5053
A4392	A5071

Non-Medicare codes	
A4455	A5121
A4405	A4366
A4410	A4408
A4415	A4413
A4420	A4418
A4425	A4423
A4430	A4428
A5061	A4433
A4363	A5122
A4406	A4387
A4411	A4409
A4416	A4414
A4421	A4419
A4426	A4424
A4431	A4429
A5120	A4434
A4364	A5126
A4407	
A4412	
A4417	
A4422	
A4427	
A4432	

**Table 122-0186-2: Complex Rehabilitation**

E0950	E2206	E2371	K0037
E0951	E2209	E2373	K0038
E0952	E2210	E2374	K0039
E0955	E2211	E2375	K0040
E0956	E2212	E2376	K0041
E0957	E2213	E2377	K0043
E0958	E2214	E2381	K0044
E0960	E2215	E2382	K0045
E0966	E2219	E2383	K0046
E0967	E2221	E2384	K0047
E0973	E2222	E2385	K0050
E0974	E2224	E2386	K0051
E0978	E2225	E2387	K0052
E0981	E2226	E2388	K0053
E0982	E2231	E2389	K0056
E0992	E2310	E2390	K0065
E0995	E2311	E2391	K0069
E1002	E2312	E2392	K0070
E1003	E2313	E2394	K0071
E1004	E2321	E2395	K0072
E1005	E2322	E2396	K0073
E1006	E2323	E2601	K0077
E1007	E2324	E2602	K0098
E1008	E2325	E2603	K0733
E1010	E2326	E2604	K0739
E1014	E2327	E2605	
E1015	E2328	E2606	
E1016	E2329	E2607	
E1020	E2330	E2608	
E1028	E2340	E2611	
E1029	E2341	E2612	
E1030	E2342	E2613	
E1161	E2343	E2614	
E1232	E2351	E2615	
E1233	E2360	E2616	
E1234	E2361	E2619	
E1235	E2362	E2620	
E1236	E2363	E2621	
E1237	E2364	K0005	
E1238	E2365	K0007	
E2201	E2366	K0015	
E2202	E2368	K0017	
E2203	E2369	K0018	