Secretary of State
Certificate and Order for Filing

PERMANENT ADMINISTRATIVE RULES

I certify that the attached copies* are true, full and correct copies of the PERMANENT Rule(s) adopted on [upon filing] by the
Date prior to or same as filing date

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

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to become effective [12/27/12]. Rulemaking Notice was published in the [12/1/12] Oregon Bulletin.**
Date upon filing or later Month and Year

RULE CAPTION

Amendment of DMEPOS rules due to legislative buyback and additional budget reductions

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

List each rule number separately (000-000-0000)

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND: OAR 410-122-0186 and OAR 410-122-0325

REPEAL:

Stat. Auth.: ORS 414.065

Other Auth.:

Stats. Implemented: ORS 414.065

RULE SUMMARY

The Division needs to permanently amend OAR 410-122-0186 to implement new payment methodology that reflects additional reimbursement provided by the legislative buyback to the DMEPOS program and factoring in additional budget reductions for the remainder of the biennium. The Division needs to permanently amend OAR 410-122-0325 to implement new payment methodology as a cost saving to meet budget mandates

Authorized Signer	Printed name	Date

*****With this original, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules. ******The Oregon Bulletin is published the 1st of each month and updates rules found in the OAR Compilation. For publication in Bulletin, rule and notice filings must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, when filings are accepted until 5:00 pm on the preceding workday. ARC 930-2005

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) which is generally based on the 2010 Medicare fee schedule.

(a) The Division fee schedule amount is 84.5% of 2010 Medicare Fee Schedule for items covered by Medicare and the Division, except for:

(A) Ostomy supplies fee schedule amounts are 95.4% of 2010 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 84.5% of 2010 Medicare Fee Schedule; and

(C) Complex Rehabilitation/Wheelchair fee schedule amounts are 90% of 2010 Medicare Fee Schedule (See Table 122-0186-2 for list of codes subject to this pricing);

(b) For items that are not covered by Medicare, but covered by the Division, the fee schedule amount shall be 99% of DMAP's published rate effective 7/31/11.

(c) For new codes added by the Center for Medicare and Medicaid Services (CMS), payment will be based on the most current Medicare fee schedule and will follow the same payment methodology as stated in (1)(a) and (b).

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

(a) The Division fee schedule amount, using the above methodology in (1) (a) & (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) 75% of Manufacturer's Suggested Retail Price (MSRP) verifiable with quote, invoice or bill from the manufacturer which clearly states the amount indicated is MSRP; or

(b) If MSRP is not available then reimbursement shall be acquisition cost plus 20%, verifiable with quote, invoice, or bill from the manufacturer which 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 $3,200.00.

(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 must submit the following documentation:

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

(b) Name of the manufacturer, description of the item, including product name/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 must 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 that supports 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 $150.00 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 may 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 must not exceed 75% 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 must transfer title of the equipment to the client.

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

Statutory Authority: ORS 413.042 and 414.065
Statutes Implemented: 414.065

7/1/12

Table 122-0186-1: Ostomy Codes

Medicare codes		Non-Medicare codes (These are not subject to reduction)	
	A4392		A4417
	A4397		A4422
A4361	A5051		A4427
A4372	A5062		A4432
A4378	A5081		A5121
A4383	A4369	A4455	A4366
A4390	A4376	A4405	A4408
A4395	A4381	A4410	A4413
A4402	A4388	A4415	A4418
A5054	A4393	A4420	A4423
A5072	A4398	A4425	A4428
A4362	A5052	A4430	A4433
A4373	A5063	A5061	A5122
A4379	A5093	A4363	A4387
A4384	A4371	A4406	A4409
A4391	A4377	A4411	A4414
A4396	A4382	A4416	A4419
A4404	A4389	A4421	A4424
A5055	A4394	A4426	A4429
A5073	A4399	A4431	A4434
A4367	A5053	A5120	A5126
A4375	A5071	A4364	
A4380	A4456	A4407	
A4385		A4412	

