DHS Oregon Department of Human Services

Division of Medical Assistance Programs

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Rulebook

Includes:

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DEPARTMENT OF HUMAN SERVICES, DEPARTMENTAL ADMINISTRATION AND MEDICAL ASSISTANCE PROGRAMS

DIVISION 122

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

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DMEPOS Services Rulebook

Update Information
January 1, 2007

The Department of Human Services (DHS) changed the name of Office of Medical Assistance Programs (OMAP) to Division of Medical Assistance Programs (DMAP). DMAP amended all rules in this Rulebook to reflect this and other DHS division name changes, plus the following:

DMAP repealed:

410-122-0000: Purpose; DMAP repealed unnecessary rules;

410-122-0085: Information moved to OAR 410-122-0184;

410-122-0190: Information in this rule is found in other rules;

410-122-0530: Information moved to OAR 410-122-0184.

DMAP amended the following rules to clarify conditions of coverage as follows:

410-122-0020 Orders: Adds that signature and date stamps are only acceptable for use on certificates of medical necessity (CMNs) when allowed by Medicare;

410-122-0055 Standard Benefit Package Limitations: Adds code A4604 (tubing with integrated heating element for use with positive airway pressure device);

410-122-0080 Conditions of Coverage, Limitations, Restrictions and Exclusions: Removes reimbursement information (moved to 410-122-0186);

410-122-0182 Legend: Clarifies some abbreviations used in the tables;

410-122-0184 Repairs, Maintenance, Replacement and Delivery: Changes name to *Repairs, Maintenance, Replacement, Delivery and Dispensing*, adds dispensing (from 410-122-0085), proof of delivery (from 410-122-0530) and documentation requirements;

410-122-0186 Reimbursement and Prior Authorization Requirements for Codes E1399 and K0108: Changes name to *Payment Methodology* and specifies payment methodology for DMEPOS;

410-122-0202 CPAP: Adds code A4604 (tubing with integrated heating element for use with positive airway pressure device) and clarifies payment authorization requirements;

410-122-0203 Oxygen and Oxygen Equipment: Rule rewritten and reformatted to clarify conditions of coverage, and add prior authorization requirements. Currently DMAP makes continuous monthly payments for oxygen equipment as long as medically appropriate. In keeping with the Deficit Reduction Act (DRA), beginning with items newly rented on or after January 1, 2006, the rental period changes to not more than 36 months for oxygen equipment. Once the rental period ends, title to the equipment transfers to the client. DMAP will continue to pay for reasonable and necessary service and maintenance after the end of the rental period for covered equipment;

410-122-0207 Respiratory Supplies: Moves A4608 (transtracheal oxygen catheter), A4615 (cannula, nasal), A4616 (tubing, oxygen), A4617 (mouthpiece) and A4620 (variable concentration mask) to OAR 410-122-0203. Adds E0605 (vaporizer);

410-122-0209 Tracheostomy Care Supplies: Moves A7525 (tracheostomy mask) to 410-122-0203 Oxygen and Oxygen Equipment;

410-122-0240 Apnea Monitors for Infants: DHS Division name changes (housekeeping) only;

410-122-0320 Manual Wheelchair Base: Clarifies conditions of coverage;

410-122-0325 Motorized Power Wheelchair Base: Adds 63 new power wheelchair codes and clarifies conditions of coverage;

410-122-0340 Wheelchair Options/Accessories: Adds: "A shoulder harness/straps or chest strap (E0960) and a safety belt/pelvic strap (E0978) are covered only to treat a client's medical symptoms;
(I) A medical symptom is defined as an indication or characteristic of a physical or psychological condition;
(II) E0960 and E0978 are not covered when intended for use as a physical restraint or for purposes intended for discipline or convenience of others;"

410-122-0380 Hospital Beds: Adds: "Payment Authorization: Subject to service limitations of DMAP rules, from the initial date of service through the second date of service, a hospital bed rental may be dispensed without prior authorization. The provider is still responsible to ensure all rule requirements are met. Payment authorization is required prior to submitting claims and will be given once all required documentation has been received and any other applicable rule requirements have been met. Payment authorization is obtained from the same authorizing authority as specified in OAR 410-122-0040. All subsequent services starting with the third date of service require prior authorization;"

410-122-0400 Pressure Reducing Support Surfaces: Adds: "DMAP may consider coverage for bariatric pressure reducing support surfaces coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility only when the following requirements are met:
(A) The client meets the conditions of coverage as specified in this rule; and
(B) The bariatric pressure reducing support surface has been assigned code E1399 by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC);"

410-122-0420 Hospital Bed Accessories: Adds: "Bariatric trapeze bars coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility, subject to service limitations of DMAP rules, may be considered for coverage;"

410-122-0510 Osteogenesis Stimulator: Clarifies coverage criteria for an ultrasonic osteogenesis stimulator;

410-122-0580 Bath Supplies: Adds E0705 (transfer board or device);

410-122-0600 Toilet Supplies: Adds: "Bariatric commodes coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility, subject to service limitations of DMAP rules, may be considered for coverage;"

410-122-0620 Miscellaneous Supplies: Clarifies conditions of coverage for some miscellaneous items;

410-122-0660 Orthotics and Prosthetics: Removes L7520 (repair prosthetic device, labor component, per 15 minutes) from exclusions list;

410-122-0700 Negative Pressure Wound Therapy Pumps: Removes PA from A7000 (canister, disposable, used with suction pump) and clarifies conditions of coverage;

410-122-0720 Pediatric Wheelchairs: Rewrites rule to reflect the same coverage criteria in 410-122-0320 Manual Wheelchair Base (which became effective 7/1/06).

The Table of Contents is updated.

If you have questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697.

RB 680 1/1/07

Other Provider Resources

DMAP has developed the following additional materials to help you bill accurately and receive timely payment for your services.

Supplemental Information

The Durable Medical Equipment, Prosthetic and Orthotic Supplies (DME-POS) Supplemental Information booklet contains important information not found in the rulebook, including:

- ✓ Payment authorization instructions and contact information
- ✓ Billing instructions
- ✓ Third Party Resource codes
- ✓ Forms for billing and prior authorization
- ✓ Electronic claims information
- ✓ Other helpful information not found in the rulebook

Be sure to download a copy of the DME-POS Supplemental Information booklet at:

http://www.dhs.state.or.us/policy/healthplan/guides/dme/main.html

Note: DMAP revises the supplement booklet throughout the year, without notice. Check the Web page regularly for changes to this document.

Provider Contact Booklet

This booklet lists general information phone numbers, frequent contacts, phone numbers to use to request prior authorization, and mailing addresses.

Download the Provider Contact Booklet at:

http://www.oregon.gov/DHS/healthplan/data_pubs/add_ph_conts.pdf

Other Resources

We have posted other helpful information, including provider announcements, at:
http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml

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When you register for our FREE subscription service, you will be notified by email whenever the content changes on the Web pages that you designate. Just click on the eSubscribe link on individual OHP pages, or subscribe to multiple pages from the master list by choosing the eSubscribe link above. Esubscribe at:

http://www.oregon.gov/DHS/govdelivery.shtml

410-122-0010 Definitions

(1) Activities of daily living (ADL's) -- Activities related to personal care. Personal care services include activities such as bathing, dressing, grooming, hygiene, eating, elimination, etc. that are necessary to maintain or improve the client's health, when possible.

(2) Buy up -- "Buy-up" refers to a situation in which a client wants to upgrade to a higher level of service than he or she is eligible for; e.g., a heavy duty walker instead of a regular walker.

(3) Consecutive Months -- Any period of continuous use where no more than a 60-day break occurs.

(4) Durable Medical Equipment -- Equipment, furnished by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or a home health agency that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a client in the absence of an illness or injury and is appropriate for use in the home. Some examples include wheelchairs, crutches and hospital beds. Durable medical equipment extends to supplies and accessories that are necessary for the effective use of covered durable medical equipment.

(5) Home -- For purposes of purchase, rental and repair of durable medical equipment that is used primarily as a supportive measure to support a client's basic daily living activities, home is a place of permanent residence, such as an assisted living facility (includes the common dining area), a 24-hour residential care facility, an adult foster home, a child foster home or a private home. This does not include hospitals or nursing facilities or any other setting that exists primarily for the purpose of providing medical/nursing care.

(6) Lifetime need -- 99 months or more.

(7) Manufacturer Part Number (MPN):

(a) Each manufacturer provides an MPN to identify that manufacturer's part. It is a specification used by the manufacturer to store a part in an illustrated part catalog (graphics and text);

(b) An MPN uniquely identifies a part when used together with manufacturer code (external manufacturer), which is the own name used by the manufacturer and not the manufacturer name provided by other.

(8) Medical Records -- Include the physician's office records, hospital records, nursing facility records, home health agency records, records from other healthcare professionals, diagnostic and test reports. This documentation must be made available to the Division of Medical Assistance Programs (DMAP) on request.

(9) Medical Supplies – Generally nonreusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing. Some medical supplies may also be used on a repeated, limited duration basis.

(10) Mobility-related activities of daily living (MRADL's) -- Include toileting, eating, dressing, grooming and bathing.

(11) Morbidity -- A diseased state, often used in the context of a "morbidity rate" (i.e. The rate of disease or proportion of diseased people in a population). In common clinical usage, any disease state, including diagnosis and complications is referred to as morbidity.

(12) Morbidity Rate -- The rate of illness in a population. The number of people ill during a time period divided by the number of people in the total population.

(13) The DMAP Maximum Allowable Rate -- The maximum amount paid by DMAP for a service.

(14) Practitioner -- A person licensed pursuant to Federal and State law to engage in the provision of health care services within the scope of the practitioner's license and certification.

(15) Prosthetic and Orthotic Devices -- Devices that replace all or part of an internal body organ, including ostomy bags and supplies directly related to ostomy care, and replacement of such devices and supplies. Prosthetic and orthotic devices also include leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the client's physical condition.

(16) Purchase price -- Includes:

(a) Delivery;

(b) Assembly;

(c) Adjustments, if needed; and

(d) Training in the use of the equipment or supply.

(17) Rental fees -- Include:

(a) Delivery;

(b) Training in the use of the equipment;

(c) Pick-up;

(d) Routine service, maintenance and repair; and

(e) Moving equipment to new residence, if coverage is to continue.

(18) Technician -- A DMEPOS provider staff professionally trained through product or vendor-based training, technical school training (e.g., electronics) or through apprenticeship programs with on-the-job training.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-122-0020 Orders

(1)The purchase, rental or modifications of durable medical equipment, and the purchase of supplies must have an order prior to dispensing items to a client.

(2) For any durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), a provider must have a written order signed and dated by the treating practitioner prior to submitting a claim to the Division of Medical Assistance Programs (DMAP).

(3) A provider may dispense some items based on a verbal order from the treating practitioner, except those items requiring a written order prior to delivery (see below) or as specified in a particular rule:

(a) A provider must maintain documentation of the verbal order and this documentation must be available to DMAP upon request;

(b)The verbal order must include all the following elements:

(A) Client's name; and,

(B) Name of the practitioner; and,

(C) Description of the item; and,

(D) Start date of the order; and,

(E) Primary ICD-9 diagnosis code for the equipment/supplies requested.

(c) For items that are dispensed based on a verbal order, the provider must obtain a written order that meets the requirements outlined below for written orders.

(4) For an item requiring a written order prior to delivery, Medicare criteria must be met.

(5) The DMEPOS provider must have on file a written order, information from the treating practitioner concerning the client's diagnosis and medical condition, and any additional information required in a specific rule.

(6) DMAP accepts any of the following forms of orders and Certificates of Medical Necessity (CMN): a photocopy, facsimile image, electronically maintained or original "pen and ink" document.

(a) An electronically maintained document is one which has been created, modified, and stored via electronic means such as commercially available software packages and servers;

(b) It is the provider's responsibility to ensure the authenticity/validity of a facsimile image, electronically maintained or photocopied order;

(c) A provider must also ensure the security and integrity of all electronically maintained orders and/or certificates of medical necessity;

(d) The written order may serve as the order to dispense the item if the written order is obtained before the item is dispensed; (7) A written order must be legible and contain the following elements:

(a) Client's name; and,

(b) Detailed description of the item that can either be a narrative description (e.g., lightweight wheelchair base) or a brand name/model number including medically appropriate options or additional features; and,

(c) The detailed description of the item may be completed by someone other than the practitioner. However, the treating practitioner must review the detailed description and personally indicate agreement by his signature and the date that the order is signed;

(A) DMAP requires practitioners to sign for services they order;
(B) This signature may be handwritten, electronic, or stamped, and it must be in the client's medical record;
(C) The ordering practitioner is responsible for the authenticity of the signature;

(D) If a practitioner allows a signature stamp, the provider performing the service must retain a signed statement in their records that this practitioner is the only person who has and uses the stamp;

(d) Primary ICD-9 diagnosis code for the equipment/supplies requested;

(8) A provider is responsible to obtain as much documentation from the client's medical record as necessary for assurance that DMAP coverage criteria for an item(s) is met.

(9) Certain items require one or more of the following additional elements in the written order:

(a) For accessories or supplies that will be provided on a periodic basis:

(A) Quantity used;

(B) Specific frequency of change or use – "as needed" or "prn" orders are not acceptable;

(C) Number of units;

(D) Length of need: Example: An order for surgical dressings might specify one 4" x 4" hydrocolloid dressing which is changed one to two times per week for one month or until the ulcer heals;

(b) For orthoses: If a custom-fabricated orthosis is ordered by the physician, this must be clearly indicated on the written order;

(c) Length of need:

(A) If the coverage criteria in a rule specifies length of need; or,

(B) If the order is for a rental item;

(d) Any other medical documentation required by rule.

(10) For repairs: Labor for repairs, parts for DME repairs and replacement parts for DME (e.g., batteries) do not require a written order.

(11) A new order is required:

(a) When required by Medicare (for a Medicare covered service) (www.cignamedicare.com); or,

(b) When there is a change in the original order for an item; or,

(c) When an item is permanently replaced; or,

(d) When indicated by the treating practitioner;

(A) A new order is required when an item is being replaced because the item is worn or the client's condition has changed; and,

(B) The provider's records should also include client-specific information regarding the need for the replacement item; and,

(C)This information should be maintained in the provider's files and be available to DMAP on request; and,

(D) A new order is required before replacing lost, stolen or irreparably damaged items to reaffirm the medical appropriateness of the item;

(e) When there is a change of DMEPOS provider: In cases where two or more providers merge, the resultant provider should make all reasonable attempts to secure copies of all active CMN's and written orders from the provider(s) purchased. This document should be kept on file by the resultant provider for future presentation to DMAP, if requested;

(f) On a regular or specific basis (even if there is no change in the order) only if it is so specified in a particular rule.

(12) A provider is required to maintain and provide (when required by a particular rule) legible copies of facsimile image and electronic transmissions of orders.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065 1-1-07

410-122-0040 Prior Authorization Authority

(1) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers must obtain prior authorization (PA) for HCPCS Level II codes when indicated, unless otherwise noted in a specific rule.

(2) Providers must request PA as follows (see the DMEPOS Supplemental Information for contact information):

(a) For Medically Fragile Children's Unit (MFCU) clients, from the Department of Human Services (DHS) MFCU;

(b) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, from the MCM contractor;

(c) For clients enrolled in a prepaid health plan (PHP), from the PHP;

(d) For all other clients, from the Division of Medical Assistance Programs (DMAP).

(3) For clients with Medicare coverage, PA is only required for DMEPOS not covered by Medicare.

(4) For DMEPOS provided after normal working hours, providers must submit PA requests within five working days from the initiation of service.

(5) See OAR 410-120-1320 for more information about PA.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-122-0055 OHP Standard Benefit Package Limitations

(1) Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) coverage for the Oregon Health Plan (OHP) Standard benefit package is limited to the codes listed in Table 122-0055. Coverage requirements and limitations as specified in chapter 410, division 122 apply. For more information about the OHP Standard benefit package, see the Division of Medical Assistance Programs (DMAP) General Rules (Chapter 410, Division 120).

(2) OHP Standard benefit package coverage includes limited home enteral/parenteral nutrition and intravenous services. For more information, see Home Enteral/Parenteral Nutrition and Intravenous Services (Chapter 410, Division 148).

(3)Table 122-0055

Stat. Auth.: ORS 409

Stats.Implemented: ORS 414.065

1-1-07

Table 122-0055

Category	Codes
Diabetic Supplies	A4210, A4211, A4244, A4245, A4250, A4253, A4254, A4255, A4256, A4258, A4259, A4772, E0607, E2100, E2101, S8490
Respiratory:	A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0470, E0471, E0561, E0562, E0601, S8186
Oxygen	E1390, E1391, E1405, E1406, E0424, E0425, E0430, E0431, E0441, E0443, E0434, E0435, E0439, E0440, E0442, E0444, E0455, E0550, E0555, E0560
Ventilator	A4611, A4612, A4613, A4618, E0450, E0454, E0461, E0463, E0464, E0459, E0460, E0472
Suction Pump	A4605, A4624, A4628, A7000, A7001, A7002, E0600, E2000
Tracheostomy Supplies:	A4481, A4483, A4623, A4625, A4626, A4629, A7501, A7502, A7503, A7504, A7505, A7506, A7507, A7508, A7509, A7520, A7521, A7522, A7524, A7526, A7527, S8189
Urology Supplies:	A4310, A4311, A4312, A4313, A4314, A4315, A4316, A4320, A4322, A4326, A4327, A4328, A4331, A4332, A4333, A4334, A4338, A4340, A4344, A4346, A4348, A4349, A4351, A4352, A4353, A4354, A4355, A4356, A4357, A4358, A4359, A4927, A5102, A5105, A5112, A5113, A5114, A5131, A5200
Ostomy Supplies:	A4331, A4361, A4362, A4364, A4365, A4366, A4367, A4369, A4371, A4372, A4373, A4375, A4376, A4377, A4378, A4379, A4380, A4381, A4382, A4383, A4384, A4385, A4387, A4388, A4389, A4390, A4391, A4392, A4393, A4394, A4395, A4396, A4397, A4398, A4399, A4402, A4404, A4405, A4406, A4407, A4408, A4409, A4410, A4413, A4414, A4415, A4416, A4417, A4418, A4419, A4420, A4421, A4422, A4423, A4424, A4425, A4426, A4427, A4428, A4429, A4430, A4431, A4432, A4433, A4434, A4455, A5051, A5052, A5053, A5054, A5055, A5061, A5062, A5063, A5071, A5072, A5073, A5081, A5082, A5093, A5119, A5121, A5122, A5126, A5131 K0462 – Only for equipment codes in this table

410-122-0080 Conditions of Coverage, Limitations, Restrictions and Exclusions

(1) The Division of Medical Assistance Programs (DMAP) may cover durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) for payment when the item meets all the criteria in this rule, including all of the following conditions:

(a) Has been approved for marketing by the Food and Drug Administration (FDA) and is otherwise generally considered to be safe and effective for the purpose intended;

(b) Is reasonable and medically appropriate for the individual client;

(c) Is primarily and customarily used to serve a medical purpose;

(d) Is generally not useful to a person in the absence of illness or injury;

(e) Is appropriate for use in a client's home;

(f) Specifically, for durable medical equipment, can withstand repeated use; i.e., could normally be rented, and used by successive clients;

(g) Meets the coverage criteria as specified in this division and subject to service limitations of DMAP rules;

(h) Is requested in relation to a diagnosis and treatment pair that is above the funding line on the Prioritized List of Health Services, OAR 410-141-0520, consistent with treatment guidelines for the Prioritized List of Health Services, and not otherwise excluded under OAR 410-141-0500; and

(i) Is included in the OHP Client's benefit package of covered services.

(2) Conditions for Medicare-Medicaid Services

(a) When Medicare is the primary payer for a covered service and when DMAP DMEPOS coverage criteria differs from Medicare coverage criteria, DMAP DMEPOS coverage criteria are waived, except as provided in subsection (b) of this section, and only if the item is requested in relation to a diagnosis and treatment pair that is above the funding line on the

Prioritized List of Health Services, OAR 410-141-0520, consistent with treatment guidelines for the Prioritized List of Health Services, and not otherwise excluded under OAR 410-141-0500; and included in the OHP Client's benefit package of covered services;

(b) If Medicare is the primary payer and Medicare denies payment, Medicare appeals must be timely filed prior to submitting the claim for payment to DMAP. Medicare denial on the basis of failure to submit a timely appeal may result in DMAP reducing from the amount of the claim any amount DMAP determines could have been paid by Medicare;

(c) If Medicare denies coverage on appeal, DMAP will apply DMEPOS coverage criteria in this rule to determine whether the item or service is covered under the Oregon Health Plan.

(3) DMAP will not cover DMEPOS when the item or the use of the item meets any of the following charactertistics:

(a) Not primarily medical in nature;

(b) For personal comfort or convenience of client or caregiver;

(c) Inappropriate or unsuitable for home use;

(d) A self-help device;

(e) Not therapeutic or diagnostic in nature;

(f) Used for precautionary reasons (e.g., pressure-reducing support surface for prevention of decubitus ulcers);

(g) Inappropriate for client use in the home (e.g., institutional equipment like an oscillating bed);

(h) For a purpose where the medical effectiveness is not supported by evidence-based clinical practice guidelines; or

(i) Reimbursed as part of the all-inclusive rate in a nursing facility, or as part of a home and community based care waiver service, or by any other public, community or third party resource.

(4) Particular coverage criteria, limitations and restrictions for durable medical equipment, prosthetics, orthotics and supplies are specified in the appropriate rule. If prior authorization is required, the request must document that prior authorization was obtained in compliance with the rules in this division.

(5) DMEPOS providers must have documentation on file that supports coverage criteria are met.

(6) Billing records must demonstrate that the provider has not exceeded any limitations and restrictions in rule. DMAP may require additional claim information from the provider consistent with program integrity review processes.

(7) Documentation described in (4), (5) and (6) above must be made available to DMAP on request.

(8) To identify non-covered items at a code level, providers can refer to DMAP's fee schedule for further assistance.

(9) Some benefit packages do not cover equipment and supplies (see OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System).

(10) Buy-ups are prohibited. Advanced Beneficiary Notices (ABN) constitute a buy-up and are prohibited. Refer to the DMAP General Rules for specific language on buy-ups.

(11) Equipment purchased by DMAP is the property of the client.

(12) Rental charges, starting with the initial date of service, regardless of payer, apply to the purchase price.

(13) A provider who supplies rented equipment is to continue furnishing the same item throughout the entire rental period, except under documented reasonable circumstances.

(14) Before renting, providers should consider purchase for long-term requirements.

(15) Medical supplies are not separately payable to a DMEPOS provider while a client with Medicare Part A coverage is under a home health plan of care and covered home health care services.

(16) Medical supplies are not separately payable while a client is under a hospice plan of care where the supplies are included as part of the written plan of care and for which payment may otherwise be made by Medicare, DMAP or other carrier.

(17) The items listed in Table 122-0080 generally do not meet the requirements under DMEPOS rules for purchase, rent or repair of equipment or items. A request for equipment or an item on this list must meet all criteria in this rule.

(18) Table 122-0080

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0080 Exclusions

Air conditioners, air cleaners, air purifiers
Ankle-foot orthoses, graphite, spiral
Appliances, household, small electrics
Assistive devices for activities of daily living
Balls, therapy
Bandages, adhesive (i.e., Bandaids)
Bed cradle, any type
Bedding, any kind
Beds, age-specific, enclosed bed systems, metal-caged, total electric, water, youth
Bedwetting prevention devices
Bladder stimulators (pacemakers)
Bracelets, medical alert
Car seats, any type, standard, customized or custom-made
Chairs, geriatric, positioning
Cleanser, incontinent, perineal, wound
Clothing, except some orthopedic shoes & support hose
Cough stimulating device, alternating positive & negative airway pressure
Cribs, any type, including hospital cribs, rail padding
Deodorizers, room
Dilators, esophageal
Elevators
Exercise equipment
Feminine hygiene products
Furnishings, household, any kind
Generators
Hand controls for vehicles
High frequency chest wall oscillation air-pulse generator system
Humidifiers, room
Hot tubs/spas
Identification tags
Incubators/Isolates
Jacuzzis
Lifts, barrier-free ceiling track, chair, mechanism, stairs, van
Light box for SAD
Linens, any type
Mattresses, egg crate
Medicine cups, paper or plastic
Mobility monitor
Mucus trap (included in laboratory fee)

Nipple shields
Oscillatory positive expiratory pressure device
Overbed tables
Passive motion exercise device (CPM device)
Positioning seats, any type, standard, customized or custom-made
Ramps, van, wheelchair
Reachers
Restraints
Safety enclosures frame/canopy for use with hospital bed, any type
Scales, bath, diet
Sharps containers
Sheets, cloth draw, rubber
Showerheads, hand held
Sports equipment
Strollers
Supplemental Breast Feeding Nutrition System
Swamp coolers
Telephone alert systems
Telephones
Therapeutic Electrical Stimulator
Thermometers
Tie-downs for wheelchairs in vans
Tissue, facial, toilet
Tocolytic Pumps
Towelettes, any type
Utensils, eating
Typewriters
Vans
Washcloths, any type
Waterpiks® (and similar oral irrigation appliances)
Whirlpool
Wipes, any type

410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding

(1) The Healthcare Common Procedure Coding System (HCPCS) level II is a comprehensive and standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing. For each alphanumeric HCPCS code, there is descriptive terminology that identifies a category of like items. These codes are used primarily for billing purposes. The Centers for Medicare and Medicaid Services (CMS) maintain and distribute HCPCS Level II Codes.