Table 122-0186-2: Complex Rehabilitation/Wheelchair Codes

E0950	E2201	E2362	E2614
E0951	E2202	E2363	E2615
E0952	E2203	E2364	E2616
E0955	E2204	E2365	E2619
E0956	E2206	E2366	E2620
E0957	E2209	E2368	E2621
E0958	E2210	E2369	K0005
E0960	E2211	E2370	K0007
E0966	E2212	E2371	K0015
E0967	E2213	E2373	K0017
E0973	E2214	E2374	K0018
E0974	E2215	E2375	K0020
E0978	E2219	E2376	K0037
E0981	E2221	E2377	K0038
E0982	E2222	E2381	K0039
E0992	E2224	E2382	K0040
E0995	E2225	E2383	K0041
E1002	E2226	E2384	K0043
E1003	E2231	E2385	K0044
E1004	E2310	E2386	K0045
E1005	E2311	E2387	K0046
E1006	E2312	E2388	K0047
E1007	E2313	E2389	K0050
E1008	E2321	E2390	K0051
E1010	E2322	E2391	K0052
E1014	E2323	E2392	K0053
E1015	E2324	E2394	K0056
E1016	E2325	E2395	K0065
E1020	E2326	E2396	K0069
E1028	E2327	E2601	K0070
E1029	E2328	E2602	K0071
E1030	E2329	E2603	K0072
E1161	E2330	E2604	K0073
E1232	E2340	E2605	K0077
E1233	E2341	E2606	K0098
E1234	E2342	E2607	K0733
E1235	E2343	E2608	K0739
E1236	E2351	E2611	K0848
E1237	E2360	E2612	K0849
E1238	E2361	E2613	K0850

K0851
K0852
K0853
K0854
K0855
K0856
K0857
K0858
K0859
K0860
K0861
K0862
K0863
K0864

410-122-0325 Motorized/Power Wheelchair Base

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division of Medical Assistance Programs (Division) may cover a power wheelchair (PWC) (K0813-K0816, K0820-K0829, K0835-K0843, K0848-K0864, K0898) when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs); places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010, Definitions, for complete definition of MRADLs;

(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation;

(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day:

(i) Assessment of upper extremity function should consider limitations of strength, endurance, range of motion or coordination, presence of pain, and deformity or absence of one or both upper extremities;

(ii) An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories;

(D) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the PWC that is being requested;

(E) Use of a PWC will significantly improve the client's ability to move within the home to the areas customarily used for their MRADLs to allow completion of these activities within a reasonable time frame;

(F) The client is willing to use the requested PWC in the home, and the client will use it on a regular basis in the home;

(G) The client has either:

(i) Strength, postural stability, or other physical or mental capabilities insufficient to safely operate a power-operated vehicle (POV) in the home; or

(ii) Living quarters that do not provide adequate access between rooms, maneuvering space, and surfaces for the operation of a POV with a small turning radius;

(H) The client has either:

(i) Sufficient mental and physical capabilities to safely operate the PWC that is being requested; or

(ii) A caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the PWC that is being requested;

(I) The client’s weight is less than or equal to the weight capacity of the PWC that is being requested;

(b) Only when conditions of coverage as specified in (1) (a) of this rule are met, may the Division authorize a PWC for any of the following situations:

(A) When the PWC can be reasonably expected to improve the client’s ability to complete MRADLs by compensating for other limitations in addition to mobility deficits, and the client is compliant with treatment:

(i) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a PWC will be reasonably expected to significantly improve the client’s ability to perform or obtain assistance to participate in MRADLs in the home, a PWC may be considered for coverage;

(ii) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of PWC coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a PWC;

(B) When a client’s current wheelchair is no longer medically appropriate, or repair and/or modifications to the wheelchair exceed replacement costs;

(C) When a covered client-owned wheelchair is in need of repair, the Division may pay for one month's rental of a wheelchair (see OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing);

(c) For a PWC to be covered, the treating physician or nurse practitioner must conduct a face-to-face examination of the client before writing the order and the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the face-to-face examination and prior to delivery of the device:

(A) When this examination is performed during a hospital or nursing facility stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(B) The physician or nurse practitioner may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination;

(i) If the client was referred to the PT/OT before being seen by the physician or nurse practitioner, then once the physician or nurse practitioner has received and reviewed the written report of this examination, the physician or nurse practitioner must see the client and perform any additional examination that is needed. The physician's or nurse practitioner's report of the visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician or nurse practitioner must provide the DMEPOS provider with a copy of both examinations within 45 days of the face-to-face examination with the physician or nurse practitioner;

(ii) If the physician or nurse practitioner examined the client before referring the client to a PT/OT, then again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician or nurse practitioner visit. However, it is also acceptable for the physician or nurse practitioner to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician or nurse practitioner must send a copy of the note from his/her initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider. The 45-day period begins when the physician or nurse practitioner signs and dates the PT/OT examination;

(iii) If the PWC is a replacement of a similar item that was previously covered by the Division or when only PWC accessories are being ordered and all other coverage criteria in this rule are met, a face-to-face examination is not required;

(d) The Division does not reimburse for another chair if a client has a medically appropriate wheelchair, regardless of payer;

(e) The client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. The Division does not reimburse for adapting the living quarters;

(f) The equipment must be supplied by a DMEPOS provider that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the client;

(g) The provider's ATP must be employed by a provider in a full-time, part-time or contracted capacity as is acceptable by state law. The provider's ATP, if part-time or contracted, must be under the direct control of the provider;

(h) Documentation must be complete and detailed enough so a third party would be able to understand the nature of the provider's ATP involvement, if any, in the licensed/certified medical professional (LCMP) specialty evaluation;

(i) The provider's ATP may not conduct the provider evaluation at the time of delivery of the power mobility device to the client's residence;

(j) Reimbursement for wheelchair codes include all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education and on-going assistance with use of the wheelchair;

(k) The delivery of the PWC must be within 120 days following completion of the face-to-face examination;

(l) A PWC may not be ordered by a podiatrist;

(m) The following services are not covered:

(i) A PWC for use only outside the home;

(ii) A PWC with a captain's chair for a client who needs a separate wheelchair seat and/or back cushion;

(iii) Items or upgrades that primarily allow performance of leisure or recreational activities including but not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, wheelchair gloves, head lights, and tail lights;

(iv) Power mobility devices, not coded by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) or does not meet criteria (K0899);

(v) Power wheelchairs, group 4 (K0868-K0871, K0877-K0880, K0884-K0886);

(vi) Power wheelchairs, not otherwise classified (K0898);

(vii) Seat elevator PWCs (E2300, K0830, K0831).

(2) Coding Guidelines:

(a) Specific types of PWCs:

(A) A Group 1 PWC (K0813-K0816) or a Group 2 Heavy Duty (HD), Very Heavy Duty (VHD), or Extra Heavy Duty (EHD) wheelchair (K0824-K0829) may be covered when the coverage criteria for a PWC are met;

(B) A Group 2 Standard PWC with a sling/solid seat (K0820, K0822) may be covered when:

(i) The coverage criteria for a PWC are met; and

(ii) The client is using a skin protection and/or positioning seat and/or back cushion that meets the coverage criteria defined in Wheelchair Options/Accessories, 410-122-0340;

(C) A Group 2 Single Power Option PWC (K0835 – K0840) may be covered when the coverage criteria for a PWC are met; and

(i) The client either:

(I) Requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); or

(II) Meets the coverage criteria for a power tilt or recline seating system (see Wheelchair Options/Accessories, 410-122-0340) and the system is being used on the wheelchair; and

(ii) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, nurse practitioner or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical appropriateness for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, nurse practitioner or physician may have no financial relationship with the DMEPOS provider;

(D) A Group 2 Multiple Power Option PWC (K0841-K0843) may be covered when the coverage criteria for a PWC are met; and

(i) The client either:

(I) Meets the coverage criteria for a power tilt or recline seating system with three or more actuators (see Wheelchair Options/Accessories, 410-122-0340); or