(2) HCPCS is a system for identifying items and services. It is not a methodology or system for making coverage or payment determinations. The existence of a code does not, of itself, determine coverage or non-coverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or revision of HCPCS codes are made independently of the process for making coverage and payment determinations for medical services.

(3) The Division of Medical Assistance Programs (DMAP) uses the HCPCS Level II Code Set to ensure that claims are processed in an orderly and consistent manner.

(4) When requesting authorization and submitting claims, DMEPOS providers must use these codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code.

(5) This rule division may not contain all code updates needed to report medical services and supplies.

(6) For the most up-to-date information on code additions, changes, or deletions, refer to the fee schedule posted on the DMAP Web site.

(7) The DMAP fee schedule lists all of the current HCPCS codes in an alphanumeric index.

(8) Newly established temporary codes and effective dates for their use are also posted on the DMAP Web site at <http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml>.

(9) CMS updates permanent national codes annually on January 1st.

(10) CMS may add, change, or delete temporary national codes on a quarterly basis.

(11) The statistical analysis durable medical equipment carrier (SADMERC) is responsible for assisting DMEPOS providers and manufacturers in determining which HCPCS code should be used to describe DMEPOS items. SADMERC assistance is available by calling 1-877-735-1326 between 9 AM to 4 PM (EST). In addition, the SADMERC has a product classification list on its Web site <www.palmettogba.com> that lists individual items to code categories.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

410-122-0182 Legend

(1)The Division of Medical Assistance Programs (DMAP) uses abbreviations in the tables within this division.

(2)This rule explains the meaning of these abbreviations.

(3) PA – Prior authorization (PA): “PA” indicates that PA is required, even if the client has private insurance. See OAR 410-122-0040 for more information about PA requirements.

(4) PC – Purchase: “PC” indicates that purchase of this item is covered for payment by DMAP.

(5) RT – Rent: “RT” indicates that the rental of this item is covered for payment by DMAP.

(6) MR – Months Rented:

(a) “13” – Indicates that after 13 months of continuous rental or when the usual purchase price is reached (whichever is lesser), the equipment is considered paid for and owned by the client. After 13 months of rental payments, the provider must transfer title of the equipment to the client.

(b) “36” – Beginning with the first rental month on or after January 1, 2006, indicates that after 36 months of continuous rental or when the usual purchase price is reached (whichever is lesser), the equipment is considered paid for and owned by the client. After 36 months of rental payments, the provider must transfer title of the equipment to the client.

(7) RP – Repair: “RP” indicates that repair of this item is covered for payment by DMAP.

(8) NF – Nursing Facility: “NF” indicates that this procedure code is covered for payment by DMAP when the client is a resident of a nursing facility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing

(1) Indications and Limitations of Coverage and/or Medical Appropriateness: The Division of Medical Assistance Programs (DMAP) may cover repairs, maintenance, and replacement of medically appropriate, covered durable medical equipment, prosthetics and orthotics, including those items purchased or in use before the client enrolled with DMAP.

(a) Repairs:

(A) To repair means to fix or mend and to put the equipment back in good condition after damage or wear to make the equipment serviceable;

(B) If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment will be made for the amount of the excess;

(C) Payment for repairs is not covered when:

(i) The skill of a technician is not required; or

(ii) The equipment has been previously denied; or

(iii) Equipment is being rented, including separately itemized charges for repair; or

(iv) Parts and labor are covered under a manufacturer's or supplier's warranty;

(D) Code E1340 must not be used on an initial claim for equipment. Payment for any labor involved in assembling, preparing, or modifying the equipment on an initial claim is included in the allowable rate;

(b) Maintenance:

(A) Additional payment for routine periodic servicing, such as testing, cleaning, regulating, and checking of the client's equipment is not covered. However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, may be covered as repairs for medically appropriate client-owned equipment. For example, this might include, breaking down sealed components and performing tests that require specialized testing equipment not available to the client;

(B) Payment for maintenance/service is not covered for rented equipment, unless it is a capped rental item. DMAP may authorize payment for covered

maintenance and servicing of capped rental items after six months have passed from the end of the final paid rental month or from the end of the period the item is no longer covered under the provider's or manufacturer's warranty, whichever is later. Use the corresponding Healthcare Common Procedure Coding System (HCPCS) code for the equipment in need of maintenance and servicing at no more than the rental fee schedule allowable amount;

(C) Up to one month's rental will be reimbursed at the level of either the equipment provided; or, the equipment being repaired, whichever is less costly;

(D) Maintenance that includes parts and labor covered under a manufacturer's or supplier's warranty is not covered;

(c) Replacement - Replacement refers to the provision of an identical or nearly identical item:

(A) Temporary Replacement: One month's rental of temporary replacement for client-owned equipment being repaired, any type (K0462) may be reimbursed when covered client-owned equipment such as a wheelchair is in need of repair. The equipment in need of repair must be unavailable for use for more than one day. For example, the repair takes more than one day or a part has to be ordered and the wheelchair is non-functional;

(B) Permanent Replacement: Situations involving the provision of a different item because of a change in medical condition must meet the specific coverage criteria identified in Chapter 410, Division 122;

(C) Equipment which the client owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.). Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment;

(i) Reasonable useful lifetime of durable medical equipment (DME) is no less than five years;

(ii) Computation of the useful lifetime is based on when the equipment is delivered to the client, not the age of the equipment;

(iii) Replacement due to wear is not covered during the reasonable useful lifetime of the equipment;

(iv) During the reasonable useful lifetime, repair up to the cost of replacement (but not actual replacement for medically appropriate equipment owned by the client) may be covered;

(D) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment may not be covered;

(d) Delivery:

(A) Providers may deliver directly to the client or the designee (person authorized to sign and accept delivery of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) on behalf of the client);

(B) Providers, their employees, or anyone else having a financial interest in the delivery of an item are prohibited from signing and accepting an item on behalf of a client;

(C) A provider may deliver DMEPOS to a client in a hospital or nursing facility for the purpose of fitting or training the client in its proper use. This may be done up to two days prior to the client's anticipated discharge to home. On the claim bill the date of service as the date of discharge and specify the place of service (POS) as the client’s home. The item must be for subsequent use in the client's home;

(D) A provider may deliver DMEPOS to a client's home in anticipation of a discharge from a hospital or nursing facility. The provider may arrange for actual delivery approximately two days prior to the client's anticipated discharge to home. On the claim bill the date of service as the date of discharge and specify the POS as the client’s home;

(E) No payment is made on dates of service the client receives training or fitting in the hospital or nursing facility for a particular DMEPOS item;

(e) For Dispensing Refills:

(A) For DMEPOS products that are supplied as refills to the original order, providers must contact the client or designee prior to dispensing the refill to check the quantity on hand and continued need for the product;

(B) Contact with the client or designee regarding refills may only take place no sooner than approximately seven days prior to the delivery/shipping date;

(C) For subsequent deliveries of refills, the provider may deliver the DMEPOS product no sooner than approximately fifteen days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

DMAP will allow for the processing of claims for refills delivered/shipped prior to the client exhausting their supply, but the provider must not dispense supplies that exceed a client's expected utilization;

(D) Supplies dispensed are based on the practitioner's order. Regardless of utilization, a provider must not dispense more than a three-month quantity of supplies at a time. This three-month dispensing restriction for supplies may be further limited by rule limitations of coverage;

(E) The provider must not automatically ship, dispense or deliver a quantity of supplies on a predetermined regular basis, even if the client or designee has "authorized" this in advance.

(F) Shipping and handling charges are not covered;

(f) The following services are not covered:

(A) Pick-up, delivery, shipping and handling charges for DMEPOS, whether rented or purchased including travel time:

(i) These costs are included in the calculations for allowable rates;

(ii)These charges are not billable to the client;

(B) Supplies used with DME or a prosthetic device prior to discharge from a hospital or nursing facility;

(C) Surgical dressings, urological supplies, or ostomy supplies applied in the hospital or nursing facility, including items worn home by the client.

(2) Documentation Requirements:

(a) For Repairs, Maintenance and Temporary Replacement: A new Certificate of Medical Necessity (CMN) and/or physician's order is not required;

(b) Submit the following documentation with the prior authorization request:

(A) For Repairs/Maintenance:

(i) Narrative description, manufacturer and brand name/model name and number, serial number and original date of purchase for the covered equipment in need of repair; and

(ii) Itemized statement of parts needed for repair including the estimated date of service, manufacturer's name (if billing for parts, include manufacturer's name and part number for each part), product name, part number, manufacturer's

suggested retail price or manufacturer's invoice price and estimated labor time; and

(iii) Justification of the client's medical need for the item and statement that client owns the equipment in need of repair;

(B) For Temporary Replacement:

(i) Narrative description, manufacturer and brand name/model name and number, serial number and original date of purchase for the covered equipment in need of repair; and

(ii) Narrative description, manufacturer and brand name/model name and number of the replacement equipment; and

(iii) Itemized statement of parts needed for repair including the estimated date of service, manufacturer's name (if billing for parts, include manufacturer's name and part number for each part), product name, part number, manufacturer's suggested retail price or manufacturer's invoice price and estimated labor time; and

(iv) Justification of the client's medical need for the item and statement that client owns the equipment in need of repair; and

(v) Description of why repair takes more than one day to complete;

(C) For Permanent Replacement: See specific coverage criteria in Chapter 410, Division 122 for more information;

(D) For Proof of Delivery: DMEPOS providers are required to:

(I) Maintain proof of delivery documentation to the client in their records for seven years;

(II) Maintain documentation that supports that conditions of coverage in this rule are met;

(III) Make proof of delivery documentation available to DMAP upon request;

(c) Proof of delivery requirements are based on the method of delivery;

(d) A signed and dated delivery slip is required for items delivered directly by the provider to the client or designee. The delivery slip must include the following:

(A) When a designee signs the delivery slip, their relationship to the client must be noted and the signature legible;

(B) The client or designee's signature with the date the items were received; and

(C) Client's name, and

(D) Quantity, brand name, serial number and a detailed description of the items being delivered; and

(E) The date of signature on the delivery slip must be the date the DMEPOS item is received by the client or designee; and

(F) The date the client receives the item is the date of service;

(e) If the provider uses a delivery/shipping service or mail order, an example of proof of delivery would include the service's tracking slip and the provider's own shipping invoice:

(A) The provider's shipping invoice must include the:

(i) Client's name, and

(ii) Quantity, brand name, serial number and a detailed description of the items being delivered, and

(iii) Delivery service's package identification number associated with each individual client's package with a unique identification number and delivery address, including the actual date of delivery, if possible; and

(iv) The shipping date must be used as the date of service, unless the actual date of delivery is available, then use this date as the date of service;

(B) The delivery service's tracking slip must reference:

(i) Each client's packages; and

(ii) The delivery address and corresponding package identification number given by the delivery service;

(f) Providers may utilize a signed/dated return postage-paid delivery/shipping invoice from the client or designee as a form of proof of delivery that must contain the following information:

(A) Client's name;

(B) Quantity, brand name, serial number and a detailed description of items being delivered;

(C) Required signatures from either the client or the designee;

(g) Delivery to Nursing Facilities or Hospitals:

(A) The date of service is the date the DMEPOS item(s) is received by the nursing facility if delivered by the DMEPOS provider;

(B) The date of service is the shipping date (unless the actual delivery date is known and documented) if the DMEPOS provider uses a delivery/shipping service;

(h) For those clients who are residents of an assisted living facility, a twenty-four hour residential facility, an adult foster home, a child foster home, a private home or other similar living environment, providers must ensure supplies are identified and labeled for use only by the specific client for whom the supplies/items are intended.

(3) Procedure Codes:

(a) Replacement parts for wheelchair repair are billed using the specific Healthcare Common Procedure Coding System (HCPCS) code, if one exists, or code K0108 (other accessories);

(b) E1340:

(A) Repair or non-routine service requiring the skill of a technician, labor component, per 15 minutes;

(B) This code is used for services not covered by other codes or combination of codes in reference to the repairs of DMEPOS;

(c) K0108 – Other wheelchair accessories - PA;

(d) K0462 – Temporary replacement for client-owned equipment being repaired, any type – Prior authorization (PA) required – PA.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-122-0186 Payment Methodology

(1) The Division of Medical Assistance Programs (DMAP) utilizes a payment methodology for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) which is generally based on Medicare's fee schedule.

(2) Payment is calculated using the DMAP fee schedule amount, the manufacturer's suggested retail price (MSRP) or the actual charge submitted, whichever is lowest.

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

(4) Reimbursement for durable medical equipment, miscellaneous (E1399) and other wheelchair accessories (K0108) is capped as follows:

(a) E1399 – $6000.00;

(b) K0108 – $12,000.00.

(5) Reimbursement for codes E1399 and K0108 is determined as either:

(a) 80% of the Manufacturer's Suggested Retail Price (MSRP); or,

(b) If the MSRP is not available, the lowest amount of the following, plus 20 percent:

(A) Manufacturer's invoice; or

(B) Manufacturer's wholesale price; or

(C) Acquisition cost; or

(D) Manufacturer's bill to provider;

(c) If (5) (a) or (b) are not available, reimbursement will be the "estimated price" plus 20 percent. An "estimated price" is the price the provider expects the manufacturer to charge.

(6) When requesting prior authorization (PA) for items billed at or above $100, the DMEPOS provider:

(a) Must submit a copy of:

(A) The items from (5) (a-c) that will be used to bill; and,

(B) Name of the manufacturer, description of the item, including product name/model name and number and technical specifications;.

(b) May be required to submit a picture of the item.

(7) The DMEPOS provider must submit verification for items billed under code E1399 when no specific Healthcare Common Procedure Coding System (HCPCS) code is available and an item category is not specified in Chapter 410, Division 122 rules. Verification can come from an organization such as the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

(8) DMAP may review items that exceed the maximum allowable/cap on a case-by-case basis. For these situations, the provider must submit the following documentation:

(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) which 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 client's condition.

(9) For codes A4649 (surgical supplies; miscellaneous) and E1399 when $50.00 or less per each unit;

(a)The DMEPOS provider must have documentation on file which supports the correct Healthcare Common Procedure Coding System (HCPCS) code was used for billing according to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC);

(b) Subject to service limitations of DMAP rules;

(c) PA is not required.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-122-0200 Pulse Oximeter for Home Use

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a tamper-proof pulse oximeter rental for home use when all of the following criteria are met:

(A) The client has frequently fluctuating oxygen saturation levels that are clinically significant;

(B) Measurements are integral in dictating acute therapeutic intervention;

(C) The absence of readily available saturation measurements represents an immediate and demonstrated health risk;

(D) The client has a caregiver trained to provide whatever care is needed to reverse the low oxygen saturation level ordered by the physician;

(b) Some examples of when home pulse oximetry may be covered include the following:

(A) When weaning a client from home oxygen or a ventilator; or

(B) When a change in the client's physical condition requires an adjustment in the liter flow of their home oxygen needs; or

(C) To determine appropriate home oxygen liter flow for ambulation, exercise, or sleep; or

(D) To monitor a client on a ventilator at home; or

(E) To periodically re-assess the need for long-term oxygen in the home; or

(F) In conjunction with infant home apnea monitoring; or

(G) When a client exhibits a certain unstable illness and has compromised or potentially compromised respiratory status; or

(H) When evidence-based clinical practice guidelines support the need;

(c) Home pulse oximetry for indications other than those listed above may be considered medically appropriate upon medical review;

(d) The use of home pulse oximetry for indications considered experimental and investigational, including the following, are not covered:

(A) Asthma management;

(B) When used alone as a screening/testing technique for suspected obstructive sleep apnea;

(C) Routine use (e.g., client with chronic, stable cardiopulmonary condition);

(e) The durable medical equipment prosthetics, orthotics and supplies (DMEPOS) provider is responsible to ensure the following services for home pulse oximetry rental are provided:

(A) Training regarding the use and care of the equipment and care of the client as it relates to the equipment, including progressive intervention and cardiopulmonary resuscitation (CPR) training prior to use of the equipment by the client; and

(B) A follow-up home visit within the first 30 days of equipment setup to ensure a CPR/emergency area has been designated; and

(C) Monthly telephone follow-up and support to ensure caregivers are using the equipment as ordered by the physician; and

(D) 24-hour/7 day a week respiratory therapist on-call availability for troubleshooting, exchanging of malfunctioning equipment, etc.;

(f) DMAP may cover probes for a client-owned covered oximeter:

(A) DMAP will consider the least costly alternative for payment of probes, whether disposable or reusable, which meets the medical need of the client;

(B) Disposable probes (oxisensors) may be used on the same client as long as the adhesive attaches without slippage; or

(C) Probes must be used and replaced based on the manufacturer's recommendations.

(2) Documentation Requirements:

(a) Submit the following documentation for prior authorization (PA) review:

(A) An order from the treating physician that clearly specifies the medical appropriateness for home pulse oximetry testing;

(B) Documentation of signs/symptoms/medical condition exhibited by the client, that require continuous pulse oximetry monitoring as identified by the need for oxygen titration, frequent suctioning or ventilator adjustments, etc.;

(C) Plan of treatment that identifies a trained caregiver available to perform the testing, document the frequency and the results and implement the appropriate therapeutic intervention, when necessary;

(D) For probes for a client-owned oximeter, documentation that probes requested are the least costly alternative;

(E) Other medical records that corroborate conditions for coverage are met as specified in this rule;

(b) An appropriate history and physical exam and progress notes must be available for review by DMAP, upon request;

(c) For an initial request, approval may be given for no longer than the first three months of rental;

(d) Continued approval beyond the initial authorization, is based on ongoing review of above documentation including appropriate and medical oversight as indicated and direction to support the need, including an identified intervention plan by the treating physician.

(3) Procedure Codes:

(a) A4606 – Oxygen probe for use with client-owned oximeter device, replacement:

(A) PA required;

(B) DMAP will purchase;

(b) E0445 – Oximeter device for measuring blood oxygen levels non-invasively, per month:

(A) PA required;

(B) DMAP will rent;

(C) DMAP will repair;

(D) Item considered purchased after seven months of rent;

(E) Quantity (units) is one on a given date of service;

(F) The allowable rental fee includes all equipment, supplies. services, including all probes, routine maintenance and necessary training for the effective use of the pulse oximeter.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

410-122-0202 Continuous Positive Airway Pressure (CPAP) System

(1) Indications and Limitations of Coverage and/or Medical Appropriateness

(a) Initial Coverage:

(A) A single-level continuous positive airway pressure (CPAP) device (E0601) may be covered by the Division of Medical Assistance Programs (DMAP) when the client has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (i or ii):

(i) The apnea-hypopnea index (AHI) is greater than or equal to 15 events per hour; or,

(ii) The AHI is from 5 to 14 events per hour with documented symptoms of:

(I) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,

(II) Hypertension, ischemic heart disease, or history of stroke;

(B) A three-month rental period is required for CPAP prior to purchase;

(b) Continued coverage of an E0601 beyond the first three months of therapy: Ongoing rental beyond the first three months is an option in lieu of purchase if medically appropriate and cost effective;

(c) For a client using a CPAP prior to Medicaid enrollment, and, with recent, supportive documentation from the treating practitioner indicative of effective treatment with a CPAP device, coverage criteria in this rule may be waived;

(d) Payment Authorization: From the initial date of service through the second date of service, CPAP rental and only related accessories necessary for the effective use of the CPAP during this time period and subject to rule limitations may be dispensed without prior authorization. The provider is still responsible to ensure all rule requirements are met. Payment authorization is required prior to submitting claims and will be given once all required documentation has been received and any other

applicable rule requirements have been met. Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040. All subsequent services starting with the third date of service require prior authorization;

(e) An order refill does not have to be approved by the ordering physician; however, a client or their caregiver must specifically request ongoing CPAP supplies and accessories, subject to rule limitations and requirements, before they are dispensed. The DMEPOS provider must not automatically dispense a quantity of supplies and accessories on a predetermined regular basis, even if the client has "authorized" this in advance.

(2) Guidelines:

(a) A continuous positive airway pressure (CPAP) device delivers a constant level of positive air pressure (within a single respiratory cycle) by way of tubing and a noninvasive interface (such as a nasal, oral, or facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs;

(b) A respiratory cycle is defined as an inspiration, followed by an expiration;

(c) Polysomnography is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and report. It must include sleep staging, which is defined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). It must also include at least the following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry. It may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment;

(d) For the purpose of this rule, polysomnographic studies must be performed in an attended, facility-based sleep study laboratory, and not in the home or in a mobile facility. These labs must be qualified providers of Medicare services and comply with all applicable state regulatory requirements;

(e) The diagnostic portion of the polysomnogram recording must be a minimum of two hours;

(f) Polysomnographic studies must not be performed by a durable medical equipment (DME) provider;

(g) The apnea-hypopnea index (AHI) is defined as the average number of episodes of apneas and hypopneas per hour and must be based on a minimum of two hours of recording time without the use of a positive airway pressure device, reported by polysomnogram. The AHI may not be extrapolated or projected;

(h) Apnea is defined as the cessation of airflow for at least 10 seconds documented on a polysomnogram;

(i) Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation;

(j) The AHI calculation must be based on the sleep time (in hours) within the two hours (or more) of recorded time.

(3) Documentation Requirements:

(a) Initial Coverage: Prior to the third date of service, submit the following documentation:

(A) A facility-based polysomnogram report that supports a diagnosis of obstructive sleep apnea (OSA); and, if applicable;

(B) Any other medical documentation that supports indications of coverage;

(b) Continued coverage beyond the first three months of therapy: No sooner than the 61st day after initiating therapy and prior to the fourth date of service, submit documentation from the treating physician that indicates the client is continuing to effectively comply (time spent at the effective pressure) with CPAP treatment. This means that the client is continuing to use the CPAP at the effective pressure for at least four hours in a 24-hour continuous period at least 80 percent of the time.

(4) Accessories:

(a) Accessories used with an E0601 device are covered when the coverage criteria for the device are met;

(b) Accessories are separately reimbursable at the time of initial issue and when replaced;

(c) Either a non-heated (E0561) or heated (E0562) humidifier is covered when ordered by the treating physician for use with a covered E0601 device;

(d) The following represents the usual maximum amount of accessories expected to be medically appropriate:

(A) A4604 – 1 per 3 months;

(B) A7030 - 1 per 3 months;

(C) A7031 - 1 per 6 months;

(C) A7032 - 2 per month;

(D) A7033 - 2 per month;

(E) A7034 - 1 per 3 months;

(F) A7035 - 1 per 6 months;

(G) A7036 - 1 per 6 months;

(H) A7037 - 1 per 1 month;

(I) A7038 - 2 per 1 month;

(J) A7039 - 1 per 6 months;

(K) A7046 – 1 per 6 months.

(5) Miscellaneous:

(a) It is the provider's responsibility to monitor appropriate and effective use of the device as ordered by the treating physician. When the equipment is not being used as prescribed, the provider must stop billing for the equipment and related accessories and supplies;

(b) For auto-titrating CPAP devices, use HCPCS code E0601;

(c) Products must be coded as published by SADMERC's Product Classification List for CPAP Systems and Respiratory Assist Devices.

(6) Table 122-0202.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0202 Continuous Positive Airway Pressure (CPAP) System

For the code legend see OAR 410-122-0182

* See section (1)(d) of this rule for authorization requirements.

Code	Description	PA	PC	RT	MR	RP	NF
*E0601	Continuous airway pressure device (CPAP)		PC	RT	13	RP	NF
Accessories for CPAP							
*A4604	Tubing with integrated heating element for use with positive airway pressure device, each		PC				NF
*A7030	Full face mask used with positive airway pressure device, each ■ One per six months		PC				NF
*A7031	Face mask interface, replacement for full face mask, each ■ One per six months		PC				NF
*A7032	Replacement cushion for nasal application device, each ■ Two per month		PC				NF
*A7033	Replacement pillows for nasal application device, pair ■ Two per month		PC				NF
*A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head straps		PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
	■ One per three months						
*A7035	Headgear, used with positive airway pressure device		PC				NF
	■ One per six months						
*A7036	Chin strap, used with positive airway pressure device		PC				NF
	■ One per six months						
*A7037	Tubing, used with positive airway pressure device		PC				NF
	■ One per month						
*A7038	Filter, disposable, used with positive airway pressure device		PC				NF
	■ Two per month						
*A7039	Filter, non-disposable, used with positive airway pressure device		PC				NF
	■ One per six months						
*A7044	Oral interface used with positive airway pressure device, each		PC				NF
*A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only		PC				NF
*A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each		PC		13		NF

Code	Description	PA	PC	RT	MR	RP	NF
*E0561	Humidifier, non-heated, used with positive airway pressure device		PC	RT	13	RP	NF
*E0562	Humidifier, heated, used with positive airway pressure device		PC	RT	13	RP	NF
S8186	Swivel adapter		PC				NF

410-122-0203 Oxygen and Oxygen Equipment

(1) Indications and limitations:

(a) For all the sleep oximetry criteria described in (b) (c) and (d) below, the five minutes do not have to be continuous:

(A) When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria are met;

(B) If an ABG test at rest/awake is nonqualifying, but an exercise or sleep oximetry test on the same day is qualifying, the oximetry test result will determine coverage;

(b) The Division of Medical Assistance Programs (MAP) may cover home oxygen therapy services for clients who are:

(A) Children under age 19 when the treating practitioner has determined it to be medically appropriate;

(B) Adults 19 years of age and older if the following conditions are met:

(i) The treating practitioner has determined that the client has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy; and
(ii) The client's blood gas study meets the criteria stated below; and
(iii) A physician or qualified provider or supplier of laboratory services performed the qualifying blood gas study; and
(iv) The qualifying blood gas study was obtained under the following conditions:

(I) If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to the hospital discharge date; or
(II) If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the client is in a chronic stable state, that is, not during a period of acute illness or an exacerbation of their underlying disease;

(v) Alternative treatment measures have been tried or considered and deemed clinically ineffective;

(C) Clients residing in a nursing facility only when continuous oxygen is required that exceeds 1000 liters in a 24-hour period. See OAR 410-120-1340 and 411-070-0085;

(c) Group I coverage duration and indications:

(A) DMAP limits initial Group I coverage to 12 months or the practitioner-specified length of need, whichever is shorter. See documentation requirements for information on recertification;

(B) Criteria for Group I include any of the following:

(i) An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake); or

(ii) An arterial PO 2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least five minutes taken during sleep for a client who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake; or

(iii) A decrease in arterial PO 2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, for at least 5 minutes taken during sleep associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis); or

(iv) An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a client who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air;

(d) Group II coverage duration and indications:

(A) Initial coverage limited to three months or the practitioner-specified length of need, whichever is shorter. See documentation requirements for information on recertification;

(B) Criteria include presence of PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least five minutes, or during exercise (as described under Group I criteria); and any of the following:

(i) Dependent edema suggesting congestive heart failure; or
(ii) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or
(iii) Erythrocythemia with a hematocrit greater than 56 percent.