(II) Uses a ventilator which is mounted on the wheelchair; and

(ii) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT, OT, nurse practitioner or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical appropriateness for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, nurse practitioner or physician may have no financial relationship with the DMEPOS provider;

(E) A Group 3 PWC with no power options (K0848-K0855) may be covered when:

(i) The coverage criteria for a PWC are met; and

(ii) The client’s mobility limitation is due to a neurological condition, myopathy or congenital skeletal deformity; and

(iii) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, physician or nurse practitioner may have no financial relationship with the DMEPOS provider;

(F) A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) may be covered when:

(i) The Group 3 criteria (2)(a)(E) (i-ii) are met; and

(ii) The Group 2 Single Power Option (2)(a)(C)(i)(I) or (II) and (2)(a)(C)(ii) or Multiple Power Options (2)(a)(D)(i)(I) or (II) and (2)(a)(D)(ii) (respectively) are met;

(b) PWC Basic Equipment Package: Each PWC code is required to include the following items on initial issue (i.e., no separate billing/payment at the time of initial issue, unless otherwise noted):

(A) Lap belt or safety belt (E0978);

(B) Battery charger single mode (E2366);

(C) Complete set of tires and casters any type (K0090, K0091, K0092, K0093, K0094, K0095, K0096, K0097, K0099);

(D) Legrests. There is no separate billing/payment if fixed or swingaway detachable non-elevating legrests with/without calf pad (K0051, K0052, E0995) are provided. Elevating legrests may be billed separately;

(E) Fixed/swingaway detachable footrests with/without angle adjustment footplate/platform (K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0052);

(F) K0040 may be billed separately with K0848 through K0864;(G) Armrests. There is no separate billing/ payment if fixed/swingaway detachable non-adjustable armrests with arm pad (K0015, K0019, K0020) are provided. Adjustable height armrests may be billed separately;

(H) Upholstery for seat and back of proper strength and type for patient weight capacity of the power wheelchair (E0981, E0982);

(I) Weight specific components per patient weight capacity;

(J) Controller and Input Device: There is no separate billing/payment if a non-expandable controller and proportional input device (integrated or remote) is provided. If a code specifies an expandable controller as on option (but not a requirement) at the time of initial issue, it may be separately billed;

(c) If a client needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it may be appropriate to

request a captain's chair seat rather than a sling/solid seat/back and a separate general use seat and/or back cushion;

(d) A PWC with a seat width or depth of 14" or less is considered a pediatric PWC base and is coded E1239, PWC, pediatric size, not otherwise specified (see OAR 410-122-0720 Pediatric Wheelchairs);

(e) Contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor regarding correct coding. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation Requirements: Submit all of the following documentation with the prior authorization (PA) request:

(a) A copy of the written report of the face-to-face examination of the client by the physician or nurse practitioner:

(A) This report must include information related to the following:

(i) This client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(iii) Why a manual wheelchair can't meet this client's mobility needs in the home;

(iv) Why a POV can't meet this client's mobility needs in the home;

(v) This client's physical and mental abilities to operate a PWC safely in the home:

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in activities of daily living (ADLs), how these conditions will be ameliorated or compensated by use of the wheelchair;

(II) How these other conditions will be ameliorated or compensated sufficiently such that the additional provision of mobility assistive equipment (MAE) will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home;

(B) The face-to-face examination should provide pertinent information about the following elements, but may include other details. Only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or PWC and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment – any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and power mobility device;

(II) Walking around their home – to bathroom, kitchen, living room, etc. – provide information on distance walked, speed, and balance;

(C) Although a client who qualifies for coverage of a PWC may use that device outside the home, because the Division coverage of a wheelchair is determined solely by the client's mobility needs within the home, the examination must clearly distinguish the client's abilities and needs within the home from any additional needs for use outside the home;

(b) The physician's or nurse practitioner's written order, received by the DMEPOS provider within 45 days (date stamp or equivalent must be used to document receipt date) after the physician's or nurse practitioner's face-to-face examination. The order must include all of the following elements:

(A) Client's name;

(B) Description of the item that is ordered. This may be general – e.g., “power wheelchair” or “power mobility device”– or may be more specific:

(i) If this order does not identify the specific type of PWC that is being requested, the DMEPOS provider must clarify this by obtaining another written order which lists the specific PWC that is being ordered and any options and accessories requested;

(ii) The items on this clarifying order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating physician or nurse practitioner, received by the DMEPOS provider and submitted to the authorizing authority, but does not have to be received within 45 days following the face-to-face examination;

(C) Date of the face-to-face examination;

(D) Pertinent diagnoses/conditions and diagnosis codes that relate specifically to the need for the PWC;

(E) Length of need;

(F) Physician’s or nurse practitioner’s signature;

(G) Date of physician’s or nurse practitioner’s signature;

(c) For all requested equipment and accessories, the manufacturer’s name, product name, model number, standard features, specifications, dimensions and options;

(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client’s medical needs, including how long it has been used by the client and why it can’t be grown or modified, if applicable;

(e) For the home assessment, prior to or at the time of delivery of a PWC, the DMEPOS provider or practitioner must perform an on-site, written evaluation of the client’s living quarters. This assessment must support that the client’s home can accommodate and allow for the effective use of a PWC. Assessment must include, but is not limited to, evaluation of physical layout, doorway widths, doorway thresholds, surfaces, counter/table height, accessibility (e.g., ramps), electrical service, etc; and

(f) A written document (termed a detailed product description) prepared by the DMEPOS provider and signed and dated by the physician or nurse practitioner that includes:

(i) The specific base (HCPCS code and manufacturer name/model) and all options and accessories (including HCPCS codes), whether PA is required or not, that will be separately billed;

(ii) The DMEPOS provider's charge and the Division fee schedule allowance for each separately billed item;

(iii) If there is no Division fee schedule allowance, the DMEPOS provider must enter "not applicable";

(iv)The DMEPOS provider must receive the signed and dated detailed product description from the physician or nurse practitioner prior to delivery of the PWC;

(v) A date stamp or equivalent must be used to document receipt date of the detailed product description; and

(g) Any additional documentation that supports indications of coverage are met as specified in this rule;

(h) The DMEPOS provider must keep the above documentation on file;

(i) Documentation that the coverage criteria have been met must be present in the client's medical records and made available to the Division on request.

(4) Prior Authorization:

(a) All codes in this rule required PA and may be purchased, rented and repaired;

(b) Codes specified in this rule are not covered for clients residing in nursing facilities;

(c) Reimbursement on standard Group 1 and 2 wheelchairs without power option (K0813-K0816, K0820-K0829) will only be made on a monthly rental basis.

(d) Rented equipment is considered purchased when the Division fee schedule allowable for purchase is met, or the actual charge from the provider is met, whichever is the lowest;

(5) Table 122-0325

Statutory Authority: ORS 413.042 and 414.065

Statutes Implemented: 414.065

7/1/12

Table 122-0325

Code	Description	PA	PC	RT	MR	RP	NF
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0814	Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0816	Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0821	Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0823	Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	

Table 122-0325

Code	Description	PA	PC	RT	MR	RP	NF
K0824	Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA		RT	13	RP	
K0825	Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds	PA		RT	13	RP	
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA		RT	13	RP	
K0827	Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds	PA		RT	13	RP	
K0828	Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	PA		RT	13	RP	
K0829	Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more	PA		RT	13	RP	
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0836	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	

Table 122-0325

Code	Description	PA	PC	RT	MR	RP	NF
K0837	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0838	Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0839	Power wheelchair, group 2 very heavy duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0840	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more	PA	PC	RT	13	RP	
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0842	Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0843	Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	

Table 122-0325

Code	Description	PA	PC	RT	MR	RP	NF
K0849	Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0850	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0851	Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0852	Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0853	Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0854	Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	PA	PC	RT	13	RP	
K0855	Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more	PA	PC	RT	13	RP	
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	

Table 122-0325

Code	Description	PA	PC	RT	MR	RP	NF
K0857	Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0858	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds	PA	PC	RT	13	RP	
K0859	Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0860	Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0862	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0863	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0864	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more	PA	PC	RT	13	RP	