(e) Group III indications include a presumption of non-coverage and are considered precautionary, not therapeutic, in nature. Criteria include arterial PO2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent;

(f) DMAP does not cover oxygen therapy and related services, equipment or supplies for any of the following:

(A) Angina pectoris in the absence of hypoxemia;

(B) Dyspnea without cor pulmonale or evidence of hypoxemia;
(C) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia;

(D) Terminal illnesses that do not affect the respiratory system;

(E) Humidifiers (E0550, E0555 and E0560) with rented oxygen equipment. All accessories, such as humidifiers necessary for the effective use of oxygen equipment, are included in the monthly rental payment;

(F) Group III clients;

(G) Emergency or stand-by oxygen systems, including oxygen as needed (i.e., PRN), since they are precautionary and not therapeutic in nature;
(H) Topical hyperbaric oxygen chambers (A4575);

(I) Oxygen for topical use;

(J) Back-up equipment, since it is part of the all-inclusive rate;

(K) Travel oxygen:

(i) Clients traveling outside the DMEPOS provider's service area must make their own arrangements for oxygen;

(ii) DMAP will only pay one DMEPOS provider for oxygen during any one rental month;
(iii) The traveling client is responsible to pay for oxygen furnished by an airline, not the DMEPOS provider.

(2) Guidelines for testing and certification:

(a) Testing specifications:

(A) The term blood gas study in this policy refers to either an arterial blood gas (ABG) test or an oximetry test:

(i) An ABG is the direct measurement of the partial pressure of oxygen (PO2) on a sample of arterial blood;

(ii) The PO2 is reported as mm Hg;

(iii) An oximetry test is the indirect measurement of arterial oxygen saturation using a sensor on the ear or finger;

(iv) The saturation is reported as a percent;

(B) The qualifying blood gas study must be performed by a qualified provider (a laboratory, physician, etc.);

(i) DMAP does not consider a DMEPOS provider a qualified provider or a qualified laboratory for purposes of this policy;

(ii) DMAP will not accept blood gas studies either performed by, or paid for, by a DMEPOS provider;

(iii) This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests;

(C) For sleep oximetry studies, the tester must provide the client a tamper-proof oximeter that has the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value;

(D) When oxygen services are based on an oxygen study obtained during exercise, DMAP requires documentation of three oxygen studies in the client's medical record:

(i) Testing at rest without oxygen; and

(ii) Testing during exercise without oxygen; and

(iii) Testing during exercise with oxygen applied, to demonstrate the improvement of the hypoxemia.

(E) The qualifying test value (i.e., testing during exercise without oxygen) on the Certificate of Medical Necessity (CMN). The other results do not have to be routinely submitted but must be available to DMAP on request;
(F) The qualifying blood gas study may be performed while the client is on oxygen, as long as the reported blood gas values meet the Group I or Group II criteria.

(b) Certification:

(A) On the CMN, the blood gas study obtained must be the most recent study prior to the initial date, indicated in Section A of the CMN, and this study must be obtained within 30 days prior to that initial date;

(B)There is an exception for clients who were on oxygen prior to enrollment with DMAP. For those clients, the blood gas study does not have to be obtained 30 days prior to the initial date, but must be the most recent test obtained prior to enrollment with DMAP;

(C) For clients initially meeting Group I criteria:

(i) The tester must report the most recent blood gas study prior to the 13th month of therapy on the recertification CMN;
(ii) If the estimated length of need on the initial CMN is less than lifetime and the practitioner wants to extend coverage, a repeat blood gas study must be performed within 30 days prior to the date of the revised certification;

(D) For clients initially meeting Group II criteria:

(i) On the recertification CMN, the tester must report the most recent blood gas study that was performed between the 61st and 90th day following the date of the initial certification CMN;

(ii) If a tester does not obtain a qualifying test between the 61st and 90th day of home oxygen therapy, but the client continues to use oxygen and a test is obtained at a later date, if that test meets Group I or II criteria, DMAP will resume coverage beginning with the date of that test;

(iii) If the estimated length of need on the initial CMN is less than lifetime and the practitioner wants to extend coverage, a repeat blood gas study must be performed within 30 days prior to the date of the revised certification;

(E) On any revised CMN, the tester must report the most recent blood gas study performed prior to the revision date;
(F) DMAP may request a repeat blood gas study at any time;
(G) The treating practitioner must see and evaluate the client:

(i) Within 30 days prior to the date of initial certification;

(ii) Within 90 days prior to the date of any recertification;

(iii) If the treating practitioner fails to see and reevaluate the client within 90 days prior to recertification, but subsequently evaluates and determines the client meets the blood gas study criteria, DMAP will cover the dates of service between the scheduled recertification date and the practitioner visit date.

(3) Portable oxygen system coverage:

(a) A portable oxygen system may be covered if the client is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen is not covered;
(b) If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system. (See the exception in Section (4) of this rule);
(c) If a portable oxygen system is covered, the DMEPOS provider must provide whatever quantity of oxygen the client uses;
(d) DMAP's reimbursement is the same, regardless of the quantity of oxygen dispensed;

(e) Code K0738 (portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flow meter, humidifier, cannula or mask, and tubing) is to be used for billing and payment for oxygen transfilling equipment used in the beneficiary's home to fill portable gaseous oxygen cylinders.

(4) Liter flow greater than 4 liters per minute (LPM):

(a) DMAP will pay for a higher allowance of a flow rate of greater than 4 LPM only if:

(A) Basic oxygen coverage criteria have been met; and

(B) The client meets Group I or II criteria; and

(C) A blood gas study is performed while client is on 4 LPM oxygen;

(b) DMAP will limit payment to the standard fee schedule allowance if the provider requests a flow rate greater than 4 LPM when the coverage criterion for the higher allowance is not met;

(c) If a client qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen:

(A) DMAP will pay for either the stationary system (at the higher allowance) or the portable system (at the standard fee schedule allowance for a portable system), but not both;

(B) In this situation, if both a stationary system and a portable system are requested for the same rental month, DMAP will not cover the portable oxygen system.

(5) Oxygen contents:

(a) The DMAP allowance for rented oxygen systems includes oxygen contents;

(b) Stationary oxygen contents (E0441, E0442) are separately payable only when the coverage criteria for home oxygen have been met and they are used with a client-owned stationary gaseous or liquid system respectively;

(c) Portable contents (E0443, E0444) are separately payable only when the coverage criteria for home oxygen have been met and:

(A) The client owns a concentrator and rents or owns a portable system; or
(B) The client rents or owns a portable system and has no stationary system (concentrator, gaseous, or liquid);
(C) If the criteria for separate payment of contents are met, they are separately payable regardless of the date that the stationary or portable system was purchased.

(6) Oxygen accessory items:

(a) The DMAP allowance for rented systems includes, but is not limited to, the following accessories:

(A) Transtracheal catheters (A4608);

(B) Cannulas (A4615);

(C) Tubing (A4616);

(D) Mouthpieces (A4617);

(E) Face tent (A4619);

(F) Masks (A4620, A7525);

(G) Oxygen tent (E0455);

(H) Humidifiers (E0550, E0555, E0560);

(I) Nebulizer for humidification (E0580);

(J) Regulators (E1353);

(K) Stand/rack (E1355);

(b) The DMEPOS provider must provide any accessory ordered by the practitioner;

(c) Accessories are separately payable only when they are used with a client-owned system that was purchased prior to June 1, 1989. DMAP does not cover accessories used with a client-owned system that was purchased on or after June 1, 1989;

(7) Billing for miscellaneous oxygen items:

(a) DMAP only covers rented oxygen systems (E0424, E0431, E0434, E0439, E1390RR, E1405 RR, E1406RR, E1392RR);

(b) For gaseous or liquid oxygen systems or contents, report one unit of service for one month rental. Do not report in cubic feet or pounds;

(c) Use the appropriate modifier if the prescribed flow rate is less than 1 LPM (QE) or greater than 4 LPM (QF or QG). DMAP only accepts these modifiers with stationary gaseous (E0424) or liquid (E0439) systems or with an oxygen concentrator (E1390, E1391). Do not use these modifiers with codes for portable systems or oxygen contents;

(d) Use Code E1391 (oxygen concentrator, dual delivery port) in situations in which two clients are both using the same concentrator. In this situation, this code must only be requested for one of the clients;

(e) Use Codes E1405 and E1406 (oxygen and water vapor enriching

systems) only for products for which a written coding verification has been received from the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC);

(f) Code E1392 describes a portable oxygen concentrator system. Use E1392 when billing DMAP for the portable equipment add-on fee for clients using lightweight oxygen concentrators that can function as both the client's stationary equipment and portable equipment. A portable concentrator:

(A) Weighs less than 10 pounds;

(B) Is capable of delivering 85% or greater oxygen concentration; and

(C) Is capable of providing at least two hours of remote portability at a 2 LPM order equivalency;

(g) Contact the SADMERC for guidance on the correct coding of these items.

(8) Documentation Requirements: The DMEPOS provider must have the following documentation on file which supports conditions of coverage as specified in this rule are met:

(a) Medical records that reflect the need for the oxygen care provided include records from:

(A) Physician's or practitioner's office;

(B) Hospital;

(C) Nursing home;

(D) Home health agency;

(E) Other health care professionals;

(F) Test reports;

(b) The treating practitioner's signed and dated orders for each item billed. When the DMEPOS provider bills DMAP before the provider

receives a signed and dated order, the provider must submit the claim with an EY modifier added to each affected HCPCS code;

(A) In the following situations, a new order must be obtained and kept on file by the DMEPOS provider, but neither a new CMN nor a repeat blood gas study are required:

(i) Prescribed maximum flow rate changes but remains within one of the following categories:

(I) Less than 1 LPM;

(II) 1-4 LPM;

(III) Greater than 4 LPM;

(ii) Change from one type of system to another (i.e., concentrator, liquid, gaseous);

(c) A completed, signed, dated CMN from the treating practitioner;

(A) The CMN may substitute for a written order if it is sufficiently detailed;

(B) The CMN for home oxygen is CMS form 484. Section B (order information) of the CMN must be completed by the physician or the practitioner, not the DMEPOS provider. The DMEPOS provider may use Section C to record written confirmation of other details of the oxygen order, or the practitioner can enter other details directly, such as means of deliver (e.g., cannula, mask, etc.) and the specifics of varying oxygen flow rates or non-continuous use of oxygen;

(C) The ABG PO2 must be reported on the CMN if both an ABG and oximetry test were performed the same day under the condition reported on the CMN (that is, at rest, awake, during exercise, or during sleep);

(D) A completed sleep study documenting the qualifying desaturation for clients who qualify for oxygen coverage based only on a sleep oximetry study. The saturation value reported in Question 1(b) of the Oxygen CMN must be the lowest value (not related to artifact) during the five-minute qualifying period reported on the sleep study;

(E) The blood gas study reported on the initial CMN must be the most recent study obtained prior to the initial date and this study must be obtained within 30 days prior to that initial date;

(i) There is an exception for clients who were on oxygen in a Medicare Health Maintenance Organization (HMO) and who transition to fee-for-service Medicare;

(ii) For those clients, the blood gas study does not have to be obtained 30 days prior to the initial date, but must be the most recent test obtained while in the HMO;

(F) The DMEPOS provider must submit to DMAP an initial CMN in the situations described below. The initial date refers to the dates reported in Section A of the CMN;

(i) With the first claim to DMAP for home oxygen, even if the client was on oxygen prior to becoming eligible for DMAP coverage, or oxygen was initially covered by a Medicare HMO;

(ii) When the first CMN did not meet coverage criteria and the client was subsequently retested and meets coverage criteria, the initial date on the new CMN is the date of the subsequent, qualifying blood gas study;

(iii) When a change occurs in the client's condition that caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended. This indication does not apply if there was just a break in billing because the client was in a hospital, nursing facility, hospice or Medicare HMO, but the client continued to need oxygen during that time;

(iv) When a Group I client with length of need less than or equal to 12 months was not retested prior to Revised Certification/ Recertification, but a qualifying study was subsequently performed. The initial date on this new CMN is the date of the subsequent, qualifying blood gas study;

(v) When a Group II client did not have a qualifying, repeat blood gas study between the 61st and 90th days of coverage, but a qualifying

study was subsequently performed. The initial date on the new CMN is the date of the subsequent, qualifying blood gas study;

(vi) When a change of provider occurs due to an acquisition and the previous provider did not file a recertification when it was due or the requirements for recertification were not met when it was due. The initial date on this new CMN is the date of the subsequent qualifying blood gas study;

(G) The DMEPOS provider must submit to DMAP a recertification CMN in the following circumstances. The initial date refers to the dates reported in Section A of the CMN:

(i) For Group I oxygen test results, 12 months after the initial certification (i.e., with the 13th month's claim). The blood gas reported study must be the most recent study performed prior to the 13th month of therapy;

(ii) If a Group I client with a lifetime length of need was not seen and evaluated by the practitioner within 90 days prior to the 12-month recertification, but was subsequently seen, the date on the recertification CMN must be the date of the practitioner visit;

(iii) For Group II oxygen test results, three months after the initial certification (i.e., with the fourth month's claim). The reported blood gas study must be the most recent study performed between the 61st and 90th day following the initial date;

(iv) If there was a change of provider due to an acquisition and the previous DMEPOS provider did not file a recertification when it was due, but all the requirements for the recertification were met when it was due, the provider would file a recertification CMN with the recertification date being 12 months (for a Group I initial CMN) or three months (for a Group II initial CMN) after the initial date;

(v) In other situations at the discretion of DMAP. The blood gas study must be the most recent study that was performed within 30 days prior to the recertification date;

(H) The DMEPOS provider must submit to DMAP a revised CMN in the following circumstances. Submission of a revised CMN does not

change the recertification schedule specified elsewhere. The initial date refers to the dates reported in Section A of the CMN:

(i) When the prescribed maximum flow rate changes from one of the following categories to another:

(I) Less than 1 LPM;

(II) 1-4 LPM;

(III) Greater than 4 LPM;

(IV) If the change is from category (a) or (b) to category (c), a repeat blood gas study with the client on 4 LPM must be performed within 30 days prior to the start of the greater than 4 LPM flow;

(ii) When a portable oxygen system is added subsequent to initial certification of a stationary system. In this situation, DMAP does not require a repeat blood gas study, unless the initial qualifying study was performed during sleep, in which case a repeat blood gas study must be performed while the client is at rest (awake) or during exercise within 30 days prior to the revised date;

(iii) When a stationary system is added subsequent to initial certification of a portable system. In this situation, DMAP does not require a repeat blood gas study;

(iv) When the length of need expires, if the practitioner specified less than lifetime length of need on the most recent CMN. In this situation, a blood gas study must be performed within 30 days prior to the revised date;

(v) When there is a new treating practitioner, but the oxygen order is the same. In this situation, DMAP does not require a repeat blood gas study. Note: In this situation, the revised CMN does not have to be submitted with the claim but must be kept on file by the provider;

(vi) If there is a new provider, that provider must be able to provide DMAP with a CMN on request. That CMN would not necessarily be an initial CMN or the first CMN for that client. If the provider obtains a new CMN, it would be considered a revised CMN;

(vii) If the indications for a revised CMN are met at the same time that a recertification CMN is due, file the CMN as a recertification CMN.

(9) Table 122-0203

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0203 Oxygen and Oxygen Equipment

Code	Description	PA	PC	RT	MR	RP	NF
See 410-122-0182 Legend for explanation of abbreviations.							
Equipment:							
E0424	Stationary compressed gaseous oxygen system rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing, per month			RT	36		
E0425	Stationary compressed gaseous system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing		PC			RP	
E0430	Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing		PC			RP	
E0431	Portable gaseous oxygen system, rental; includes			RT	36		

Code	Description	PA	PC	RT	MR	RP	NF
See 410-122-0182 Legend for explanation of abbreviations.							
	portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing, per month						
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing, per month			RT	36		
E0435	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adaptor		PC			RP	
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing, per month			RT	36		
E0440	Stationary liquid oxygen system, purchase; includes use of reservoir, contents		PC			RP	

Code	Description	PA	PC	RT	MR	RP	NF
See 410-122-0182 Legend for explanation of abbreviations.							
	indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing						
E0441	Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned). One month supply = one unit		PC				
E0442	Oxygen contents, liquid, (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned) One month supply = one unit		PC				
E0443	Portable oxygen contents, gaseous, (for use only with portable gaseous systems when no stationary gas or liquid system is used) One month supply = one unit		PC				

Code	Description	PA	PC	RT	MR	RP	NF
See 410-122-0182 Legend for explanation of abbreviations.							
E0444	Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used) One month supply = one unit		PC				
E1390	Oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate, per month All equipment and supplies needed for the operation of the concentrator are included in the rental fee			RT	36		Covered only when continuous oxygen is required which exceeds 1,000 liters per 24 hrs.
E1391	Oxygen concentrator, dual delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate, each, per month All equipment and supplies needed for the operation of the concentrator are included in the rental fee			RT	36		Covered only when continuous oxygen is required which exceeds 1,000 liters per 24 hrs.
E1392	Portable oxygen concentrator, rental, per			RT	36		Covered only when

Code	Description	PA	PC	RT	MR	RP	NF
See 410-122-0182 Legend for explanation of abbreviations.							
	concentrator, rental, per month						only when continuous oxygen is required which exceeds 1,000 liters per 24 hrs.
E1405	Oxygen and water vapor enriching system with heated delivery			RT	36		NF
E1406	Oxygen and water vapor enriching system without heated delivery			RT	36		NF
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flow meter, humidifier, cannula or mask, and tubing)			RT			
Accessories:							

Code	Description	PA	PC	RT	MR	RP	NF
See 410-122-0182 Legend for explanation of abbreviations.							
A4608	Transtracheal oxygen catheter, each		PC				
A4615	Cannula, nasal		PC				
A4616	Tubing, (oxygen), per foot		PC				
A4617	Mouth piece		PC				
A4619	Face tent		PC				
A4620	Variable concentration mask		PC				
A7525	Tracheostomy mask, each		PC				
E0455	Oxygen tent, excluding croup or pediatric tents, per month			RT	13		
E0550	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery Not to be billed in addition to E0424, E0431, E0434, E0439, E0450, E0455, E0460, E1400, E1401, E1402, E1403, E1404,		PC	RT	13	RP	

Code	Description	PA	PC	RT	MR	RP	NF
See 410-122-0182 Legend for explanation of abbreviations.							
	E1405 or E1406						
E0555	Humidifier, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter Not to be billed in addition to E0424, E0431, E0434, E0439, E0450, E0455, E0460, E1400, E1401, E1402, E1403, E1404, E1405 or E1406		PC				
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery Not to be billed in addition to E0424, E0431, E0434, E0439, E0450, E0455, E0460, E1400, E1401, E1402, E1403, E1404, E1405, or E1406		PC	RT	13	RP	
E1353	Regulator (yoke or other)		PC			RP	
E1355	Stand/rack for oxygen tank		PC				

410-122-0204 Nebulizer

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) Equipment:

(A) Small Volume Nebulizer:

(i) A small volume nebulizer and related compressor may be covered to administer inhalation drugs based on evidence-based clinical practice guidelines;

(ii) When appropriate, the physician must have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, the MDI was not sufficient for the administration of needed inhalation drugs;

(B) Large Volume Nebulizer:

(i) A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or saline (A4217 or A7018) may be covered when it is medically appropriate to deliver humidity to a client with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent;

(ii) Combination code E0585 will be covered for the same indications as in (1)(a)(B)(i);

(D) The Division of Medical Assistance Programs (DMAP) will consider other uses of compressors/generators individually on a case by case basis, to determine their medical appropriateness, such as a battery powered compressor (E0571);

(b) Accessories:

(A) A large volume pneumatic nebulizer (E0580) and water or saline (A4217 or A7018) are not separately payable and should not be separately billed when used for clients with rented home oxygen equipment;

(B) DMAP does not cover use of a large volume nebulizer, related compressor/generator, and water or saline when used predominately to provide room humidification;

(C) A non-disposable unfilled nebulizer (A7017 or E0585) filled with water or saline (A4217 or A7018) by the client/caregiver is an acceptable alternative to the large volume nebulizer when used as indicated in (1)(a)(B)(i) of this rule;

(D) Kits and concentrates for use in cleaning respiratory equipment are not covered;

(E) Accessories are separately payable if the related aerosol compressor and the individual accessories are medically appropriate. The following table lists each covered compressor/ generator and its covered accessories. Other compressor/generator/accessory combinations are not covered;

(F) Compressor/Generator (Related Accessories): E0565 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7017, A7525, E1372); E0570 (A7003, A7004, A7005, A7006, A7013, A7015, A7525); E0571 (A7003, A7004, A7005, A7006, A7013, A7015, A7525) ; E0572 (A7006, A7014); E0585 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7525);

(G) This array of accessories represents all possible combinations but it may not be appropriate to bill any or all of them for one device;

(H) The following table lists the usual maximum frequency of replacement for accessories. DMAP will not cover claims for more than the usual maximum replacement amount unless the request has been prior approved by DMAP before dispensing. The provider must submit requests for more than the usual maximum replacement amount to DMAP for review;

Table 122-0204-1
Accessory (Usual maximum replacement)
A4619 (One/month)
A7003 (Two/month)
A7004 (Two/month (in addition to A7003))
A7005 (One/6 months)
A7006 (One/month)
A7010 (One unit (100 ft.)/2 months)
A7011 (One/year)
A7012 (Two/month)
A7013 (Two/month)

A7014 (One/3 months)
A7015 (One/month)
A7017 (One/3 years)
A7525 (One/month)
E1372 (One/3 years) .

(2) Coding Guidelines:

(a) Accessories:

(A) Code A7003, A7005, and A7006 include the lid, jar, baffles, tubing, T-piece and mouthpiece. In addition, code A7006 includes a filter;
(B) Code A7004 includes only the lid, jar and baffles;

(C) Code A7012 describes a device to collect water condensation, which is placed in line with the corrugated tubing, used with a large volume nebulizer;

(D) Code E0585 is used when a heavy-duty aerosol compressor (E0565), durable bottle type large volume nebulizer (A7017), and immersion heater (E1372) are provided at the same time. If all three items are not provided initially, the separate codes for the components would be used for billing.

(E) Code A7017 is billed for a durable, bottle type nebulizer when it is used with a E0572 compressor or a separately billed E0565 compressor.

(F) Code A7017 would not be separately billed when an E0585 system was also being billed. Code E0580 (Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flow meter) describes the same piece of equipment as A7017, but should only be billed when this type of nebulizer is used with a client-owned oxygen system;

(b) Equipment:

(A) In this policy, the actual equipment (i.e., electrical device) will generally be referred to as a compressor (when nebulization of liquid is achieved by means of air flow). The term nebulizer is generally used for the actual chamber in which the nebulization of liquid occurs and is an accessory to the equipment. The nebulizer is attached to an aerosol compressor in order to achieve a functioning delivery system for aerosol therapy;

(B) Code E0565 describes an aerosol compressor, which can be set for

pressures above 30 psi at a flow of 6-8 L/m and is capable of continuous operation;

(C) A nebulizer with compressor (E0570) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It is only AC powered;

(D) A portable compressor (E0571) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It must have battery or DC power capability and may have an AC power option;

(E) A light duty adjustable pressure compressor (E0572) is a pneumatic aerosol compressor which can be set for pressures above 30 psi at a flow of 6-8 L/m, but is capable only of intermittent operation.

(3) Documentation Requirements:

(a) When billing and dispensing for an item in Table 122-0204, medical records must corroborate that all criteria in this rule are met;

(b) When a battery powered compressor (E0571) is dispensed, supporting documentation which justifies the medical appropriateness must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider;

(c) The DMEPOS provider must maintain these medical records and make them available to DMAP on request.

(4) Table 122-0204-1 (above)

(5) Table 122-0204-2

Stat.Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0204-2 Nebulizer

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4217	Sterile water/saline, 500 ml.		PC				
A4619	Face Tent		PC				
A7003	Administration set, with small volume non-filtered pneumatic nebulizer, disposable		PC				
A7004	Small volume non-filtered pneumatic nebulizer, disposable		PC				
A7005	Administration set, with small volume non-filtered pneumatic nebulizer, non-disposable		PC				
A7006	Administration set, with small volume filtered pneumatic nebulizer		PC				
A7010	Corrugated tubing, disposable, used with large volume nebulizer (1 unit of service = 100 feet)		PC				
A7011	Corrugated tubing, non-disposable, used with large volume nebulizer (1 unit of service = 10 feet)		PC				
A7012	Water collection device, used with large volume nebulizer		PC				
A7013	Filter, disposable, used with aerosol compressor		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A7014	Filter, non-disposable, used with aerosol compressor or ultrasonic generator		PC				
A7015	Aerosol mask, used with DME nebulizer		PC				
A7016	Dome and mouthpiece, used with small volume ultrasonic nebulizer		PC				
A7017	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen		PC				
A7018	Water, distilled, used with large volume nebulizer (1 unit of service = 1,000 ml)		PC				
E0565	Compressor, air power source for equipment which is not self-contained or cylinder driven		PC	RT	13	RP	
E0570	Nebulizer, with compressor	PC	RT	13	RP		
E0571	Aerosol compressor, battery powered, for use with small volume nebulizer	PC		13			
E0572	Aerosol compressor, adjustable pressure, light duty for intermittent use		PC		13		
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter		PC				
E0585	Nebulizer, with compressor and heater		PC	RT	13	RP	
E1372	Immersion external heater for nebulizer		PC	RT	13	RP	

410-122-0205 Respiratory Assist Devices

(1) As referenced in this policy, non-invasive positive pressure respiratory assistance (NPPRA) is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy).

(2) Indications and Coverage -- General:

(a) The "treating prescribing practitioner" must be one who is qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of respiratory assist devices (RAD);

(b) For the purpose of this policy, polysomnographic studies must be performed in a sleep study laboratory, and not in the home or in a mobile facility. The sleep study laboratory must comply with all applicable state regulatory requirements;

(c) For the purpose of this policy, arterial blood gas, sleep oximetry and polysomnographic studies may not be performed by a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider. For purposes of this policy's coverage and payment guidelines, a DMEPOS provider is not considered a qualified provider or supplier of these tests;

(d) If there is discontinuation of usage of E0470 or E0471 device at any time, the provider is expected to ascertain this, and stop billing for the equipment and related accessories and supplies.

(3) Coverage criteria for E0470 and E0471 devices – Table 122-0205-1.

(4) Documentation:

(a) The following documentation must be submitted with the request for prior authorization (PA) and the original kept on file by the provider:

(A) An order for all equipment and accessories including the client's diagnosis, an ICD-9-CM code signed and dated by the treating prescribing practitioner;

(B) Summary of events from the polysomnogram, if required in this rule under the indications and coverage section or Table 122-0205-1;

(C) Arterial blood gas results, if required under the indications and coverage section or Table 122-0205-1;

(D) Sleep oximetry results, if required under the indications and coverage section or Table 122-0205-1;

(E) Treating prescribing practitioner statement regarding medical symptoms characteristic of sleep-associated hypoventilation, including, but not limited to daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, and dyspnea;

(F) Other treatments that have been tried and failed. To be submitted in addition to the above at the fourth month review.

(b) A copy of the Evaluation of Respiratory Assist Device (DMAP 2461) completed and signed by the client, family member or caregiver;

(c) Clients currently using BiPapS and BiPap ST are not subject to the new criteria.

(5) Procedure Codes -- Table 122-0205-2.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0205-1 Respiratory Assist Devices

Coverage criteria for E0470 and E0471 devices – First three months

For a RAD to be covered, the treating prescribing practitioner must fully document in the client's medical record symptoms characteristic of sleep-associated hypoventilation, such as:

- Daytime hypersomnolence
- Excessive fatigue
- Morning headache
- Cognitive dysfunction
- Dyspnea, etc.

A RAD used to administer NPPRA therapy is covered for those clients with clinical disorder groups characterized as one of the following:

Restrictive Thoracic Disorders – i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities

- There is documentation in the client's medical record of a progressive neuromuscular disease (for example, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB), and

  An arterial blood gas $PaCO_2$, done while awake and breathing the client's usual FIO_2, is >= 45 mm Hg, or
- Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the client's usual FIO_2
- For progressive neuromuscular disease (only), maximal inspiratory pressures less than 60 cm/H_2O or forced vital capacity is less than 50% predicted, and
- Chronic obstructive pulmonary disease does not contribute significantly to the client's pulmonary limitation

If all above criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating prescribing practitioner) will be covered for clients within this group of conditions for the first three months of NPPRA therapy (see below for continued coverage after the initial three months). If all of the above criteria are not met, then E0470 or E0471and related accessories will be denied as not medically appropriate.

Severe Chronic Obstructive Pulmonary Disease (COPD)

- An arterial blood gas $PaCO_2$, done while awake and breathing the client's usual FIO_2, is >= 52 mm Hg, and
- Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the client's usual FIO_2 (whichever is higher), and
- Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out

If all of the above criteria for clients with COPD are met, an E0470 device will be covered for the first three months of NPPRA therapy (see below for continued coverage after the initial three months). An E0471device will not be covered for a client with COPD during the first two months, because therapy with an E0470 device with proper adjustments of the device's settings and client accommodation to its use will usually result in sufficient improvement without the need of a back-up rate. See below for coverage of an E0471 device for COPD after two month's use of an E0470 device

- If the above criteria are not met, then E0470 and E0471 are not covered

Central Sleep Apnea (CSA) – i.e., apnea not due to airway obstruction:

- Prior to initiating therapy, a complete facility-based, attended polysomnogram must be performed documenting the following:
  - The diagnosis of central sleep apnea (CSA), and
  - The exclusion of obstructive sleep apnea (OSA) as the predominant cause of sleep-associated hypoventilation, and
  - The ruling out of CPAP as effective therapy if OSA is a component of the sleep-associated hypoventilation, and
  - Oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the client's usual FIO_2, and
  - Significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the client's usual FIO_2

If all above criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating prescribing practitioner) will be covered for clients with documented CSA conditions for the first three months of NPPRA therapy (see below for continued coverage after the initial three months)

Table 122-0205-1 Respiratory Assist Devices – cont'd

If all of the above criteria are not met, then E0470 or E0471 and related accessories are not covered

Obstructive Sleep Apnea (OSA) – E0470 only

- A complete facility-based, attended polysomnogram, has established the diagnosis of obstructive sleep apnea, and
- A single level device (E0601) has been tried and proven ineffective

If the above criteria are met, an E0470 device will be covered for the first three months of NPPRA therapy. See below for continued coverage after the initial three months

An E0471 device is not medically appropriate if the primary diagnosis is OSA

Continued coverage beyond the first three months of therapy

Clients covered for the first 3 months of an E0470 or E0471 device must be re-evaluated to establish the medical appropriateness of continued coverage by the Division of Medical Assistance Programs (DMAP) beyond the first three months. While the client may need to be evaluated at earlier intervals after this therapy is initiated, the re-evaluation upon which DMAP will base a decision to continue coverage beyond this time must occur within 61 to 90 days of initiating therapy by the treating prescribing practitioner. There must be documentation in the client's medical record about the progress of relevant symptoms and client usage of the device up to that time. Failure of the client to be consistently using the E0470 or E0471 device for an average of four hours per 24-hour period by the time of this 61-90 day re-evaluation would represent non-compliant utilization for the intended purposes and expectations of benefit of this therapy. This would constitute reason for DMAP to deny continued coverage as not medically appropriate.

Aside from the above documentation in the client's medical records, the following items of documentation must be obtained by the supplier of the device for continuation of coverage beyond three months:

- A signed and dated statement completed by the treating prescribing practitioner no sooner than 61 days after initiating use of the device, declaring that the client is compliantly using the device (an average of 4 hours per 24 hour period) and that the client is benefiting from its use, and
- An Evaluation of Respiratory Assist Device (DMAP 2461) completed by the client no sooner than 61 days after initiating use of the device (see below). A copy of this form is in the Durable Medical Equipment, Prosthetics, Orthotics,

and Supplies (DMEPOS) provider guide for you to copy and use. A copy is also available on DMAP's Web site but DMAP does not furnish paper copies.

If the above criteria are not met, continued coverage of an E0470 or E0471 device and related accessories will be denied as not medically appropriate.

For Group II clients (COPD) who qualified for an E0470 device, if at a time no sooner than 61 days after initial issue and compliant use of an E0470 device, the treating prescribing practitioner believes the client requires an E0471 device, the E0471 device will be covered if the following criteria are met:

- An arterial blood gas $PaCO_2$, repeated no sooner than 61 days after initiation of compliant use of the E0470, done while awake and breathing the client's usual FIO_2, still remains >= 52 mm Hg, and
- A sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of an E0470 device, and while breathing with the E0470 device, demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the client's usual FIO_2 (whichever is higher), and
- A signed and dated statement from the treating prescribing practitioner, completed no sooner than 61 days after initiation of the E0470 device, declaring that the client has been compliantly using the E0470 device (an average of four hours per 24 hour period) but that the client is NOT benefiting from its use, and
- An Evaluation of Respiratory Assist Device (DMAP 2461) completed by the client, no sooner than 61 days after initiation of the E0470 device.

Table 122-0205-2 Respiratory Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A7030	Full face mask used with positive airway pressure device, each ■ One per six months	PA	PC				NF
A7031	Face mask interface, replacement for full face mask, each ■ One per six months	PA	PC				NF
A7032	Replacement cushion for nasal application device, each ■ Two per month	PA	PC				NF
A7033	Replacement cushion for nasal application device, pair ■ Not separately covered with E0471	PA	PC				NF
A7034	Nasal application device, used with positive airway pressure devise ■ One per 3 months	PA	PC				NF
A7035	Headgear, used with positive airway pressure device ■ One per 6 months	PA	PC				NF
A7036	Chin strap, used with positive airway pressure device ■ One per 6 months	PA	PC				NF
A7037	Tubing, used with positive airway pressure device ■ One per month	PA	PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
A7038	Filter, disposable, used with positive airway pressure device ■ 2 per month	PA	PC				NF
A7039	Filter, non-disposable, used with positive airway pressure device ■ 1 per 6 months	PA	PC				NF
A7044	Oral, interface used with positive airway pressure device, each ■ 1 per 6 months	PA	PC				NF
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each ■ 1 per 6 months	PA	PC				NF
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with non-invasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) ■ All respiratory therapy services needed are included in the fee	PA	PC	RT	13	RP	NF
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with non-invasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) ■ The rental fee includes all equipment, supplies, services (including respiratory therapy services) and training necessary for the effective use of the RAD	PA	PC	RT	13	RP	NF

Code	Description	PA	PC	RT	MR	RP	NF
E0561	Humidifier, non-heated, used with positive airway pressure device	PA	PC	RT	13	RP	NF
E0562	Humidifier, heated, used with positive airway pressure device	PA	PC	RT	13	RP	NF
S8186	Swivel adapter		PC				NF

410-122-0206 Intermittent Positive Pressure Breathing (IPPB)

E0500, IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source the Division of Medical Assistance Programs (DMAP) will rent. Covered if medically appropriate for the following indications:

(1) Clients at risk of respiratory failure because of decreased respiratory function secondary to kyphoscoliosis or neuromuscular disorders.

(2) Clients with severe bronchospasm or exacerbated chronic obstructive pulmonary disease (COPD) who fail to respond to standard therapy.

(3) The management of atelectasis that has not improved with simple therapy.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-122-0207 Respiratory Supplies

Table 122-0207

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0207 Respiratory Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4614	Peak expiratory flow meter, hand-held		PC				
A4627	Spacer, bag or reservoir, with/without mask, for use with metered dose inhaler		PC				
E0480	Percussor, electric or pneumatic, home model ■ Covered for mobilizing respiratory tract secretions when the client or the operator of the powered percussor has received appropriate training by a prescribing practitioner or therapist and no one competent to administer manual therapy is available		PC	RT	13	RP	
E0605	Vaporizer, room type Covered for a funded respiratory illness		PC	RT	13		
E0606	Postural drainage board		PC	RT	13	RP	
J7051	Sterile saline or water, up to 5 ml each		PC				
S8185	Flutter device		PC				

410-122-0208 Suction Pumps

(1) Indications and Limitations of Coverage:

(a) Use of a home model respiratory suction pump may be covered for a client who has difficulty raising and clearing secretions secondary to:

(A) Cancer or surgery of the throat or mouth; or

(B) Dysfunction of the swallowing muscles; or

(C) Unconsciousness or obtunded state; or

(D) Tracheostomy; or

(E) Neuromuscular conditions.

(b)When a respiratory suction pump (E0600) is covered, tracheal suction catheters are separately payable supplies. In most cases, in the home setting, sterile catheters are medically appropriate only for tracheostomy suctioning. Three suction catheters per day are covered for medically appropriate tracheostomy suctioning, unless additional documentation is provided. When a tracheal suction catheter is used in the oropharynx, which is not sterile, the catheter can be reused if properly cleansed and/or disinfected. In this situation, the medical appropriateness for more than three catheters per week requires additional documentation;

(c) Sterile saline solution (A4216, A4217) may be covered and separately payable when used to clear a suction catheter after tracheostomy suctioning. It is not usually medically appropriate for oropharyngeal suctioning. Saline used for tracheal lavage is not covered;

(d) Supplies (A4628) are covered and are separately payable when they are medically appropriate and used with a medically appropriate suction pump (E0600) in a covered setting;

(e) When a suction pump (E0600) is used for tracheal suctioning, other supplies (e.g., cups, basins, gloves, solutions, etc.) are included in the tracheal care kit code, A4625–(see OAR 410-122-0209 for details). When a suction pump is used for oropharyngeal suctioning, these other supplies are not medically appropriate;

(f) The suction device must be appropriate for home use without technical or professional supervision. Those using the suction apparatus must be sufficiently trained to adequately, appropriately and safely use the device.

(2) A client's medical record must reflect the need for the supplies dispensed and billed. The medical record must be kept on file by the DME provider and made available to the Division of Medical Assistance Programs (DMAP) upon request.

(3) A portable or stationary home model respiratory suction pump (E0600) is an electric aspirator designed for oropharyngeal and tracheal suction.

(4) A portable or stationary home model gastric suction pump (E2000) is an electric aspirator designed to remove gastrointestinal secretions.

(5) A tracheal suction catheter is a long, flexible catheter.

(6) An oropharyngeal catheter is a short, rigid (usually) plastic catheter of durable construction.

(7) Code E0600 must not be used for a suction pump used with gastrointestinal tubes.

(8) Code E2000 must be used for a suction pump used with gastrointestinal tubes.

(9) Providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

(10) When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, there must be clear documentation in the client's medical records corroborating the medical appropriateness for the higher utilization. DMAP may request copies of the client's medical records that corroborate the order and any additional documentation that pertains to the medical appropriateness of items and quantities billed.

(3) Table 122-0208.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065 1-1-07

Table 122-0208 Suction Pumps

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4216	Sterile water/saline, 10 ml.		PC				
A4217	Sterile water/saline, 500 ml.		PC				
A4605	Tracheal suction catheter, each		PC				
A4628	Oropharyngeal suction catheter, each		PC				
A7000	Canister, disposable, used with suction pump, each		PC				
A7001	Canister, non-disposable, used with suction pump, each		PC				
A7002	Tubing, used with suction pump, each		PC				
E0600	Respiratory suction pump, home model, portable or stationary, electric		PC	RT	13	RP	*
E2000	Gastric suction pump, home model, portable or stationary, electric		PC	RT		13	

410-122-0209 Tracheostomy Care Supplies

(1) Indications and Coverage: For a client following an open surgical tracheostomy which has been open or is expected to remain open for at least three months.

(2) Documentation: A prescription for tracheal equipment which is signed by the prescribing practitioner must be kept on file by the DMEPOS provider. The prescribing practitioner's records must contain information which supports the medical appropriateness of the item ordered.

(3) Procedure Codes – Table 122-0209.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0209 Tracheostomy Care Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4481	Tracheostomy filter, any type, any size, each		PC				NF
A4483	Moisture exchanger, disposable		PC				NF
A4623	Tracheostomy, inner cannula		PC				NF
A4625	Tracheostomy care kit for new tracheostomy ■ Contains one plastic tray, one basin, one pair of sterile gloves, tube brush, three pipe cleaners, one pre-cut tracheostomy dressing, one roll of gauze, four 4x4 sponges, two cotton tip applicators, 30” twill tape ■ One tracheostomy care kit per day is covered for two weeks following an open surgical tracheostomy		PC				NF
A4626	Tracheostomy cleaning brush, each		PC				NF
A4629	Tracheostomy care kit for established tracheostomy ■ Contains one tube brush, two pipe cleaners, two cotton tip applicators, 30” twill tape, two 4x4 sponges		PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
	■ One tracheostomy care kit per day is considered necessary for routine care of a tracheostomy, starting with post-operative day 15						
A7501	Tracheostoma valve, including diaphragm, each		PC				NF
A7502	Replacement diaphragm/faceplate for tracheostoma valve, each		PC				NF
A7503	Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each		PC				NF
A7504	Filter for use in a tracheostoma heat and moisture exchange system, each		PC				NF
A7505	Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each		PC				NF
A7506	Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type, each		PC				NF
A7507	Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each		PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
A7508	Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each		PC				NF
A7509	Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each		PC				NF
A7520	Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each		PC				NF
A7521	Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each		PC				NF
A7522	Trachestomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each		PC				NF
A7524	Tracheostoma stent/stud/button, each		PC				NF
A7525	Tracheostomy mask, each		PC				NF
A7526	Tracheostomy tube/collar, each		PC				NF
A7527	Tracheostomy/laryngectomy tube plug/stop, each		PC				NF
S8189	Tracheostomy supply, not otherwise classified	PA	PC				NF

410-122-0210 Ventilators

(1) Indications and limitations of coverage:

(a) Mechanical ventilatory support may be provided to a client for the purpose of life support during therapeutic support of suboptimal cardiopulmonary function, or therapeutic support of chronic ventilatory failure;

(b) A ventilator may be covered by the Division of Medical Assistance Programs (DMAP) for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. This includes both positive and negative pressure types.

(2) Primary Ventilators:

(a) A primary ventilator may be covered if supporting documentation indicates:

(A) A client is unable to be weaned from the ventilator or is unable to be weaned from use at night; or

(B) Alternate means of ventilation were used without success; or

(C) A client is ready for discharge and has been on a ventilator more than 10 days.

(b) E0450, E0460, E0461 or E0472 may be covered if:

(A) A client has no respiratory drive either due to paralysis of the diaphragm or a central brain dysfunction; or

(B) A client has a stable, chronic condition with no orders to wean from the ventilator; or

(C) A client has had a trial with blood gases and has no signs or symptoms of shortness of breath or increased work of breathing; or

(D) A client has uncompromised lung disease;

(c) E0463 or E0464 may be covered if supporting documentation indicates:

(A) A client has chronic lung disease where volume ventilation may further damage lung tissue; or

(B) A client has a compromised airway or musculature and has respiratory drive and a desire to breathe; or

(C) A client will eventually be weaned from the ventilator; or

(D) A client has compromised respiratory muscles from muscular dystrophies or increased resistance from airway anomalies or scoliosis conditions.

(3) Backup Ventilators – A backup ventilator may be covered if supporting documentation indicates:

(a) The client is more than 60 minutes from the nearest hospital or a backup ventilator and has no documented spontaneous respirations; or

(b) Documentation supports medical appropriateness; or

(c) The client is transported frequently with a portable ventilator, and the ventilator is not a portable model; or

(d) The primary ventilator is used at maximum performance with high pressure and rate.

(4) Rental fee:

(a) The rental fee for the ventilator is all-inclusive of any equipment, supplies, services, including respiratory therapy (respiratory care) services, routine maintenance and training necessary for the effective use of the ventilator; and

(b) The ventilator provider must provide 24-hour emergency coverage, including an emergency telephone number; and

(c) The client must have a telephone or reasonable access to one.

(5) Payment authorization: Prior authorization (PA) is not required when E0450, E0460, E0461 or E0472 is dispensed as the primary ventilator. The provider is responsible to ensure all rule requirements are met. Payment authorization is required prior to the second date of service and before submitting claims. Payment authorization will be given once all required documentation has been received and any other applicable rules and criteria have been met. Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040.

(6) PA:

(a) PA is required for a backup ventilator; and

(b) Reimbursement for a backup ventilator is paid at 50% of the fee schedule amount, 50% of the manufacturer's suggested retail price (MSRP) or 50% of the actual charge, whichever is lowest.

(7) Documentation: For services requiring payment authorization or PA, submit documentation that supports requirements found in this rule.

Table 122-0210

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0210 Ventilators

For the code legend see OAR 410-122-0182

* See sections (5) and (6) of this rule for authorization requirements.

Code	Description	PA	PC	RT	MR	RP	NF
A4611	Battery, heavy duty; replacement for client-owned ventilator			PC			NF
A4612	Battery, cables; replacement for client-owned ventilator			PC			NF
A4613	Battery charger; replacement for client-owned ventilator			PC		RP	NF
A4618	Breathing circuits, for client-owned ventilator			PC			NF
E0450	Volume ventilator; stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube)		*		RT		NF
E0457	Chest shell (cuirass)	PA	PC	RT	13	RP	NF
E0459	Chest wrap	PA	PC	RT	13	RP	NF
E0460	Negative pressure ventilator; portable or stationary		*		RT		NF
E0461	Volume ventilator, stationary or * portable, with back-up rate feature used with non-invasive interface				RT		NF

Code	Description	PA	PC	RT	MR	RP	NF
E0463	Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube	PA		RT			NF
E0464	Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface (e.g., mask)	PA		RT			NF
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous position airway pressure device)	*	PC	RT	13	RP	NF
S8999	Resuscitation bag		PC				NF

410-122-0220 Pacemaker Monitor

(1) E0610 – Pacemaker monitor, self-contained, checks battery depletion, includes audible and visible check systems:

(a) The Division of Medical Assistance Programs (DMAP) will purchase;

(b) Also covered for payment by DMAP when client is a resident of a nursing facility.

(2) E0615 – Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems:

(a) DMAP will purchase;

(b) Also covered for payment by DMAP when client is a resident of a nursing facility.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.065

1-1-07

410-122-0240 Apnea Monitor for Infants

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) For infants less than 12 months of age with documented apnea, or who have known risk factors for life-threatening apnea, the Division of Medical Assistance Programs (DMAP) may cover home apnea monitors and related supplies for any of the following indications:

(A) Up to three months for:

(i) Apnea of prematurity: Sudden cessation of breathing that lasts for at least 20 seconds, is accompanied by bradycardia (heart rate less than 80 beats per minute), or is accompanied by oxygen desaturation (O2 saturation less than 90 % or cyanosis) in an infant younger than 37 weeks gestational age;

(ii) Apparent life-threatening event (ALTE): An episode that is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking, or gagging;

(iii) Documented gastroesophageal reflux disease (GERD) that results in apnea, bradycardia, or oxygen desaturation;

(iv) Documented prolonged apnea of greater than 20 seconds in duration;

(v) Documented apnea accompanied by bradycardia to less than 80 beats per minute;

(vi) Documented apnea accompanied by oxygen desaturation (below 90 %), cyanosis or pallor;

(vii) Documented apnea accompanied by marked hypotonia;

(viii) When off medication for bradycardia previously treated with caffeine, theophylline, or similar agents;

(B) Upon discharge from an acute care facility for up to one month post-diagnosis for diagnosis of pertussis, with positive cultures;

(C) As the later sibling of an infant who died of Sudden Infant Death Syndrome (SIDS), until the later sibling is one month older than the age at which the earlier sibling died and remains event-free;

(D) On a case by case basis for:

(i) Infants with tracheostomies or anatomic abnormalities that make them vulnerable to airway compromise;

(ii) Infants with neurologic or metabolic disorders affecting respiratory control;

(iii) Infants with chronic lung disease (bronchopulmonary dysplasia), especially those requiring supplemental oxygen, continuous positive airway pressure, or mechanical ventilation;

(b) Infant apnea monitors are usually considered medically appropriate for no longer than approximately three months except for specific conditions listed above;

(c) The rental fee includes all training, instruction, assistance, 24-hour on-call support and any other needed services for effective use of the apnea monitor, including cardiopulmonary resuscitation training. The durable medical equipment prosthetics orthotics and supplies (DMEPOS) provider is responsible for ensuring delivery of these services;

(d) DMAP may cover related supplies necessary for the effective functioning of the apnea monitorfor a three-month period, based on the following limitations:

(A) Electrodes, per pair (A4556) – 3 units;

(B) Lead wires, per pair (A4557) – 2 units;

(C) Conductive paste or gel (A4558) – 1 unit;

(D) Belts (A4649) – 2 units;

(e) The cost of apnea monitor rental includes the cost of cables;

(f) DMAP does not cover apnea monitors with memory recording (E0619) when the attending physician is monitoring the infant with ongoing sleep studies and pneumograms.

(2) Coding Guidelines: For billing purposes, use diagnosis code 798.0, Sudden Infant Death Syndrome (SIDS), for later siblings of infants who died of SIDS.

(3) Documentation Requirements: Submit the following information with the prior authorization request:

(a) Documentation (medical records including hospital records, sleep studies, physician's progress notes, physician-interpreted report from an apnea monitor with memory recording, etc.) of the episode or episodes that led to the diagnosis;

(b) An order from the physician who has diagnosed the infant as having clinically significant apnea or known risk factors for life-threatening apnea. The physician's order must indicate the specific type of apnea monitor (with or without recording feature) and detailed information about the type and quantity of related supplies needed;

(c) For an apnea monitor with recording feature (E0619), submit documentation that supports why an apnea monitor without recording feature (E0618) is not adequate to meet the medical need;

(d) When dispensing and billing for an item in Table 122-0240, the provider must ensure that documentation corroborates that all criteria in this rule are met;

(e) The DMEPOS provider must maintain documentation and make it available to DMAP on request.

(4) Table 122-0240

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0240 APNEA Monitor

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4649	Surgical supplies; miscellaneous	PA	PC				
A4556	Electrodes (e.g., apnea monitor) per pair	PA	PC				
A4557	Lead wires (e.g., apnea monitor) per pair	PA	PC				
A4558	Conductive paste or gel	PA	PC				
E0618	Apnea monitor without recording feature, monthly rental	PA		RT			
E0619	Apnea Monitor with recording feature, monthly rental	PA		RT			

410-122-0250 Breast Pumps

(1) Electric breast pumps will only be rented if documentation supports:

(a) Local resources were explored, e.g., Health Department, Hospital, etc.;

(b) Medical appropriateness for infant:

(A) Pre-term; or

(B) Term and hospitalized beyond five days; or

(C) Cleft palate or cleft lip; or

(D) Cranial-facial abnormalities; or

(E) Unable to suck adequately; or

(F) Re-hospitalized for longer than five days; or

(G) Failure to thrive.

(c) Medical appropriateness for mother:

(A) Has breast abscess; or

(B) Mastitis; or

(C) Hospitalized due to illness or surgery (for short-term use to maintain lactation); or

(D) Taking contraindicated medications (for short-term use to maintain lactation); and

(E) A hand pump or manual expression has been tried for one week without success in mothers with established milk supply.

(2) Other information:

(a) Electric pump is not for the comfort and convenience of the mother;

(b) Documentation that transition to breast feeding started as soon as the infant was stable enough to begin breast feeding;

(c) Use E1399 for an electric breast pump starter kit for single or double pumping;

(d) A starter kit will be reimbursed separately from the pump rental;

(e) Rental will not exceed 60 days;

(f) Supplemental Nutrition System (SNS), is not covered.

(3) Procedure Codes:

(a) E0602 – Breast pump, manual, any type – the Division of Medical Assistance Programs (DMAP) will purchase;

(b) E0603 – Breast pump, electric (AC and/or DC), any type, per day:

(A) DMAP will rent;

(B) Prior authorization required by DMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-122-0255 External Breast Prostheses

(1) Indications and Coverage:

(a) A breast prosthesis is covered for a client who has had a mastectomy;

(b) Useful lifetime expectancy:

(A) For silicon breast prosthesis two years;

(B) For fabric, foam, or fiber filled breast prostheses is six months.

(2) Procedure Codes: Table 122-0255.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0255 External Breast Prostheses

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4280	Adhesive skin support attachment for use with external breast prosthesis, each ■ Used when billing for an adhesive skin support that attaches an external breast prosthesis directly to the chest wall		PC				NF
L8000	Breast prosthesis, mastectomy bra ■ Four per year		PC				NF
L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral		PC				NF
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral		PC				NF
L8015	External breast prosthesis garment, with mastectomy form, post mastectomy ■ A camisole type undergarment with polyester fill used, post mastectomy. ■ An external breast prosthesis garment, with mastectomy form is covered for use in the post-operative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis.		PC				NF
L8020	Breast prosthesis, mastectomy form ■ One per year, per side		PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
L8030	Breast prosthesis, silicone or equal ■ One per year, per side		PC				NF
L8035	Custom breast prosthesis, post mastectomy, molded-to-client model ■ One per year, per side ■ A custom fabricated prosthesis is one which is individually made for a specific client starting with basic materials. ■ Describes a molded-to-client-model custom breast prosthesis. ■ Is a particular type of custom fabricated prosthesis in which an impression is made of the chest wall and this impression is then used to make a positive model of the chest wall. The prosthesis is then molded on this positive model.		PC				NF
L8039	Breast prosthesis, not otherwise classified	PA	PC				NF

410-122-0260 Home Uterine Monitoring

(1) The following criteria will be used to determine payment. Monitors will be approved for:

(a) Pre-term labor – this pregnancy:

(A) Incompetent cervix;

(B) Cervical cerclage;

(C) Polyhydramnios;

(D) Anomalies of the uterus;

(E) Cone biopsy;

(F) Cervical dilation or effacement;

(G) Unknown etiology.

(b) History of pre-term labor and/or delivery;

(c) Multiple gestation.

(2) Uterine monitoring will only be approved for the above conditions between the 24th and through the completion of the 36th week of pregnancy.

(3) The allowable rental fee for the uterine monitor includes all equipment, supplies, services and nursing visits necessary for the effective use of the monitor. This does not include medications or prescribing practitioner's professional services.

(4) The client must have a telephone or reasonable access to one. The Division of Medical Assistance Programs (DMAP) will not be responsible for providing the telephone.

(5) S9001 – Uterine home monitoring, with or without associated nursing services:

(a) Prior Authorization (PA) required;

(b) DMAP will rent.
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065 1-1-07

410-122-0280 Heating/Cooling Accessories

Procedure Codes for Heating/Cooling Accessories: Table 122-0280.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0280 Heating/Cooling Accessories

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4265	Paraffin, per pound		PC				
E0200	Heat lamp without stand (table model) includes bulb or infrared element		PC	RT	13		
E0205	with stand		PC	RT	13		
E0210	Electric heat pad – standard		PC				
E0215	moist		PC				
E0217	Water circulating heat pad with pump		PC	RT	13	RP	
E0220	Hot water bottle		PC				
E0230	Ice cap or collar		PC				
E0235	Paraffin bath unit portable (without paraffin)		PC	RT	13	RP	
E0236	Pump for water circulating pad		PC	RT	13	RP	
E0238	non-electric		PC				
E0249	Pad for water circulating heat unit		PC				

410-122-0300 Light Therapy

(1) Phototherapy (bilirubin light therapy):

(a)The Division of Medical Assistance Programs (DMAP) may cover home phototherapy for a term or near-term infant whose elevated bilirubin is not due to a primary hepatic disorder or other hemolytic disorder that requires inpatient care;

(b) E0202 includes equipment rental, supplies, delivery, set-up, pick-up, training, instruction and 24 hour on-call service necessary for the effective use of the equipment;

(c) Documentation by the treating physician must indicate home phototherapy is an appropriate treatment modality;

(d) The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must make supporting documentation available to DMAP on request.

(2) Table 122-0300

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0300 Light Therapy

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4633	Replacement bulb/lamp for ultraviolet light therapy system, each		PC				
E0202	Phototherapy (bilirubin) light with photometer						
	See (1)(a) above			RT			
E0691	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less	PA	PC	RT	13	RP	
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel	PA	PC	RT	13	RP	
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel	PA	PC	RT	13	RP	
E0694	Ultraviolet multi-directional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection	PA	PC	RT	13	RP	

410-122-0320 Manual Wheelchair Base

(1) Indications and Limitations of Coverage and/or Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a manual wheelchair 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 (MRADL) entirely; places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a 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 MRADL;

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

(C) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for use of the manual wheelchair that is being requested;

(D) Use of a manual wheelchair will significantly improve the client's ability to move within the home to the areas customarily used for their MRADL so that the client can complete these MRADLs within a reasonable time frame;

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

(F) The client has either:

(i) Sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the requested manual wheelchair in the home, during a typical day. Proper assessment of upper extremity function should consider limitations of strength, endurance, range of motion, coordination, presence of pain, and deformity or absence of one or both upper extremities; or

(ii) A caregiver who is available, willing, and able to provide assistance with the wheelchair;

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

(A) When the wheelchair 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 manual wheelchair will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home, a manual wheelchair 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 a manual wheelchair 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 manual wheelchair;

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

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

(c) DMAP does not reimburse for another wheelchair if the client has a medically appropriate wheelchair, regardless of payer;

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

(e) DMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves;

(f) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair, as well as support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education, and ongoing assistance with the use of the wheelchair;

(g) DMAP may cover an adult tilt-in-space wheelchair (E1161) when a client meets all of the following conditions:

(A) Is dependent for transfers;

(B) Spends a minimum of four hours a day continuously in a wheelchair;

(C) The client's plan of care addresses the need to change position at frequent intervals and the client is not left in the tilt position most of the time; and

(D) Has one of the following:

(i) High risk of skin breakdown;

(ii) Poor postural control, especially of the head and trunk;

(iii) Hyper/hypotonia;

(iv) Need for frequent changes in position and has poor upright sitting;

(h) DMAP may cover a standard hemi (low seat) wheelchair (K0002) when a client requires a lower seat height (17" to 18") because of short stature or needing assistance to place his/her feet on the ground for propulsion;

(i) DMAP may cover a lightweight wheelchair (K0003) when a client:

(A) Cannot self-propel in a standard wheelchair using arms and/or legs; and

(B) Can and does self-propel in a lightweight wheelchair;

(j) High-strength lightweight wheelchair (K0004):

(A) DMAP may cover a high-strength lightweight wheelchair (K0004) when a client:

(i) Self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; and/or

(ii) Requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair;

(B) If the expected duration of need is less than three months (e.g., post-operative recovery), a high-strength lightweight wheelchair is rarely medically appropriate;

(k) DMAP may cover an ultralightweight wheelchair (K0005) when a client has medical needs that require determination on a case by case basis;

(l) DMAP may cover a heavy-duty wheelchair (K0006) when a client weighs more than 250 pounds or has severe spasticity;

(m) DMAP may cover an extra heavy-duty wheelchair (K0007) when a client weighs more than 300 pounds;

(n) For more information on coverage criteria regarding repairs and maintenance, see 410-122-0184 Repairs, Maintenance, Replacement and Delivery;

(o) A manual wheelchair for use only outside the home is not covered.

(2) Coding Guidelines:

(a) Adult manual wheelchairs (K0001-K0007, K0009, E1161) have a seat width and a seat depth of 15” or greater;

(b) For codes K0001-K0007 and K0009, the wheels must be large enough and positioned so that the user can self-propel the wheelchair;

(c) In addition, specific codes are defined by the following characteristics:

(A) Adult tilt-in-space wheelchair (E1161):

(i) Ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining the same back-to-seat angle; and

(ii) Lifetime warranty on side frames and crossbraces;

(B) Standard wheelchair (K0001):

(i) Weight: Greater than 36 pounds; and

(ii) Seat height: 19” or greater; and

(iii) Weight capacity: 250 pounds or less;

(C) Standard hemi (low seat) wheelchair (K0002):

(i) Weight: Greater than 36 pounds; and

(ii) Seat height: Less than 19”; and

(iii) Weight capacity: 250 pounds or less;

(D) Lightweight wheelchair (K0003):

(i) Weight: 34-36 pounds; and

(ii) Weight capacity: 250 pounds or less;

(E) High strength, lightweight wheelchair (K0004):

(i) Weight: Less than 34 pounds; and

(ii) Lifetime warranty on side frames and crossbraces;

(F) Ultralightweight wheelchair (K0005):

(i) Weight: Less than 30 pounds;

(ii) Adjustable rear axle position; and

(iii) Lifetime warranty on side frames and crossbraces;

(G) Heavy duty wheelchair (K0006) has a weight capacity greater than 250 pounds;

(H) Extra heavy duty wheelchair (K0007) has a weight capacity greater than 300 pounds;

(d) Coverage of all adult manual wheelchairs includes the following features:

(A) Seat width: 15" - 19";

(B) Seat depth: 15" – 19”;

(C) Arm style: Fixed, swingaway, or detachable, fixed height;

(D) Footrests: Fixed, swingaway, or detachable;

(e) Codes K0003-K0007 and E1161 include any seat height;

(f) For individualized wheelchair features that are medically appropriate to meet the needs of a particular client, use the correct codes for the wheelchair base, options and accessories (see 410-122-0340 Wheelchair Options/Accessories);

(g) For wheelchair frames that are modified in a unique way to accommodate the client, submit the code for the wheelchair base used and submit the modification with code K0108 (wheelchair component or accessory, not otherwise specified);

(h) Wheelchair "poundage" (pounds) represents the weight of the usual configuration of the wheelchair with a seat and back, but without front riggings;

(i) A manual wheelchair with a seat width and/or depth of 14” or less is considered a pediatric size wheelchair and is billed with codes E1231-E1238 or E1229 (see 410-122-0720 Pediatric Wheelchairs);

(j) For more information on other features included in the allowance for the wheelchair base, see 410-122-0340 Wheelchair Options/Accessories;

(k) Contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) regarding correct coding. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation Requirements:

(a) Wheelchair and Seating Justification and Prescription form (DMAP 3125):

(A) Providers must submit this form or a reasonable facsimile for purchase and modifications of all manual wheelchairs except for K0001, K0002, or K0003 (unless modifications are required).

(B) Information must include, but is not limited to:

(i) Medical justification, needs assessment, prescription, and specifications for the wheelchair, completed by a physical therapist, occupational therapist or treating physician. The person who provides this information must have no direct or indirect financial relationship, agreement or contract with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider requesting authorization; and

(ii) Client identification and rehab technology supplier identification information which may be completed by the DMEPOS provider; and

(iii) Signature and date by the treating physician and physical or occupational therapist.

(C) If the information on this form includes all the elements of an order, the provider may submit the completed form in lieu of an order; and

(b) Additional Documentation:

(A) Information from a physical therapist, occupational therapist or treating physician that specifically indicates:

(i) The 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;

(B) Pertinent information from a physical therapist, occupational therapist or treating physician about the following elements that support coverage criteria are met for a manual wheelchair; 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 power wheelchair 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 a manual wheelchair or power mobility device;

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

(C) Documentation from a physical therapist, occupational therapist or treating physician that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home since DMAP

determines coverage of a wheelchair solely by the client's mobility needs within the home, even though a client who qualifies for coverage of a manual wheelchair may use the wheelchair outside the home; and

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

(E) 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; and

(F) For the home assessment, prior to or at the time of delivery of the wheelchair, 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 wheelchair. This 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

(G) All Healthcare Common Procedure Coding System (HCPCS) codes, including the base, options and accessories, whether prior authorization (PA) is required or not, that will be separately billed; and

(c) A written order by the treating physician, identifying the specific type of manual wheelchair needed. If the order does not specify the type requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific manual wheelchair that is being ordered and any options and accessories requested. The DMEPOS provider may enter the items on this order. This order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority; and

(d) For purchase of K0001, K0002 or K0003 (without modifications):

(A) Information from a physical therapist, occupational therapist or treating physician that specifically indicates:

(i) The 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;

(B) Pertinent information from a physical therapist, occupational therapist or treating physician about the following elements that support coverage criteria are met for a manual wheelchair;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 power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

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

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

(IV) 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 a manual wheelchair or power mobility device;

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

(C) Documentation from a physical therapist, occupational therapist or treating physician that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home since DMAP's coverage of a wheelchair is determined solely by the client's mobility needs within the home, even though a client who qualifies for coverage of a manual wheelchair may use the wheelchair outside the home; and

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

(E) 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 the age of the equipment and why it can't be grown or modified, if applicable;

(F) The DMAP 3125 (Wheelchair and Seating Justification and Prescription form or a reasonable facsimile is not required.

(e) For an ultralight wheelchair (K0005), documentation from a physical therapist, occupational therapist or treating physician that includes a description of the client's mobility needs within the home, even though a client who qualifies for coverage of a manual wheelchair may use the wheelchair outside the home. This may include what types of activities the client frequently encounters and whether the client is fully independent in the use of the wheelchair. Describe the features of the K0005 base which are needed compared to the K0004 base; and

(f) When code K0009 requested, all information from a physical therapist, occupational therapist or treating physician that justifies the medical appropriateness for the item; and

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

(h) The above documentation must be kept on file by the DMEPOS provider; and

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

(4) Table 122-0320.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0320 Manual Wheelchair Base

For the code legend see OAR 410-122-0182

* *May be covered when coverage criteria in this policy are met*

Code	Description	PA	PC	RT	MR	RP	NF
E1161	Manual adult size wheelchair, includes tilt-in-space	PA	PC	RT	13	RP	
K0001	Standard wheelchair	PA	PC	RT	13	RP	
K0002	Standard hemi (low seat) wheelchair	PA	PC	RT	13	RP	
K0003	Light-weight wheelchair	PA	PC	RT	13	RP	
K0004	High strength, light-weight wheelchair	PA	PC	RT	13	RP	
K0005	Ultra-light-weight wheelchair	PA	PC	RT	13	RP	
K0006	Heavy-duty wheelchair	PA	PC	RT	13	RP	
K0007	Extra heavy-duty wheelchair	PA	PC	RT	13	RP	
K0009	Other manual wheelchair/base	PA	PC	RT	13	RP	NF

410-122-0325 Motorized/Power Wheelchair Base

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a power wheelchair (PWC) (K0815-K0816, K0822-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) entirely; 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 DMAP 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 a 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, DMAP 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 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 home stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

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

(ii) If the physician saw the client to begin the examination before referring the client to a PT/OT, then if the physician sees the client again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician 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 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 signs and dates the PT/OT examination;

(iii) If the PWC is a replacement of a similar item that was previously covered by DMAP 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) DMAP 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. DMAP does not reimburse for adapting the living quarters;

(f) DMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are 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;

(g) Reimbursement for the wheelchair codes includes 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;

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

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

(j) The following are not covered:

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

(ii) Portable PWCs (K0813, K0814, K0820, K0821);

(iii) Seat elevator PWCs (K0830, K0831);

(iv) A PWC for use only outside the home.

(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 physical therapist (PT) or occupational therapist (OT), 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, 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 or OT, 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, 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 is unable to stand and pivot to transfer due to a neurological condition or myopathy; 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, or physician 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) and (2)(a) (E) (ii) are met; and

(ii) The Group 2 Single Power Option (2)(a)(C)(i)(I) and (2)(a)(C)(i)(II) or Multiple Power Options (criteria (2)(a)(D)(i)(I) and (2)(a)(D)(i)(II) 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):

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

(ii) Battery charger single mode (E2366);

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

(iv) 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;

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

(vi) 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;

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

(viii) Weight specific components per patient weight capacity;

(ix) 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 Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) 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:

(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 power-operated vehicle (POV/scooter) 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. Each element does not have to be addressed in every evaluation:

(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 DMAP's 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 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 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, 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 signature;

(G) Date of physician 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 that includes:

(i) The specific base (Healthcare Common Procedure Coding System (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 DMAP fee schedule allowance for each separately billed item;

(iii) If there is no DMAP 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 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 DMAP on request.

(4) Prior Authorization:

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

(b) See DMAP's fee schedule for more information;

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

(d) Rented equipment is considered purchased when the client has used the equipment for 13 months, when the provider's actual charge for purchase is met, when the manufacturer's suggested retail price (MSRP) is met or when DMAP's fee schedule allowable for purchase is met, whichever is the lowest;

(e) For PWC's furnished on a rental basis with dates of services prior to November 15, 2006, use codes K0010, K0011, K0012 and K0014 as appropriate.

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Stats. Implemented: ORS 414.065

1-1-07

410-122-0330 Power-Operated Vehicle

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a power-operated vehicle (POV) 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) entirely; 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 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 features an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories;

(D) The client has sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV in the home;

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

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

(b) For a POV to be covered, the treating physician must conduct a face-to-face examination of the client before writing the order.

(A)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.

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

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

(ii) If the physician saw the client to begin the examination before referring the client to a PT/OT, then if the physician sees the client again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician 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 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 signs and dates the PT/OT examination;

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

(c) DMAP may authorize a new POV when a client's existing POV is no longer medically appropriate; or repair and/or modifications to the POV exceed replacement costs;

(d) If a client has a medically appropriate POV regardless of payer, DMAP will not reimburse for another POV;

(e) The cost of the POV includes all options and accessories that are provided at the time of initial purchase, including but not limited to batteries, battery chargers, seating systems, etc.;

(f) Reimbursement for the POV includes all labor charges involved in the assembly of the POV 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 POV;

(g) If a patient-owned POV meets coverage criteria, medically appropriate replacement items, including but not limited to batteries, may be covered;

(h) If a POV is covered, a manual or power wheelchair provided at the same time or subsequently will usually be denied as not medically appropriate;

(i) DMAP will cover one month's rental of a POV if a client-owned POV is being repaired;

(j) A POV for use only outside the home is not covered.

(2) Coding Guidelines:

(a) Code E1230 is used only for POVs that can be operated inside the home;

(b) Code E1230 is not used for a manual wheelchair with an add-on tiller control power pack;

(c) A replacement item, including but not limited to replacement batteries, should be requested using the specific wheelchair option or accessory code if one exists (see 410-122-0340, Wheelchairs Options/Accessories). If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified);

(d) For guidance on correct coding, DMEPOS providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

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.

(A) The 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) This client's physical and mental abilities to operate a POV (scooter) safely in the home;

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in MRADLs, how these conditions will be ameliorated or compensated.

(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. Each element does not have to be addressed in every evaluation:

(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 power wheelchair 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 POV may use that device outside the home, because the DMAP coverage of a POV 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 written order, received by the DMEPOS provider within 30 days after the physician's face-to-face examination, which includes all of the following elements:

(A) Client's name;

(B) Description of the item that is ordered. This may be general – e.g., "POV" or "power mobility device"– or may be more specific;

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

(ii) The items on this order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority, but does not have to be received within 30 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 POV;

(E) Length of need;

(F) Physician's signature;

(G) Date of physician signature;

(c) For all requested equipment and accessories, include 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 the age of the equipment and why it can't be grown or modified, if applicable;

(e) A written evaluation of the client's living quarters, performed by the DMEPOS provider. This assessment must support that the client's home can accommodate and allow for the effective use of a POV, including, but is not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps), electrical service, etc; and

(f) All Healthcare Common Procedure Coding System codes (HCPCS) to be billed on this claim (both codes that require authorization and those that do not require authorization); and

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

(h) The above documentation must be kept on file by the DMEPOS provider;

(i) Documentation that the coverage criteria have been met must be present in the client's medical record. This documentation and any additional medical

information from the DMEPOS provider must be made available to DMAP on request.

(4) E1230 – Power operated vehicle (3 or 4 wheel, non-highway):

(a) PA required;

(b) DMAP will purchase, rent and repair;

(c) Item considered purchased after 13 months of rent.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-122-0340 Wheelchair Options/Accessories

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover options and accessories for covered wheelchairs when the following criteria are met:

(A) The client has a wheelchair that meets DMAP coverage criteria; and

(B) The client requires the options/accessories to accomplish their mobility-related activities of daily living (MRADLs) in the home. See 410-122-0010 Definitions for definition of MRADLs;

(b) DMAP does not cover options/accessories whose primary benefit is allowing the client to perform leisure or recreational activities;

(c) Arm of Chair

(A) Adjustable arm height option (E0973, K0017, K0018, K0020) may be covered when the client:

(i) Requires an arm height that is different than what is available using nonadjustable arms; and

(ii) Spends at least two hours per day in the wheelchair;

(B) An arm trough (K0106) is covered if the client has quadriplegia, hemiplegia, or uncontrolled arm movements;

(d) Footrest/Legrest:

(A) Elevating legrests (E0990, K0046, K0047, K0053, K0195) may be covered when:

(i) The client has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or

(ii) The client has significant edema of the lower extremities that requires having an elevating leg rest; or

(iii) The client meets the criteria for and has a reclining back on the wheelchair;

(B) Elevating leg rests that are used with a wheelchair that is purchased or owned by the patient are coded E0990. This code is per leg rest;

(C) Elevating leg rests that are used with a capped rental wheelchair base should be coded K0195. This code is per pair of leg rests;

(e) Nonstandard Seat Frame Dimensions:

(A) For all adult wheelchairs , DMAP includes payment for seat widths and/or seat depths of 15-19 inches in the payment for the base code. These seat dimensions must not be separately billed;

(B) Codes E2201-E2204 and E2340-E2343 describe seat widths and/or depths of 20 inches or more for manual or power wheelchairs;

(C) A nonstandard seat width and/or depth (E2201-E2204 and E2340-E2343) is covered only if the patient's dimensions justify the need;

(f) Rear Wheels for Manual Wheelchairs: Code K0064 (flat free insert) is used to describe either:

(A) A removable ring of firm material that is placed inside of a pneumatic tire to allow the wheelchair to continue to move if the pneumatic tire is punctured; or

(B) Nonremovable foam material in a foam filled rubber tire;

(C) K0064 is not used for a solid self-skinning polyurethane tire;

(g) Batteries/Chargers:

(A) Up to two batteries (E2360-E2365) at any one time are allowed if required for a power wheelchair;

(B) Batteries/chargers for motorized/power wheelchairs are separately payable from the purchased wheelchair base;

(h) Seating:

(A) DMAP may cover a general use seat cushion and a general use wheelchair back cushion for a client whose wheelchair that meets DMAP coverage criteria;

(B) A skin protection seat cushion may be covered for a client who meets both of the following criteria:

(i) The client has a wheelchair that meets DMAP coverage criteria; and

(ii) The client has either of the following:

(I) Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or

(II) Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis), post polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease;

(C) A positioning seat cushion, positioning back cushion, and positioning accessory (E0955-E0957, E0960) may be covered for a client who meets both of the following criteria:

(i) The client has a wheelchair that meets DMAP coverage criteria; and

(ii) The client has any significant postural asymmetries due to one of the diagnoses listed in criterion (h)(A)(ii)(II) or to one of the following diagnoses: monoplegia of the lower limb; hemiplegia due to stroke, traumatic brain injury, or other etiology; muscular dystrophy; torsion dystonias; spinocerebellar disease;

(D) A combination skin protection and positioning seat cushion may be covered when a client meets the criteria for both a skin protection seat cushion and a positioning seat cushion;

(E) Separate payment is allowed for a seat cushion solid support base (E2618) with mounting hardware when it is used on an adult manual wheelchair (K0001-K0009, E1161) or ligh0tweight power wheelchair (K0012). There is no separate payment when this is used with other types of power wheelchairs because those wheelchairs include a solid support base;

(F) There is no separate payment for a solid insert (E0992) that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion;

(G) There is no separate payment for mounting hardware for a seat or back cushion;

(H)There is no separate payment for a headrest (E0955, E0966) on a captain’s seat on a power wheelchair;

(I) A custom fabricated seat cushion (E2609) and a custom fabricated back cushion (E2617) are cushions that are individually made for a specific patient.

(i) Basic materials include liquid foam or a block of foam and sheets of fabric or liquid coating material;

(I) A custom fabricated cushion may include certain prefabricated components (e.g., gel or multi-cellular air inserts); these components must not be billed separately;

(II) The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface;

(ii) The cushion must be fabricated using molded-to-patient-model technique, direct molded-to-patient technique, CAD-CAM technology, or detailed measurements of the patient used to create a configured cushion;

(I) If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual client, the cushion must be billed as a prefabricated cushion, not custom fabricated;

(II) The cushion must have structural features that significantly exceed the minimum requirements for a seat or back positioning cushion;

(iii) If a custom fabricated seat and back are integrated into a one-piece cushion, code as E2609 plus E2617;

(J) A custom fabricated seat cushion may be covered if criteria (I) and (III) are met. A custom fabricated back cushion may be covered if criteria (II) and (III) are met:

(I) Client meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion;

(II) Client meets all of the criteria for a prefabricated positioning back cushion;

(III) There is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider) which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs;

(J) A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion which has not received a written coding verification from the Statistical Analysis DME Regional Carrier SADMERC or which does not meet the criteria stated in this rule is not covered;

(K) A headrest extension (E0966) is a sling support for the head. Code E0955 describes any type of cushioned headrest;

(L) The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, that is an integral part of the cushion;

(M) A solid insert (E0992) is a separate rigid piece of wood or plastic which is inserted in the cover of a cushion to provide additional support and is included in the allowance for a seat cushion;

(N) A solid support base for a seat cushion is a rigid piece of plastic or other material that is attached with hardware to the seat frame of a wheelchair in place of a sling seat. A cushion is placed on top of the support base. Use code E2618 for this solid support base;

(i) DMAP will only cover accessories billed under the following codes when SADMERC has made written confirmation of use of the code for the specific product(s) being billed: E2601-E2608, E2611-E2616, E2620, E2621; E2609 and E2617 (brand-name products), K0108 (for wheelchair cushions).

(A) Information concerning the documentation that must be submitted to the SADMERC for a Coding Verification Request can be found on the SADMERC Web site or by contacting the SADMERC;

(B) A Product Classification List with products that have received a coding verification can be found on the SADMERC Web site;

(j) Code E1028 (swingaway or removable mounting hardware upgrade) may be billed in addition to codes E0955-E0957. It must not be billed in addition to code E0960. It must not be used for mounting hardware related to a wheelchair seat cushion or back cushion code;

(k) Power seating systems:

(A) A power tilt seating system (E1002):

(i) Includes all the following:

(I) A solid seat platform and a solid back; any frame width and depth;

(II) Detachable or flip-up fixed height or adjustable height armrests;

(III) Fixed or swingaway detachable leg rests;

(IV) Fixed or flip-up footplates;

(V) Motor and related electronics with or without variable speed programmability;

(VI) Switch control that is independent of the power wheelchair drive control interface;

(VII) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability for the supplier to adjust the seat to back angle;

(IV) Ability to support patient weight of at least 250 pounds.

(B) A power recline seating system (E1003-E1005):

(i) Includes all the following:

(I) A solid seat platform and a solid back;

(II) Any frame width and depth;

(III) Detachable or flip-up fixed height or adjustable height arm rests;

(IV) Fixed or swingaway detachable leg rests;

(V) Fixed or flip-up footplates;

(VI) A motor and related electronics with or without variable speed programmability;

(VII) A switch control that is independent of the power wheelchair drive control interface;

(VIII) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to recline to greater than or equal to 150 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability to support patient weight of at least 250 pounds.

(C) A power tilt and recline seating system (E1006-E1008)

(i) Includes the following:

(I) A solid seat platform and a solid back;

(II) Any frame width and depth; detachable or flip-up fixed height or adjustable height armrests;

(III) Fixed or swingaway detachable leg rests; fixed or flip-up footplates;

(IV) Two motors and related electronics with or without variable speed programmability;

(V) Switch control that is independent of the power wheelchair drive control interface;

(VI) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Ability to recline to greater than or equal to 150 degrees from horizontal;

(III) Back height of at least 20 inches; ability to support patient weight of at least 250 pounds.

(D) A mechanical shear reduction feature (E1004 and E1007) consists of two separate back panels. As the posterior back panel reclines or raises, a mechanical linkage between the two panels allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(E) A power shear reduction feature (E1005 and E1008) consists of two separate back panels. As the posterior back panel reclines or raises, a separate motor controls the linkage between the two panels and allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(F) A power leg elevation feature (E1010) involves a dedicated motor and related electronics with or without variable speed programmability which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s);

(j) Codes E2310 and E2311 (Power Wheelchair Accessory):(A) Describe the electronic components that allow the client to control two or more of the following motors from a single interface (e.g., proportional joystick, touchpad, or nonproportional interface): power wheelchair drive, power tilt, power recline, power shear reduction, power leg elevation, power seat elevation, power standing;

(B) Include a function selection switch that allows the client to select the motor that is being controlled and an indicator feature to visually show which function has been selected;

(C) When the wheelchair drive function is selected, the indicator feature may also show the direction that is selected (forward, reverse, left, right). This indicator feature may be in a separate display box or may be integrated into the wheelchair interface;

(D) Payment for the code includes an allowance for fixed mounting hardware for the control box and for the display box (if present);

(E) When a switch is medically appropriate and a client has adequate hand motor skills, a switch would be considered the least costly alternative;

(F) E2310 or E2311 may be considered for coverage when a client does not have hand motor skills or presents with cognitive deficits, contractures or limitation of movement patterns that prevents operation of a switch;

(G) In addition, an alternate switching system must be medically appropriate and not hand controlled (not running through a joystick);

(H) If a wheelchair has an electrical connection device described by code E2310 or E2311 and if the sole function of the connection is for a power seat elevation or power standing feature, it is not covered;

(k) Power Wheelchair Drive Control Systems:

(A) The term interface in the code narrative and definitions describes the mechanism for controlling the movement of a power wheelchair. Examples of

interfaces include, but are not limited to, joystick, sip and puff, chin control, head control, etc.;

(B) A proportional interface is one in which the direction and amount of movement by the client controls the direction and speed of the wheelchair. One example of a proportional interface is a standard joystick;

(C) A nonproportional interface is one that involves a number of switches. Selecting a particular switch determines the direction of the wheelchair, but the speed is pre-programmed. One example of a nonproportional interface is a sip-and-puff mechanism;

(D) The term controller describes the microprocessor and other related electronics that receive and interpret input from the joystick (or other drive control interface) and convert that input into power output to the motor and gears in the power wheelchair base;

(E) A switch is an electronic device that turns power to a particular function either “on” or “off”. The external component of a switch may be either mechanical or nonmechanical. Mechanical switches involve physical contact in order to be activated. Examples of the external components of mechanical switches include, but are not limited to, toggle, button, ribbon, etc. Examples of the external components of nonmechanical switches include, but are not limited to, proximity, infrared, etc. Some of the codes include multiple switches. In those situations, each functional switch may have its own external component or multiple functional switches may be integrated into a single external switch component or multiple functional switches may be integrated into the wheelchair control interface without having a distinct external switch component;

(F) A stop switch allows for an emergency stop when a wheelchair with a nonproportional interface is operating in the latched mode. (Latched mode is when the wheelchair continues to move without the patient having to continually activate the interface.) This switch is sometimes referred to as a kill switch;

(G) A direction change switch allows the client to change the direction that is controlled by another separate switch or by a mechanical proportional head control interface. For example, it allows a switch to initiate forward movement one time and backward movement another time;

(H) A function selection switch allows the client to determine what operation is being controlled by the interface at any particular time. Operations may include, but are not limited to, drive forward, drive backward, tilt forward, recline backward, etc.;

(I) An integrated proportional joystick and controller is an electronics package in which a joystick and controller electronics are in a single box, which is mounted on the arm of the wheelchair;

(J) The interfaces described by codes E2320-E2322, E2325, and E2327-E2330 must have programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking;

(K) A remote joystick (E2320, E2321) is one in which the joystick is in one box that is mounted on the arm of the wheelchair and the controller electronics are located in a different box that is typically located under the seat of the wheelchair. These codes include remote joysticks that are used for hand control as well as joysticks that are used for chin control. Code E2320 includes any type of proportional remote joystick stick including, but not limited to standard, mini-proportional, compact, and short throw remote joysticks;

(L) When code E2320 or E2321 is used for a chin control interface, the chin cup is billed separately with code E2324;

(M) Code E2320 also describes a touchpad that is an interface similar to the pad-type mouse found on portable computers;

(N) Code E2322 describes a system of 3-5 mechanical switches that are activated by the client touching the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch, if provided, are included in the allowance for the code;

(O) Code E2323 includes prefabricated joystick handles that have shapes other than a straight stick – e.g., U shape or T shape – or that have some other nonstandard feature – e.g., flexible shaft;

(P) A sip and puff interface (E2325) is a nonproportional interface in which the client holds a tube in their mouth and controls the wheelchair by either sucking in (sip) or blowing out (puff). A mechanical stop switch is included in the allowance for the code. E2325 does not include the breath tube kit that is described by code E2326;

(Q) A proportional, mechanical head control interface (E2327) is one in which a headrest is attached to a joystick-like device. The direction and amount of movement of the client’s head pressing on the headrest control the direction and speed of the wheelchair. A mechanical direction control switch is included in the code;

(R) A proportional, electronic head control interface (E2328) is one in which a client's head movements are sensed by a box placed behind the client's head. The direction and amount of movement of the client's head (which does not come in contact with the box) control the direction and speed of the wheelchair. A proportional, electronic extremity control interface (E2328) is one in which the direction and amount of movement of the client's arm or leg control the direction and speed of the wheelchair;

(S) A nonproportional, contact switch head control interface (E2329) is one in which a client activates one of three mechanical switches placed around the back and sides of their head. These switches are activated by pressure of the head against the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code;

(T) A nonproportional, proximity switch head control interface (E2330) is one in which a client activates one of three switches placed around the back and sides of their head. These switches are activated by movement of the head toward the switch, though the head does not touch the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code;

(U) Code E2399 (not otherwise classified interface) is appropriately used in the following situations:

(i) An integrated proportional joystick and controller box are being replaced due to damage; or

(ii) The item being replaced is a remote joystick box only (without the controller); or

(iii) The item being replaced is another type of interface, e.g. sip and puff, head control without the controller); or

(iv) The item being replaced is the controller box only (without the remote joystick or other type of interface); or

(v) There is no specific E code that describes the type of drive control interface system that is provided. In this situation, E2399 would be used at the time of initial issue or if the item was being provided as a replacement;

(V) The KC modifier (replacement of special power wheelchair interface):

(i) Is used in the following situations:

(I) Due to a change in the client's condition an integrated joystick and controller is being replaced by another drive control interface – e.g., remote joystick, head control, sip and puff, etc.; or

(II) The client has a drive control interface described by codes E2320-E2322, E2325, or E2327-E2330 and both the interface (e.g., joystick, head control, sip and puff) and the controller electronics are being replaced due to irreparable damage;

(ii) The KC modifier is never used at the time of initial issue of a wheelchair;

(iii) The KC modifier specifically states replacement, therefore, the RP modifier is not required. The KC modifier is not used when billing code E2399;

(l) Other Power Wheelchair Accessories: An electronic interface (E2351) to allow a speech generating device to be operated by the power wheelchair control interface may be covered if the client has a covered speech generating device. (See Division 129, Speech-Language Pathology, Audiology and Hearing Aid Services.);

(m) Miscellaneous Accessories:

(A) Anti-rollback device (E0974) is covered if the client propels himself/herself and needs the device because of ramps;

(B) A safety belt/pelvic strap (E0978) is covered if the client has weak upper body muscles, upper body instability or muscle spasticity that requires use of this item for proper positioning;

(C) A shoulder harness/straps or chest strap (E0960) and a safety belt/pelvic strap (E0978) are covered only to treat a client's medical symptoms;
(I) A medical symptom is defined as an indication or characteristic of a physical or psychological condition;
(II) E0960 and E0978 are not covered when intended for use as a physical restraint or for purposes intended for discipline or convenience of others;

(D) One example (not all-inclusive) of a covered indication for swingaway, retractable, or removable hardware (E1028) would be to move the component out of the way so that a client could perform a slide transfer to a chair or bed;

(E) A fully reclining back option (E1226) is covered if the client spends at least 2 hours per day in the wheelchair and has one or more of the following conditions/needs:

(i) Quadriplegia;

(ii) Fixed hip angle;

(iii) Trunk or lower extremity casts/braces that require the reclining back feature for positioning;

(iv) Excess extensor tone of the trunk muscles; and/or

(v) The need to rest in a recumbent position two or more times during the day and transfer between wheelchair and bed is very difficult.

(2) Documentation Requirements: Submit documentation that supports coverage criteria in this rule are met and the specified information as follows with the prior authorization (PA) request:

(a) A Certificate of Medical Necessity (CMN) or reasonable facsimile for E0973, E0990, K0017, K0018, K0020, E1226, K0046, K0047, K0053, and K0195. For these items, the CMN may act as a substitute for a written order if it contains all of the required elements of an order. Depending on the type of wheelchair, the CMN for these options/accessories is either CMS Form 843 (power wheelchairs) or CMS Form 844 (manual wheelchairs);

(b) When code K0108 is billed, a narrative description of the item, the manufacturer, the model name or number (if applicable), and information justifying the medical appropriateness for the item;

(c) Options/accessories for individual consideration might include documentation on the client's diagnosis, the client's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the client performs, etc.), the duration of the condition, the expected prognosis, past experience using similar equipment;

(d) For a custom-fabricated seat cushion:

(A) A comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a DMEPOS provider) which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs, and;

(B) Diagnostic reports that support the medical condition;

(C) Dated and clear photographs;

(D) Body contour measurements;

(e) Documentation that the coverage criteria in this rule have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to DMAP on request.

(3) Table 122-0340

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Stats. Implemented: ORS 414.065

1/1/07

Table 122-0340 Wheelchair Options/Accessories

For the code legend see 410-122-0182

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
Arm of Chair							
E0973	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each		PC	RT	13	RP	*
K0015	Detachable, non-adjustable height armrest, each		PC	RT	13	RP	*
K0017	Detachable, adjustable height armrest, base, each		PC	RT	13	RP	*
K0018	Detachable, adjustable height armrest, upper portion, each		PC	RT	13	RP	*
K0019	Arm pad, each		PC	RT	13	RP	*
K0020	Fixed, adjustable height armrest, pair		PC	RT	13	RP	*
K0106	Arm trough, each		PC	RT	13	RP	*
L3964	Shoulder elbow orthosis, mobile arm support attached to w/c, balanced, adjustable, prefabricated, includes fitting and adjustment	PA	PC				
L3965	Shoulder elbow orthosis, mobile arm support attached to w/c, balanced, adjustable rancho type, prefabricated, includes fitting and adjustment	PA	PC				
L3966	Shoulder elbow orthosis, mobile arm support attached to w/c, balanced, reclining, prefabricated, includes fitting and adjustment	PA	PC				

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
L3968	Shoulder elbow orthosis, mobile arm support attached to w/c, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment	PA	PC				
L3969	Shoulder elbow orthosis, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support, prefabricated, includes fitting and adjustment	PA	PC				
L3970	SEO, addition to mobile arm support, elevating proximal arm	PA	PC				
L3972	SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	PA	PC				
L3974	SEO, addition to mobile arm support, supinator	PA	PC				
Footrest/Legrest							
E0951	Heel loop/holder, any type, with or without ankle strap, each		PC	RT	13	RP	*
E0952	Toe loop/holder, any type, each		PC	RT	13	RP	*
E0990	Wheelchair accessory, elevating legrest, complete assembly, each		PC	RT	13	RP	*
E0995	Wheelchair accessory, calf rest/pad, each		PC	RT	13	RP	*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E1020	Residual limb support system for wheelchair		PC	RT	13	RP	*
K0037	High mount flip-up footrest, each		PC	RT	13	RP	*
K0038	Leg strap, each		PC	RT	13	RP	*
K0039	Leg strap, H style, each		PC	RT	13	RP	*
K0040	Adjustable angle foot-plate, each		PC	RT	13	RP	*
K0041	Large size foot-plate, each		PC	RT	13	RP	*
K0042	Standard size foot-plate, each		PC	RT	13	RP	*
K0043	Footrest, lower extension tube, each		PC	RT	13	RP	*
K0044	Footrest, upper hanger bracket, each		PC	RT	13	RP	*
K0045	Footrest, complete assembly		PC	RT	13	RP	*
K0046	Elevating leg rest, lower extension tube, each		PC	RT	13	RP	*
K0047	Elevating leg rest, upper hanger bracket, each		PC	RT	13	RP	*
K0050	Ratchet assembly		PC	RT	13	RP	*
K0051	Cam release assembly, footrest or leg rest, each		PC	RT	13	RP	*
K0052	Swing-away, detachable footrests, each, replacement		PC	RT	13	RP	*
K0053	Elevating footrests, articulating (telescoping), each		PC	RT	13	RP	*
K0195	Elevating leg rests, pair (for use with capped rental wheelchair base)			RT			*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
Nonstandard Seat Frame Dimensions							
E2201	Manual wheelchair accessory, non-standard seat frame, width greater than or equal to 20 inches and less than 24 inches		PC	RT	13	RP	
E2202	Manual wheelchair accessory, non-standard seat frame width, 24-27 inches		PC	RT	13	RP	
E2203	Manual wheelchair accessory, non-standard seat frame depth, 20 to less than 22 inches		PC	RT	13	RP	
E2204	Manual wheelchair accessory, non-standard seat frame depth, 22 to 25 inches		PC	RT	13	RP	
E2340	Power wheelchair accessory, non-standard seat frame width, 20-23 inches		PC	RT	13	RP	*
E2341	Power wheelchair accessory, non-standard seat frame width, 24-27 inches		PC	RT	13	RP	*
E2342	Power wheelchair accessory, non-standard seat frame depth, 20 or 21 inches		PC	RT	13	RP	*
E2343	Power wheelchair accessory, non-standard seat frame depth, 22-25 inches		PC	RT	13	RP	*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
K0056	Seat height < 17” or > 21” for a high strength, lightweight or ultra-lightweight wheelchair		PC	RT	13	RP	
Rear Wheels for Manual Wheelchairs							
E0961	Manual wheelchair accessory, wheel lock brake extension (handle), each		PC	RT	13	RP	*
E0967	Manual wheelchair accessory, hand rim with projections, any type, replacement only, each		PC	RT			
E2205	Manual wheelchair accessory, handrim without projections, any type, replacement only, each		PC	RT			
E2206	Manual wheelchair accessory, wheel lock assembly, complete, each		PC	RT	13	RP	*
K0064	Zero pressure tube (flat free inserts), any size, each		PC	RT	13	RP	*
K0065	Spoke protectors, each		PC	RT	13	RP	*
K0066	Solid tire, any size, each		PC	RT	13	RP	*
K0067	Pneumatic tire, any size, each		PC	RT	13	RP	*
K0068	Pneumatic tire tube, each		PC	RT	13	RP	*
K0069	Rear wheel assembly, complete, with solid tire, spokes or molded, each		PC	RT	13	RP	*
K0070	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each		PC	RT	13	RP	*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
Front Casters for Manual Wheelchairs							
K0071	Front caster assembly, complete, with pneumatic tire, each		PC	RT	13	RP	*
K0072	Front caster assembly, complete, with semi-pneumatic tire, each		PC	RT	13	RP	*
K0073	Caster pin lock, each		PC	RT	13	RP	*
K0074	Pneumatic caster tire, any size, each		PC	RT	13	RP	*
K0075	Semi-pneumatic caster tire, any size, each		PC	RT	13	RP	*
K0076	Solid caster tire, any size, each		PC	RT	13	RP	*
K0077	Front caster assembly, complete, with solid tire, each		PC	RT	13	RP	*
K0078	Pneumatic caster tire tube, each		PC	RT	13	RP	*
Batteries/Chargers							
E2360	Power wheelchair accessory, 22 NF non-sealed lead acid battery, each		PC				*
E2361	Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)		PC				*
E2362	Power wheelchair accessory, Group 24 non-sealed lead acid battery, each		PC				*
E2363	Power wheelchair accessory, Group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)		PC				*
E2364	Power wheelchair accessory, U-1 non-sealed lead acid battery, each		PC				*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E2365	Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)		PC				*
E2366	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each		PC	RT	13	RP	*
K0733	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)		PC	RT			*
Power Seating Systems							
E1002	Wheelchair accessory, power seating system, tilt only	PA	PC	RT	13	RP	*
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction	PA	PC	RT	13	RP	*
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	PA	PC	RT	13	RP	*
E1005	Wheelchair accessory, power seating system, recline only, with power shear reduction	PA	PC	RT	13	RP	*
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	PA	PC	RT	13	RP	*
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	PA	PC	RT	13	RP	*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	PA	PC	RT	13	RP	*
E1010	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair	PA	PC	RT	13	RP	*
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	PA	PC	RT	13	RP	*
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	PA	PC	RT	13	RP	*
Power Wheelchair Drive Control Systems							
E2320	Power wheelchair accessory, hand or chin control interface, remote joystick or touchpad, proportional ■ Including all related electronics, and fixed mounting hardware	PA	PC	RT	13	RP	*
E2321	Power wheelchair accessory, hand control interface, remote joystick, non-proportional	PA	PC	RT	13	RP	*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
	■ Including all related electronics, mechanical stop switch, and fixed mounting hardware						
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, non-proportional ■ Including all related electronics, mechanical stop switch, and fixed mounting hardware	PA	PC	RT	13	RP	*
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, pre-fabricated		PC	RT	13	RP	*
E2324	Power wheelchair accessory, chin cup for chin control interface		PC	RT	13	RP	*
E2325	Power wheelchair accessory, sip and puff interface, non-proportional ■ Including all related electronics, mechanical stop switch, and manual swing-away mounting hardware	PA	PC	RT	13	RP	*
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	PA	PC	RT	13	RP	*
E2327	Power wheelchair accessory, head control interface, mechanical, proportional ■ Including all related electronics, mechanical direction change switch, and fixed mounting hardware	PA	PC	RT	13	RP	*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional ■ Including all related electronics and fixed mounting hardware	PA	PC	RT	13	RP	*
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, non-proportional ■ Including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	PA	PC	RT	13	RP	*
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, non-proportional ■ Including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	PA	PC	RT	13	RP	*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
Other Power Wheelchair Accessories							
E1016	Shock absorber for power wheelchair, each	PA	PC	RT	13	RP	*
E1018	Heavy-duty shock absorber for heavy-duty or extra heavy-duty power wheelchair	PA	PC	RT	13	RP	*
E2351	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface	PA	PC	RT	13	RP	*
E2368	Power wheelchair component, motor, replacement only,	PA	PC	RT	13	RP	*
E2369	Power wheelchair component, gear box, replacement only	PA	PC	RT	13	RP	*
E2370	Power wheelchair component, motor and gearbox combination, replacement only	PA	PC	RT	13	RP	*
E2399	Power wheelchair accessory, not otherwise classified interface, including all related electronics and fixed mounting hardware	PA	PC	RT	13	RP	*
K0090	Rear wheel tire for power wheelchair, any size, each		PC	RT	13	RP	*
K0091	Rear wheel tire tube other than zero pressure for power wheelchair, any size, each		PC	RT	13	RP	*
K0092	Rear wheel assembly for power wheelchair, complete, each		PC	RT	13	RP	*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
K0093	Rear wheel zero pressure tire tube (flat free insert) for power wheelchair, any size, each		PC	RT	13	RP	*
K0094	Wheel tire for power base, any size, each		PC	RT	13	RP	*
K0095	Wheel tire tube other than zero pressure for each base, any size, each		PC	RT	13	RP	*
K0096	Wheel assembly for power base, complete, each		PC	RT	13	RP	*
K0097	Wheel zero pressure tire tube (flat free insert) for power base, any size, each		PC	RT	13	RP	*
K0098	Drive belt for power wheelchair		PC	RT	13	RP	*
K0099	Front caster for power wheelchair, each		PC	RT	13	RP	*
Seat Cushions							
E2601	General use wheelchair seat cushion, width less than 22 inches, any depth	PA	PC	RT			
E2602	General use wheelchair seat cushion, width 22 inches or greater, any depth	PA	PC	RT			
E2603	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	PA	PC	RT			

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E2604	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	PA	PC	RT			
E2605	Positioning wheelchair seat cushion, width less than 22 inches, any depth	PA	PC	RT			
E2606	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	PA	PC	RT			
E2607	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	PA	PC	RT			
E2608	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	PA	PC	RT			
E2609	Custom fabricated wheelchair seat cushion, any size	PA	PC				NF
K0734	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth		PC	RT			
K0735	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth		PC	RT			
K0736	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth		PC	RT			

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
K0737	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth		PC	RT			
Back Cushions							
E2611	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	PA	PC	RT			
E2612	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	PA	PC	RT			
E2613	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	PA	PC	RT			
E2614	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	PA	PC	RT			
E2615	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	PA	PC	RT			

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E2616	Positioning wheelchair back cushion, posterior-lateral width 22 inches or greater, any height, including any type mounting hardware	PA	PC	RT			
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware	PA	PC				NF
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware	PA	PC	RT			
E2621	Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware	PA	PC	RT			
Miscellaneous & Positioning Accessories							
E0950	Wheelchair accessory, tray, each		PC	RT		RP	
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each		PC	RT		RP	
E0956	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each		PC	RT		RP	

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E0957	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each		PC	RT		RP	*
E0958	Manual wheelchair accessory, one-arm drive attachment, each ■ Covered if the client propels the chair himself/herself with only one hand and the need is expected to last at least six months		PC	RT	13	RP	*
E0959	Manual wheelchair accessory, each, adapter for amputee, each		PC	RT	13	RP	*
E0960	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware		PC	RT	13	RP	*
E0966	Manual wheelchair accessory, headrest extension, each	PA	PC	RT	13	RP	
E0971	Anti-tipping device, wheelchair		PC	RT	13	RP	
E0972	Wheelchair accessory, transfer board or device, each		PC	RT	13	RP	*
E0974	Manual wheelchair accessory, anti-rollback device, each		PC	RT	13	RP	*
E0978	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each		PC	RT	13	RP	*
E0981	Wheelchair accessory, seat upholstery, replacement only, each		PC	RT	13	RP	*

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E0982	Wheelchair accessory, back upholstery, replacement only, each		PC	RT	13	RP	*
E0985	Wheelchair accessory, seat lift mechanism	PA	PC	RT	13	RP	*
E0992	Manual wheelchair accessory, solid seat insert		PC	RT	13	RP	*
E1015	Shock absorber for manual wheelchair, each	PA	PC	RT	13	RP	*
E1017	Heavy-duty shock absorber for heavy-duty or extra heavy-duty manual wheelchair, each	PA	PC	RT	13	RP	*
E1028	Wheelchair accessory, manual swing-away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory		PC	RT	13	RP	*
E1029	Wheelchair accessory, ventilator tray, fixed		PC	RT	13	RP	*
E1030	Wheelchair accessory, ventilator tray, gimbaled	PA	PC	RT	13	RP	*
E1226	Wheelchair accessory, manual, fully reclining back (recline greater than 80 degrees), each	PA	PC	RT	13	RP	NF
E2618	Wheelchair accessory, solid seat support base (replaces sling seat), for use manual wheelchair or lightweight power wheelchair, includes any type mounting hardware	PA	PC	RT			

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E2619	Replacement cover for wheelchair seat cushion or back cushion, each	PA	PC	RT			
K0104	Cylinder tank carrier, each		PC	RT	13	RP	*
K0105	IV hanger, each		PC	RT	13	RP	*
K0108	Wheelchair component or accessory, not otherwise specified	PA	PC	RT	13	RP	*
K0452	Wheelchair bearings, any type		PC				*

410-122-0360 Canes and Crutches

(1) Indications and Coverage: When prescribed by a practitioner for a client with a condition causing impaired ambulation and there is a potential for ambulation.

(2) A white cane for a visually impaired client is considered to be a self-help item and is not covered by the Division of Medical Assistance Programs (DMAP).

(3) Table 122-0360.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0360 Canes and Crutches

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
Canes							
A4636	Replacement, handgrip, cane, crutch or walker, each		PC				
A4637	Replacement, tip, cane, crutch, walker, each		PC				
E0100	Cane, includes canes of all materials, adjustable or fixed, with tips		PC				
E0105	Quad or three prong, includes canes of all materials, adjustable or fixed, with tips		PC	RT	13		
Crutches							
A4635	Underarm pad, crutch, replacement, each		PC				
A4636	Replacement, handgrip, cane, crutch or walker, each		PC				
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips		PC	RT	13	RP	
E0111	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips		PC	RT	13	RP	
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips		PC	RT	13		
E0113	Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip		PC	RT	13		

Code	Description	PA	PC	RT	MR	RP	NF
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips		PC	RT	13	RP	
E0116	Crutch, underarm, other than wood, adjustable or fixed, each, with pad, tip and handgrip		PC	RT	13	RP	
E0117	Crutch, underarm, articulating, spring assisted, each		PC	RT	13	RP	
E0153	Platform attachment, forearm, crutch, each		PC	RT	13	RP	

410-122-0365 Standing and Positioning Aids

(1) Indications and coverage: If a client has one aid that meets his/her medical needs, regardless of who obtained it, the Division of Medical Assistance Programs (DMAP) will not provide another aid of same or similar function.

(2) Documentation to be submitted for prior authorization (PA) and kept on file by the Durable Medical Equipment (DME) provider:

(a) Documentation of medical appropriateness, which has been reviewed and signed by the prescribing practitioner;

(b) The care plan outlining positioning and treatment regime, and all DME currently available for use by the client;

(c) The physician's order;

(d) The documentation for customized positioner must include objective evidence that commercially available positioners are not appropriate;

(e) Each item requested must be itemized with description of product, make, model number, and manufacturers suggested retail price (MSRP);

(f) Submit Positioner Justification form (DMAP 3155) or reasonable facsimile, with recommendation for most appropriate equipment. This must be submitted by physical therapist, occupational therapist, or prescribing practitioner when requesting a PA;

(3) Gait Belts:

(a) Covered when:

(A) The client weighs 60 lbs. or more; and

(B) The care provider is trained in the proper use; and

(C) The client can walk independently, but needs:

(i) A minor correction of ambulation; or

(ii) Needs minimal or standby assistance to walk alone; or

(iii) Requires assistance with transfer;

(b) Use code E0700.

(4) Standing frame systems, prone standers, supine standers or boards and accessories for standing frames are covered when:

(a) The client has been sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit; and,

(b) The client is following a therapy program initially established by a physical or occupational therapist; and

(c) The home is able to accommodate the equipment; and

(d) The weight of the client does not exceed manufacturer's weight capacity; and

(e) The client has demonstrated an ability to utilize the standing aid independently or with caregiver; and

(f) The client has demonstrated compliance with other programs; and

(g) The client has demonstrated a successful trial period in a monitored setting; and

(h) The client does not have access to equipment from another source.

(5) Sidelyers and custom positioners must meet the following criteria in addition to the criteria in Table 122-0365:

(a) The client must be sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit; and

(b) The client must be following a therapy program initially established by a physical or occupational therapist; and,(c) The home must be able to accommodate the equipment; and

(d) The caregiver and/or family are capable of using the equipment appropriately.

(6) Criteria for Specific Accessories:

(a) A back support may be covered when a client:

(A) Needs for balance, stability, or positioning assistance; or

(B) Has extensor tone of the trunk muscles; or

(C) Needs for support while being raised or while completely standing;

(b) A tall back may be covered when:

(A) The client is over 5’11” tall; and

(B) The client has no trunk control and needs additional support; or

(C) The client has more involved need for assistance with balance, stability, or positioning;

(c) Hip guides may be covered when a client:

(A) Lacks motor control and/or strength to center hips; or

(B) Has asymmetrical tone which causes hips to pull to one side; or

(C) Has spasticity; or

(D) Has low tone or high tone; or

(E) Need for balance, stability, or positioning assistance;

(d) A shoulder retractor or harness may be covered when:

(A) Erect posture cannot be maintained without support due to lack of motor control or strength; or

(B) Has kyphosis; or

(C) Presents strong flexor tone;

(e) Lateral supports may be covered when a client:

(A) Lacks trunk control to maintain lateral stability; or

(B) Has scoliosis which requires support; or

(C) Needs a guide to find midline;

(f) A headrest may be covered when a client:

(A) Lacks head control and cannot hold head up without support; or

(B) Has strong extensor thrust pattern that requires inhibition;

(g) Independent adjustable knee pads may be covered when a client:

(A) Has severe leg length discrepancy; or

(B) Has contractures in one leg greater than the other;

(h) An actuator handle extension may be covered when a client:

(A) Has no caregiver; and

(B) Is able to transfer independently into standing frame; and

(C) Has limited range of motion in arm and/or shoulder and cannot reach actuator in some positions;

(i) Arm troughs may be covered when a client:

(A) Has increased tone which pulls arms backward so hands cannot come to midline; or

(B) Has poor tone, strength, or control is so poor that causes arms to hang out to side and backward, causing pain and risking injury; or

(C) Needs for posture;

(j) A tray may be covered when proper positioning cannot be accomplished by other accessories;

(k) Abductors may be covered to reduce tone for proper alignment and weight bearing;

(l) Sandals (shoe holders) may be covered when a client:

(A) Has dorsiflexion of the foot or feet; or

(B) Has planar flexion of the foot or feet or

(C) Has eversion of the foot or feet; or

(D) Needs for safety.

(7) Table 122-0365.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0365 Standing and Positioning Aids

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0637	Combination sit to stand system, any size, with seat lift feature, with or without wheels	PA	PC	RT		RP	
E0638	Standing frame system, any size, with or without wheels ■ Must meet the criteria listed in section (4) of this rule	PA	PC	RT		RP	
Not covered for electric mobility option							
E0700	Safety equipment (for gait belt only)	PA	PC				
E1399	DME, miscellaneous – Prone stander, supine stander or board ■ Must meet the criteria listed in section (4) of this rule	PA	PC	RT	13	RP	
E1399	DME, miscellaneous – Accessories for standing frame ■ Covered if the client: ◆ Must meet the criteria listed in section (4) of this rule, and ◆ Cannot be successfully positioned in equipment without specified accessories	PA	PC			RP	
E1399	DME, miscellaneous – Sidelyer includes accessories ■ Covered if the criteria in section (5) of this rule is met and one of the following: ◆ The client has contractures that are capable of being reduced or fixed contractures, or	PA	PC			RP	

Code	Description	PA	PC	RT	MR	RP	NF
	◆ The client has positioning and support needs that cannot be met with other positioning devices, or ◆ Positioning is needed to prevent reflux during feeding.						
E1399	DME, miscellaneous – Custom positioner ■ Labor is included in the purchase price ■ Not used for positioners that are ready-made and subsequently modified to fit an individual client ■ Positioners are considered customized when it is virtually impossible to meet another person's positioning needs in the equipment ■ Covered if: ◆ The configuration of the client's body cannot be supported by commercially available positioners due to size, orthopedic deformities, physical deformities or pressure ulcers, and ◆ The criteria in section (5) of this rule is met.	PA	PC			RP	

410-122-0375 Walkers

(1) Indications and Limitations of Coverage:

(a) A standard walker (E0130, E0135, E0141, E0143) and related accessories are covered if both of the following criteria are met:

(A) When prescribed by a treating practitioner for a client with a medical condition impairing ambulation and there is a potential for increasing ambulation; and

(B) When there is a need for greater stability and security than provided by a cane or crutches;

(b) For an adult gait trainer, use the appropriate walker code. If a gait trainer has a feature described by one of the walker attachment codes (E0154-E0157), that code may be separately billed;

(c) A heavy duty walker (E0148, E0149) is covered for clients who meet coverage criteria for a standard walker and who weigh more than 300 pounds;

(d) A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for clients who meet coverage criteria for a standard walker and who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand;

(e) When a walker with an enclosed frame (E0144) is dispensed to a client, documentation must support why a standard folding wheeled walker, E0143, was not provided as the least costly medically appropriate alternative;

(f) Enhancement accessories of walkers are noncovered;

(g) Leg extensions (E0158) are covered only for patients six feet tall or more.

(2) Coding Guidelines:

(a) A wheeled walker (E0141, E0143, E0149) is one with either two, three or four wheels. It may be fixed height or adjustable height. It may or may not include glide-type brakes (or equivalent). The wheels may be fixed or swivel;

(b) A glide-type brake consists of a spring mechanism (or equivalent) which raises the leg post of the walker off the ground when the patient is not pushing down on the frame;

(c) Code E0144 describes a folding wheeled walker which has a frame that completely surrounds the patient and an attached seat in the back;

(d) A heavy duty walker (E0148, E0149) is one which is labeled as capable of supporting patients who weigh more than 300 pounds. It may be fixed height or adjustable height. It may be rigid or folding;

(e) Code E0147 describes a 4-wheeled, adjustable height, folding-walker that has all of the following characteristics:

(A) Capable of supporting patients who weigh greater than 350 pounds;

(B) Hand operated brakes that cause the wheels to lock when the hand levers are released;

(C) The hand brakes can be set so that either or both can lock both wheels;

(D) The pressure required to operate each hand brake is individually adjustable;

(E) There is an additional braking mechanism on the front crossbar;

(F) At least two wheels have brakes that can be independently set through tension adjustability to give varying resistance;

(f) The only walkers that may be billed using code E0147 are those products listed in the Product Classification List on the SADMERC web site;

(g) An enhancement accessory is one which does not contribute significantly to the therapeutic function of the walker. It may include, but is not limited to style, color, hand operated brakes (other than those

described in code E0147), or basket (or equivalent);

(h) A4636, A4637, and E0159 are only used to bill for replacement items for covered, patient-owned walkers. Codes E0154, E0156, E0157, and E0158 can be used for accessories provided with the initial issue of a walker or for replacement components. Code E0155 can be used for replacements on covered, patient-owned wheeled walkers or when wheels are subsequently added to a covered, patient-owned nonwheeled walker (E0130, E0135). Code E0155 cannot be used for wheels provided at the time of, or within one month of, the initial issue of a nonwheeled walker;

(i) Hemi-walkers must be billed using code E0130 or E0135, not E1399;

(j) A gait trainer is a term used to describe certain devices that are used to support a client during ambulation;

(k) Column II code is included in the allowance for the corresponding Column I code when provided at the same time and must not be billed separately at the time of billing the Column I code:

(l) Table 122-0375-1

Column I (Column II)
E0130 (A4636, A4637)
E0135 (A4636, A4637)
E0140 (A4636, A4637, E0155, E0159)
E0141 (A4636, A4637, E0155, E0159)
E0143 (A4636, A4637, E0155, E0159)
E0144 (A4636, A4637, E0155, E0156, E0159)
E0147 (A4636, E0155, E0159)
E0148 (A4636, A4637)
E0149 (A4636, A4637, E0155, E0159)

(m) Providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

(3) Documentation: An order for each item billed must be signed and dated by the treating practitioner, kept on file by the DMEPOS provider, and made available to the Division of Medical Assistance Programs (DMAP)

upon request. The treating practitioner's records must contain information that supports the medical appropriateness of the item ordered, including height and weight.

(4) Table 122-0375-2.

Stat. Auth.: ORS 409

Stats. Implemented: 414.065

1-1-07

Table 122-0375-2 Walkers

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4636	Replacement, handgrip, cane, crutch or walker, each		PC				
A4637	Replacement, tip, cane, crutch, walker, each		PC				
E0130	Walker, rigid (pick-up), adjustable or fixed height		PC	RT	13	RP	
E0135	Walker, folding (pick-up), adjustable or fixed height		PC	RT	13	RP	
E0140	Walker, with trunk support, adjustable or fixed height, any type		PC	RT	13	RP	
E0141	Walker, rigid, wheeled, adjustable or fixed height		PC	RT	13	RP	
E0143	Walker, folding, wheeled, adjustable or fixed height		PC	RT	13	RP	
E0144	Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat		PC	RT	13	RP	
E0147	Walker, heavy duty, multiple braking system, variable wheel resistance		PC	RT	13	RP	
E0148	Walker, heavy duty, without wheels, rigid or folding, any type, each		PC	RT	13	RP	
E0149	Walker, heavy duty, wheeled, rigid or folding, any type, each		PC	RT	13	RP	

Code	Description	PA	PC	RT	MR	RP	NF
E0154	Platform attachment, walker, each		PC	RT	13	RP	
E0155	Wheel attachment, rigid pick-up walker, per pair		PC			RP	
E0156	Seat attachment, walker		PC			RP	
E0157	Crutch attachment, walker, each		PC	RT	13	RP	
E0158	Leg extensions for a walker, per set of four – for clients 6' tall or more		PC	RT	13	RP	
E0159	Brake attachment for wheeled walker replacement, each		PC	RT	13	RP	
E1399	Walker, child sized ■ Any type, any material, customized/ non-customized, adjustable/non adjustable, wheeled/non-wheeled, with/without seat, with/without braking system, extra narrow to extra wide, regular strength to heavy duty & any other accessory ■ For client less than 56" tall.	PA	PC	RT	13	RP	NF
E8000	Gait trainer, pediatric size, posterior support, includes all accessories and components	PA	PC	RT	13	RP	
E8001	Gait trainer, pediatric size, upright support, includes all accessories and Components	PA	PC	RT	13	RP	
E8002	Gait trainer, pediatric size, anterior support, includes all accessories and components	PA	PC	RT	13	RP	

410-122-0380 Hospital Beds

(1) Definitions:

(a) Fixed Height Hospital Bed – A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment;

(b) Variable Height Hospital Bed – A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments;

(c) Semi-Electric Hospital Bed – A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments.

(2) Hospital Bed Criterion:

(a) 1 – Client requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition that is expected to last at least one month;

(b) 2 – Client requires, for alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;

(c) 3 – Client requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed;

(d) 4 – Client requires traction equipment that can only be attached to a hospital bed;

(e) 5 – Client's level of functioning can only be met with a hospital bed.

(f) 6 – Client is capable of operating the controls;

(g) 7 – Client requires frequent changes in body position and/or has an immediate need for a change in body position;

(h) 8 – Client requires a bed height different from that provided by a fixed height hospital bed in order to permit transfers to chair, wheelchair or standing position;

(i) 9 – Client weighs more than 350 pounds.

(3) Indications and coverage:

(a) Fixed Height Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5.

(b) Variable Height Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5 and 8.

(c) Semi-Electric Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5, 6, and 7;

(d) Heavy-Duty and Extra Heavy-Duty Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5, 6, 7, and 9.

(4) Payment Authorization: Subject to service limitations of the Division of Medical Assistance Programs (DMAP) rules, from the initial date of service through the second date of service, a hospital bed rental may be dispensed without prior authorization. The provider is still responsible to ensure all rule requirements are met. Payment authorization is required prior to submitting claims and will be given once all required documentation has been received and any other applicable rule requirements have been met. Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040. All subsequent services starting with the third date of service require prior authorization.

(5) Documentation:

(a) Documentation of medical appropriateness that has been reviewed and signed by the prescribing practitioner must be submitted with the request for prior authorization (PA) and kept on file by the DME provider;

(b) Document the number of hours spent in bed, the type of bed currently used by the client and why it doesn't meet the needs of the client;

(c) In addition to the above documentation requirements, you must document:

(A) The reasons why a variable height bed does not meet the needs of the client when requesting PA for semi-electric hospital beds, and;

(B) The client's height and weight when requesting PA for Heavy-Duty and Extra Heavy-Duty hospital beds.

(5) Procedure Codes – Table 122-0380.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-07

Table 122-0380 Hospital Beds

For the code legend see OAR 410-122-0182

* *See section (4) of this rule for authorization requirements.*

Code	Description	PA	PC	RT	MR	RP	NF
Fixed Height							
E0250	Hospital Bed, fixed height, with any type side rails, with mattress	*	PC	RT	13	RP	
E0251	Hospital Bed, fixed height, with any type side rails, without mattress	*	PC	RT	13	RP	
E0290	Hospital Bed, fixed height, without side rails, with mattress	*	PC	RT	13	RP	
E0291	Hospital Bed, fixed height, without side rails, without mattress	*	PC	RT	13	RP	
Variable Height							
E0255	Hospital bed, variable height (Hi-Lo), with any type side rails, with mattress	*	PC	RT	13	RP	
E0256	Hospital bed, variable height (Hi-Lo), with any type side rails, without mattress	*	PC	RT	13	RP	
E0292	Hospital bed, variable height (Hi-Lo), without side rails, with mattress	*	PC	RT	13	RP	
E0293	Hospital bed, variable height (Hi-Lo), without side rails, without mattress	*	PC	RT	13	RP	
Semi-Electric							
E0260	Hospital Bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	*	PC	RT	13	RP	
E0261	Hospital Bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	*	PC	RT	13	RP	

See section (4) of this rule for authorization requirements.

Code	Description	PA	PC	RT	MR	RP	NF
E0294	Hospital Bed, semi-electric (head and foot adjustment) without side rails, with mattress	*	PC	RT	13	RP	
E0295	Hospital Bed, semi-electric (head and foot adjustment) without side rails, without mattress	*	PC	RT	13	RP	
Heavy-Duty and Extra Heavy-Duty							
E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	*	PC	RT	13	RP	
E0302	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	*	PC	RT	13	RP	NF
E0303	Hospital bed, heavy duty, extra-wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	*	PC	RT	13	RP	
E0304	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	*	PC	RT	13	RP	NF

410-122-0400 Pressure Reducing Support Surfaces

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) Group 1 (A4640, E0180-E0182, E0184-E0189, and E0196-E0199):

(A) The Division of Medical Assistance Programs (DMAP) may cover a Group 1 support surface when the client meets:

(i) Criterion (I), or;

(ii) Criteria (II) or (III) and at least one of criteria (IV)-(VII):

(I) Completely immobile - i.e., client cannot make changes in body position without assistance;

(II) Limited mobility - i.e., client cannot independently make changes in body position significant enough to alleviate pressure;

(III) Any stage pressure ulcer on the trunk or pelvis;

(IV) Impaired nutritional status;

(V) Fecal or urinary incontinence;

(VI) Altered sensory perception;

(VII) Compromised circulatory status;

(B) The DMEPOS provider must provide a support surface in which the client does not "bottom out";

(C) DMAP does not cover foam overlays or mattresses without a waterproof cover, since these are not considered durable;

(D) DMAP does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(E) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(b) Group 2 (E0193, E0277, and E0371-E0373):

(A) A Group 2 support surface may be covered for up to an initial three month rental period when the client meets:

(i) Criterion (I) and (II) and (III), or;

(ii) Criterion (IV), or;

(iii) Criterion (V) and (VI);

(I) Multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02 - 707.05);

(II) Client has been on a comprehensive ulcer treatment program for at least the past month which includes the following: use of an appropriate Group 1 support surface; education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers; regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer); appropriate turning and positioning; appropriate wound care (for a stage II, III, or IV ulcer); appropriate management of moisture/incontinence; and nutritional assessment and intervention consistent with the overall plan of care;

(III) The ulcers have worsened or remained the same over the past month;
(IV) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02 -707.05); A large wound is generally any wound of eight square centimeters (length x width) or more. Individual client circumstances may be weighed. Undermining and/or tunneling, anatomic location on the body and the size of the client may be taken into account;

(V) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) (ICD-9 707.02 - 707.05);

(VI) The client has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days);

(B) The DMEPOS provider must provide a support surface in which the patient does not "bottom out";

(C) When a Group 2 surface is requested following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery;

(D) DMAP may cover continued use of a Group 2 support surface if healing continues;

(E) DMAP does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(F) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(c) DMAP may consider coverage for bariatric pressure reducing support surfaces only coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility, subject to service limitations of DMAP rules, only when the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric pressure reducing support surface has been assigned code E1399 by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC);

(d) Group 3: Air-fluidized beds (E0194) are not covered.

(2) Definitions for Group 1 and Group 2:

(a) Bottoming out: Finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the patient's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the client in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position;

(b) Plan of care: Written guidelines developed to identify specific problems and needs of the client and interventions/regimen necessary to assist the client to achieve optimal health potential. Developing the plan of care includes establishing measurable client and nursing goals with time lines and determining nursing/caregiver/other discipline-assigned interventions to meet care objectives;

(c) The staging of pressure ulcers used in this rule is as follows:
(A) Stage I - Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin,

whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II - Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III - Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV - Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers;

(3) Guidelines:

(a) Group 1:

(A) Codes E0185 and E0197-E0199 termed "pressure pad for mattress" describe nonpowered pressure reducing mattress overlays and are designed to be placed on top of a standard hospital or home mattress;

(B) A gel/gel-like mattress overlay (E0185) is characterized by a gel or gel-like layer with a height of two inches or greater;

(C) An air mattress overlay (E0197) is characterized by interconnected air cells having a cell height of three inches or greater that are inflated with an air pump;

(D) A water mattress overlay (E0198) is characterized by a filled height of three inches or greater;

(E) A foam mattress overlay (E0199) is characterized by all of the following:

(i) Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least three inches if it is a non-convoluted overlay; and

(ii) Foam with a density and other qualities that provide adequate pressure

reduction; and

(iii) Durable, waterproof cover;

(F) Codes E0184, E0186, E0187 and E0196 describe nonpowered pressure reducing mattresses;

(G) A foam mattress (E0184) is characterized by all of the following:

(i) Foam height of five inches or greater;

(ii Foam with a density and other qualities that provide adequate pressure reduction;

(iii) Durable, waterproof cover; and

(iv) Can be placed directly on a hospital bed frame;

(H) An air, water or gel mattress (E0186, E0187, E0196) is characterized by all of the following:

(i) Height of five inches or greater of the air, water, or gel layer (respectively);

(ii) Durable, waterproof cover; and

(iii) Can be placed directly on a hospital bed frame;

(I) Codes E0180, E0181, E0182, and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss) and are characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 2 ½ inches or greater; and

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduce pressure and prevent bottoming out;

(J) Alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0180, E0181, E0182, and A4640;

(K) Code A4640 or E0182 may only be billed when they are provided as replacement components for a client-owned E0180 or E0181 mattress overlay system;

(L) A Column II code is included in the allowance for the corresponding Column I code when provided at the same time:Column I (Column II), E0180 (A4640, E0182), E0181 (A4640, E0182);

(b) Group 2:

(A) Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following:

(a) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;

(b) Inflated cell height of the air cells through which air is being circulated is five inches or greater;

(c) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out;

(d) A surface designed to reduce friction and shear; and

(e) Can be placed directly on a hospital bed frame;

(B) Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above;

(C) Code E0371 describes an advanced non-powered pressure-reducing mattress overlay which is characterized by all of the following:

(i) Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out;

(ii) Total height of three inches or greater;

(iii) A surface designed to reduce friction and shear; and

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces;

(D) Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 3 ½ inches or greater;

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out; and

(iv) A surface designed to reduce friction and shear;

(E) Code E0373 describes an advanced nonpowered pressure reducing mattress which is characterized by all of the following:

(i) Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out;

(ii) Total height of five inches or greater;

(iii) A surface designed to reduce friction and shear;

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces; and

(v) Can be placed directly on a hospital bed frame;

(F) The only products that may be coded and billed using code E0371 or E0373

are those products for which a written coding determination specifying the use of these codes has been made by the statistical analysis durable medical equipment carrier (SADMERC);

(G) Alternating pressure mattresses and low air loss mattresses are coded using code E0277;

(H) Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with three powered air cells on top of a three foam base would be coded as a powered overlay (code E0180 or E0181), not as a powered mattress (E0277).

(3) Documentation Requirements: For all pressure reducing support surfaces, other than a Group 2 surface following a myocutaneous flap or skin graft, submit the following information with the prior authorization request:

(a) Initial Request:

(A) An order for each item requested, signed and dated by the attending physician;

(B) Documentation that supports conditions of coverage are met as specified in this rule;

(C) A plan of care which has been established by the client's physician or home care nurse (by the RN resident care manager for a client in a nursing facility), which generally includes the following:

(i) Education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers;

(ii) Regular assessment by a nurse, physician, or other licensed healthcare practitioner;

(iii) Appropriate turning and positioning including the number of hours per 24-period that the client will utilize the support surface;

(iv) Appropriate wound care (for a stage II, III, or IV ulcer);

(v) Appropriate management of moisture/incontinence;

(vi) Nutritional assessment and intervention consistent with the overall plan of care by a licensed healthcare practitioner (by a registered dietitian for a client in a nursing facility) within the last 90 days;

(vii) Client's weight and height (approximation is acceptable, if unable to obtain);

(viii) Description of all pressure ulcers, which includes:

(I) Number;

(II) Locations;

(III) Stages;

(IV) Sizes;

(V) Dated photographs;

(ix) Lab reports, if relevant;

(x) Other treatments and products that have been tried and why they were ineffective; Interventions and goals for stepping down the intensity of support surface therapy;

(xi) For pressure ulcers on extremities, why pressure cannot be relieved by other methods;

(D) For a Group 2 surface following a myocutaneous flap or skin graft only, submit the following information with the prior authorization request:

(i) An order for each item requested, signed and dated by the treating physician;

(ii) Operative report;

(iii) Hospital discharge summary;

(iv) Plan of care;

(E) Required documentation may not be completed by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or anyone in a financial relationship of any kind with the DMEPOS provider;

(F) Medical records must corroborate that all criteria in this rule are met when dispensing and billing for an item in Table 122-0400-1 and Table-122-400-2;

(G) Medical records must be kept on file by the DMEPOS provider and made available to DMAP upon request;

(b) Subsequent Request: May be authorized contingent on progress towards healing: For all pressure reducing support surfaces, other than a Group 2 surface following a myocutaneous flap or skin graft, submit the following information with the prior authorization request:

(i) Progress notes from the attending physician;

(ii) Description of all pressure ulcers, including progress towards healing, by a licensed healthcare practitioner (by the RN resident care manager for a client in a nursing facility) which includes:

(I) Number;

(II) Locations;

(III) Stages;

(IV) Sizes;

(V) Dated photographs;

(iii) Current plan of care;

(iv) Any other relevant documentation;

(v) For a Group 2 surface following a myocutaneous flap or skin graft only, submit the following information with the prior authorization request:

(I) Progress notes from the attending physician;

(II) Current plan of care;

(III) Any other relevant documentation.

(4) Table 122-0400-1 – Group 1

(5) Table 122-0400-2 – Group 2

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065 1-1-07

Table 122-0400-1 Pressure Reducing Support Surfaces-Group 1

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4640	Replacement pad for use with medically appropriate alternating pressure pad owned by client		PC			RP	
E0180	Pressure pad, alternating with pump		PC	RT	13	RP	
E0181	Pressure pad, alternating with pump, heavy-duty		PC	RT	13	RP	
E0182	Pump for alternating pressure pad		PC	RT	13	RP	
E0184	Dry pressure mattress	PA	PC	RT	13		
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width	PA	PC	RT	13	RP	
E0186	Air pressure mattress	PA	PC	RT	13	RP	
E0187	Water pressure mattress	PA	PC	RT	13	RP	
E0188	Synthetic sheepskin pad		PC				
E0189	Lambs wool sheepskin pad		PC				
E0196	Gel pressure mattress	PA	PC	RT	13		
E0197	Air pressure pad for mattress, standard mattress length and width	PA	PC	RT	13		
E0198	Water pressure pad for mattress, standard mattress length and width	PA	PC	RT	13	RP	
E0199	Dry pressure pad for mattress, standard mattress length and width		PC	RT			

* *See additional criteria shown in sections (3)(f)(A) and (B) for codes E0193, E0277, E0371, E0372, and E0373.*

Code	Description	PA	PC	RT	MR	RP	NF

Table 122-0400-2 Pressure Reducing Support Surfaces- Group 2

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0193	Powered air flotation bed (low air loss therapy), per month	PA		RT	13	RP	NF
E0277	Powered pressure reducing mattress, air, per month	PA		RT	13	RP	NF
E0371	Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width, per month	PA		RT	13	RP	NF
E0372	Powered air overlay for mattress, standard mattress length and width, per month	PA		RT	13		NF
E0373	Non-powered, advanced pressure reducing mattress	PA	PC	RT	13	RP	NF
E1399	Bariatric Group 2 pressure reducing support surface coded as E1399 by SADMERC	PA	PC	RT	13	RP	NF

410-122-0420 Hospital Bed Accessories

(1) Table 122-0420.

(2) Trapeze Bars:

(a) Indications and Coverage: Trapeze bars are indicated when a client needs this device to sit up because of respiratory condition, to change body position for other medical reasons, or to get in or out of bed;

(b) The Division of Medical Assistance Programs (DMAP) may consider coverage for bariatric trapeze bars only coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility), subject to service limitations of DMAP rules, only when the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric trapeze bar has been assigned code E1399 by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC);

(C) Supporting documentation has been submitted to the appropriate authorizing authority for prior authorization;

(c) Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider;

(c) See Table 122-0420 for procedure codes.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0420 Hospital Bed Accessories

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
Frames, Traction Devices, etc.							
E0840	Traction frame, attached to headboard, cervical traction		PC	RT	13	RP	
E0849	Traction equipment, cervical free- standing stand/frame, pneumatic, applying traction force to other than mandible		PC	RT	13	RP	
E0850	Traction stand, free-standing, cervical traction		PC	RT	13	RP	
E0855	Cervical traction equipment not requiring additional stand or frame		PC	RT	13	RP	
E0860	Traction equipment, overdoor, cervical		PC				
E0870	Traction frame, attached to footboard, extremity traction (e.g., Buck's)		PC	RT	13	RP	
E0880	Traction stand, free-standing, extremity traction, (e.g., Buck's)		PC	RT	13	RP	
E0890	Traction frame, attached to footboard, pelvic traction		PC	RT	13	RP	
E0900	Traction stand, free-standing, pelvic traction (e.g., Buck's)		PC	RT	13	RP	

Code	Description	PA	PC	RT	MR	RP	NF
E0920	Fracture frame, attached to bed, includes weights		PC	RT	13	RP	
E0930	Fracture frame, free-standing, includes weights		PC	RT	13	RP	
E0941	Gravity assisted traction device, any type		PC	RT	13	RP	
E0942	Cervical head harness/halter		PC				
E0943	Cervical pillow		PC				
E0944	Pelvic belt/harness/boot		PC				
E0945	Extremity belt/harness		PC				
E0946	Fracture frame, dual with cross bars, attached to bed (e.g., Balken, 4-poster)		PC	RT	13	RP	
E0947	Fracture frame, attachments for complex pelvic traction		PC	RT	13	RP	
E0948	Fracture frame, attachments for complex cervical traction		PC	RT	13	RP	
Mattresses							
E0271	Mattress, inner-spring (replacement for client owned hospital bed)		PC				
E0272	Mattress, foam rubber (replacement for client owned hospital bed)		PC				
Rails							
E0305	Bedside rails, half-length, for use with hospital or non-hospital bed		PC	RT	13		

Code	Description	PA	PC	RT	MR	RP	NF
E0310	Bedside rails, full-length, for use with hospital or non-hospital bed		PC	RT	13		
Trapeze Bars							
E0910	Trapeze bars, a.k.a. client helper, attached to bed, complete with grab bar ■ Not covered when used on a non-hospital bed ■ Covered when it is either an integral part of or used on a hospital bed and both the hospital bed and the trapeze bar are medically appropriate		PC	RT	13	RP	
E0940	Trapeze bar, free-standing, complete with grab bar When prescribed, it must meet the same criteria as the attached equipment and the client must not be renting or own a hospital bed		PC	RT	13	RP	
E1399	Bariatric trapeze bar coded as E1399 by SADMERC	PA	PC	RT	13	RP	NF

410-122-0470 Supports and Stockings

(1) Cosmetic support panty hose (i.e., Leggs®, No Nonsense®, etc.) are not covered.

(2) Procedure Codes - Table 122-0470.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0470 Supports and Stockings

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4565	Slings		PC				
L0120	Cervical, flexible non-adjustable (foam collar)		PC				
L0210	Thoracic rib belt		PC				NF
L8300	Truss, single with standard pad		PC				NF
L8310	Truss, double		PC				NF
Elastic Supports							
L8100	Gradient compression stocking, below knee, 18-30 mm Hg, each		PC				NF
L8110	below knee, 30-40 mm Hg, each		PC				NF
L8120	below knee, 40-50 mm Hg, each		PC				NF
L8130	thigh length, 18-30 mm Hg, each		PC				NF
L8140	thigh length, 30-40 mm Hg, each		PC				NF
L8150	thigh length, 40-50 mm Hg, each		PC				NF
L8160	full length/chap style, 18-30 mm Hg, each		PC				NF
L8170	full length/chap style, 30-40 mm Hg, each		PC				NF
L8180	full length/chap style, 40-50 mm Hg, each		PC				NF
L8190	waist length, 18-30 mm Hg, each		PC				NF
L8195	waist length, 30-40 mm Hg, each		PC				NF
L8200	waist length, 40-50 mm Hg, each		PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
L8210	custom made		PC				NF
L8220	lymphedema		PC				NF
L8230	garter belt		PC				NF
L8239	not otherwise specified	PA	PC				NF
S8420	Gradient pressure aid (sleeve and glove combination), custom made		PC				NF
S8421	Gradient pressure aid (sleeve and glove combination), ready made		PC				NF
S8422	Gradient pressure aid (sleeve), custom made, medium weight		PC				NF
S8423	Gradient pressure aid (sleeve), custom made, heavy weight		PC				NF
Compression Burn Garments							
A6501	Compression burn garment, body suit (head-to-foot), custom fabricated		PC				
A6502	Compression burn garment, chin strap, custom fabricated		PC				
A6503	Compression burn garment, facial hood, custom fabricated		PC				
A6504	Compression burn garment, glove-to-wrist, custom fabricated		PC				
A6505	Compression burn garment, glove-to-elbow, custom fabricated		PC				
A6506	Compression burn garment, glove-to-axilla, custom fabricated		PC				
A6507	Compression burn garment, foot-to-knee length, custom fabricated		PC				
A6508	Compression burn garment, foot-to-thigh length, custom fabricated		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6509	Compression burn garment, upper trunk-to-waist including arm openings (vest)		PC				
A6510	Compression burn garment, trunk, including arms down-to-leg opening (leotard), custom fabricated		PC				
A6511	Compression burn garment, lower trunk, including leg opening (panty), custom fabricated		PC				
A6512	Compression burn garment, not otherwise classified, custom fabricated	PA	PC				

410-122-0475 Therapeutic Shoes for Diabetics

(1) Indications and Coverage:

(a) For each client, coverage of the footwear and inserts is limited to one of the following within one calendar year:

(A) One pair of custom-molded shoes (including inserts provided with such shoes) and two additional pair of inserts; or

(B) One pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of inserts.

(b) An individual may substitute modification(s) of custom molded or extra-depth shoes instead of obtaining one pair of inserts, other than the initial pair of inserts. The most common shoe modifications are:

(A) Rigid rocker bottoms;

(B) Roller bottoms;

(C) Metatarsal bars;

(D) Wedges;

(E) Offset heels.

(c) Payment for any expenses for the fitting of such footwear is included in the fee;

(d) Payment for the certification of the need for therapeutic shoes and for the prescription of the shoes (by a different practitioner from the one who certifies the need for the shoes) is considered to be included in the visit or consultation in which these services are provided;

(e) Following certification by the physician managing the client's systemic diabetic condition, a podiatrist or other qualified practitioner, knowledgeable in the fitting of the therapeutic shoes and inserts, may prescribe the particular type of footwear necessary.

(2) Documentation:

(a) The practitioner who is managing the individual's systemic diabetic condition documents that the client has diabetes and one or more of the following conditions:

(A) Previous amputation of the other foot, or part of either foot;

(B) History of previous foot ulceration of either foot;

(C) History of pre-ulcerative calluses of either foot;

(D) Peripheral neuropathy with evidence of callus formation of either foot;

(E) Foot deformity of either foot; or

(F) Poor circulation in either foot; and

(G) Certifies that the client is being treated under a comprehensive plan of care for his or her diabetes and that he or she needs therapeutic shoes.

(b) Documentation of the above criteria, may be completed by the prescribing practitioner or supplier but must be reviewed for accuracy of the information and signed and dated by the certifying physician to indicate agreement and must be kept on file by the DME supplier.

(3) Table 122-0475

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0475 Therapeutic Shoes for Diabetics

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A5500	For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe		PC				NF
A5501	For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of client's foot (custom molded shoe), per shoe		PC				NF
A5503	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe		PC				NF
A5504	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe		PC				NF
A5505	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe		PC				NF
A5506	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe		PC				NF
A5507	For diabetics only, not otherwise specified modification (include fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe		PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
A5510	For diabetics only, direct formed, compression molded to client's foot without external heat source, multiple-density insert(s), prefabricated, per shoe		PC				NF
K0628	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer of 3/16 inch material of shore a 40 (or higher), prefabricated, each		PC			NF	
K0629	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each		PC			NF	

410-122-0480 Pneumatic Compression Devices (Used for Lymphedema)

(1) A pneumatic compression device (lymphedema pump) is medically appropriate only for the treatment of refractory lymphedema involving one or more limbs.

(2) Causes of lymphedema include but are not limited to the following conditions with a diagnosis on the currently funded lines of the Prioritized List of Health Services:

(a) Spread of malignant tumors to regional lymph nodes with lymphatic obstruction;

(b) Radical surgical procedures with removal of regional groups of lymph nodes;

(c) Post-radiation fibrosis;

(d) Scarring of lymphatic channels (e.g., those with generalized refractory edema from venous insufficiency which is complicated by recurrent cellulitis); when all of the following criteria have been met:

(A) There is significant ulceration of the lower extremity (ies);

(B) The client has received repeated, standard treatment from a practitioner using such methods as a compression bandage system or its equivalent;

(C) The ulcer(s) have failed to heal after six months of continuous treatment.

(e) Congenital anomalies.

(3) Pneumatic compression devices may be covered only when prescribed by a practitioner and when they are used with appropriate practitioner oversight, i.e., practitioner evaluation for the client's condition to determine medical appropriateness of the device, suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment. Used as treatment of last resort.

(4) All pressure devices require a one-month trial period prior to purchase. The rental period is applied toward purchase.

(5) All necessary training to utilize a pressure device is included in rental or purchase fee.

(6) Documentation:

(a) The practitioner must document the client's condition, medical appropriateness and instruction as to the pressure to be used, the frequency and duration of use and that the device is achieving the purpose of reduction and control of lymphedema;

(b) The determination by the practitioner of the medical appropriateness of pneumatic compression device must include:

(A) The client's diagnosis and prognosis;

(B) Symptoms and objective findings, including measurements which establish the severity of the condition;

(C) The reason the device is required, including the treatments which have been tried and failed; and

(D) The clinical response to an initial treatment with the device. The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment session and parameters, and ability of the client (or caregiver) to apply the device for continued use in the home.

(c) Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(d) If the client has venous stasis ulcers, documentation supporting the medical appropriateness for the device should include a signed and dated statement from the prescribing practitioner indicating:

(A) The location and size of venous stasis ulcer(s);

(B) How long each ulcer has been continuously present;

(C) Whether the client has been treated with regular compression bandaging for the past six months;

(D) Whether the client has been treated with custom fabricated gradient pressure stockings/sleeves, approximately when, and the results of the treatment;

(E) Other treatment for the venous stasis ulcer(s) during the past six months;

(F) Whether the client has been seen regularly by a practitioner for treatment of venous stasis ulcer(s) during the past six months.

(7) Procedure Codes -- Table 122-0480.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0480 Pneumatic Compression Devices (Used for Lymphedema)

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0650	Pneumatic compressor, non-segmental home model		PC	RT		RP	NF
E0651	Pneumatic compressor, segmental home model (lymphedema pump) without calibrated gradient pressure		PC	RT		RP	NF
E0652	Pneumatic compressor, segmental home model (lymphedema pump) with calibrated gradient pressure ■ Documentation on file must show that E0650 or E0651, or other less costly alternatives, failed to manage the client's condition ■ Must include measurements of pump pressure, dates and times applied, and serial multiple level measurements of the involved extremity ■ If used for a painful focal lesion, documentation must support what prevented the use of E0650 or E0651 ■ Chamber pressure must be listed for all pumps used		PC	RT		RP	NF

Code	Description	PA	PC	RT	MR	RP	NF
	■ Must show the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a non-segmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber						
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor half arm, includes hand segment		PC	RT		RP	NF
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor full leg, includes foot segment		PC	RT		RP	NF
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor full arm, includes hand segment		PC	RT		RP	NF
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor half leg, includes foot segment		PC	RT		RP	NF
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg, includes foot segment		PC	RT		RP	NF
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm, includes hand segment		PC	RT		RP	NF
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg, includes foot segment		PC	RT		RP	NF
E0671	Segmental gradient pressure pneumatic appliance, full leg, includes foot segment		PC	RT		RP	NF

Code	Description	PA	PC	RT	MR	RP	NF
E0672	Segmental gradient pressure pneumatic appliance, full arm, includes hand segment		PC	RT		RP	NF
E0673	Segmental gradient pressure pneumatic appliance, half leg, includes foot segment		PC	RT		RP	NF

410-122-0500 Transcutaneous Electrical Nerve Stimulator (TENS)

(1) Indications and Limitations of Coverage and/or Medical Appropriateness: transcutaneous electrical nerve stimulator (TENS) (E0720, E0730) is a device which utilizes electrical current delivered through electrodes placed on the surface of the skin. A TENS unit decreases the client's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. A TENS unit must be distinguished from other electrical stimulators (e.g., neuromuscular stimulators) which are used to directly stimulate muscles and/or motor nerves.

(2) A TENS unit may be covered for the treatment of:

(a) Acute post-operative pain:

(A) Coverage is usually limited to 30 days from the day of surgery; and,

(B) Payment for more than one month is determined by individual consideration based upon supportive documentation provided by the attending physician; and,

(C) Payment is made only as a rental; and,

(D) Acute pain (less than three months duration) other than post-operative pain is not covered; or,

(b) Chronic, intractable pain:

(A) The pain has been present for at least three months; and,

(B) Other appropriate treatment modalities have been tried and failed; and,

(C) The presumed etiology of the pain is a type that is accepted as responding to TENS therapy. Examples of conditions for which a TENS unit are not considered to be medically appropriate are (not all-inclusive): headache, visceral abdominal pain, pelvic pain, and temporomandibular joint (TMJ) pain; and,

(D) The TENS unit must be used by the client on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period is paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain;

(E) For coverage of a purchase, the physician must determine that the client is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of

the client at the end of the trial period, must indicate how often the client used the TENS unit, the typical duration of use each time, and the results.

(2) Documentation Requirements: Submit the following documentation from the attending or consulting physician with the prior authorization (PA) request:

(a) For both acute post-operative pain and chronic, intractable pain:

(A) A signed and dated order by the treating physician. The physician ordering the TENS unit must be the attending physician or a consulting physician for the disease or condition resulting in the need for the TENS unit; and,

(B) Documentation of multiple medications and/or therapies that have been tried and failed; and,

(C) A new order, when purchase is requested (after the required trial period). The initial date on

this order must not overlap the dates of the trial period.

(b) In addition, for a client with acute post-operative pain: date of surgery resulting in acute post-operative pain;

(c) In addition, for a client with chronic, intractable pain: location of the pain, the duration of time the client has had the pain, and the presumed etiology of the pain;

(d) For authorization of quantities of supplies greater than those described in this policy as the usual maximum amounts:

(A) Each request must include documentation supporting the medical appropriateness for the higher utilization; and,

(B) There must be clear documentation in the client's medical records corroborating the medical appropriateness of this amount.

(e) When ordering a 4 lead TENS unit, the client's medical record must document why 2 leads are insufficient to meet the client's needs;

(f) The Division of Medical Assistance Programs (DMAP) may request copies of the client's medical records that corroborate the order and any additional documentation that pertains to the medical appropriateness of items and quantities requested.
(3) Rental Guidelines: During the rental of a TENS unit, supplies for the unit are

included in the rental allowance; there is no additional allowance for electrodes, lead wires, batteries, etc.

(4) Purchase Guidelines: If a TENS unit (E0720 or E0730) is purchased, the allowance includes lead wires and one month's supply of electrodes, conductive paste or gel (if needed), and batteries.

(5) Coding Guidelines:

(a) Separate allowance may be made for replacement supplies when they are medically appropriate and are used with a TENS unit that has been purchased and/or approved by DMAP;

(b) If 2 TENS leads are medically appropriate, then a maximum of one unit of Code A4595 would be allowed per month; if 4 TENS leads are necessary, a maximum of two units per month would be allowed;

(c) If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally;

(d) There is no separate allowance for replacement electrodes (A4556), conductive paste or gel (A4558), replacement batteries (A4630), or a battery charger used with a TENS unit;

(e) Codes A4556 (Electrodes, [e.g., apnea monitor], per pair), A4558 (Conductive paste or gel), and A4630 (Replacement batteries, medically appropriate TENS owned by the client) are not valid for prior authorization. A4595 should be used instead;

(f) For code A4557, one unit of service is for lead wires going to two electrodes. If all the lead wires of a 4 lead TENS unit needed to be replaced, billing would be for two units of service;

(g) Replacement of lead wires (A4557) will be covered when they are inoperative due to damage and the TENS unit is still medically appropriate. Replacement more often than every 12 months is rarely medically appropriate;

(h) A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used);

(i) Other supplies, including but not limited to the following, are not separately payable: adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, additional connecting cable for lead wires, carrying pouches, or covers.

(j) Providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

(k) Table 122-0500.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0500 Transcutaneous Electrical Nerve Stimulator (TENS)

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4557	Lead wires, (e.g., apnea monitor), per pair	PA	PC				NF
A4595	Electrical stimulator supplies (e.g., TENS, NMES), 2 lead, per month	PA	PC				NF
E0720	TENS, two lead, localized stimulation	PA	PC	RT	13	RP	NF
E0730	TENS, four or more leads for, multiple nerve stimulation	PA	PC	RT	13	RP	NF

410-122-0510 Osteogenesis Stimulators

(1) Definitions:

(a) An electrical osteogenesis stimulator is a device that provides electrical stimulation to augment bone repair.

(b) A noninvasive electrical stimulator is characterized by an external power source which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.

(c) An ultrasonic osteogenesis stimulator is a noninvasive device that emits low intensity, pulsed ultrasound signals to stimulate fracture healing. The device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via conductive coupling gel to stimulate fracture healing;

(2) Indications of Coverage and Medical Appropriateness:

(a) Nonspinal Electrical Osteogenesis Stimulator:

(A) The Division of Medical Assistance Programs (DMAP) may cover a non-spinal electrical osteogenesis stimulator (E0747) when any of the following criteria are met:

(i) Non-union of a long bone fracture (defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenenisis stimulator);

(ii) Failed fusion of a joint other than in the spine, where a minimum of nine months has elapsed since the last surgery;

(iii) Congenital pseudarthrosis;

(B) Non-union of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by the treating physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;

(C) A long bone is limited to a clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal or metatarsal.

(b) Spinal Electrical Osteogenesis Stimulator:

(A) DMAP may cover a spinal electrical osteogenesis stimulator (E0748) when any of the following criteria are met:

(i) Failed spinal fusion where a minimum of nine months has elapsed since the last surgery;

(ii) Following a multilevel spinal fusion surgery;

(iii) Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site;

(B) A multilevel spinal fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.);

(c) Ultrasonic Osteogenesis Stimulator:

(A) DMAP may cover an ultrasonic osteogenesis stimulator (E0760) only when all of the following criteria are met:

(i) Non-union of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenic stimulator, each separated by a minimum of 90 days. Each radiograph must include multiple views of the fracture site accompanied by a written interpretation by the treating physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs; and

(ii) The stimulator is intended for use prior to surgical intervention and with cast immobilization;

(B) Use of an ultrasonic osteogenic stimulator is not covered:

(i) For non-union fractures of the skull or vertebrae;

(ii) For tumor-related fractures;

(iii) For the treatment of a fresh fracture or delayed union; or

(iv) When used concurrently with other noninvasive osteogenic devices;

(C) DMAP may cover ultrasonic conductive coupling gel as a separate service when an ultrasonic osteogenesis stimulator is covered.

(2) Coding Guidelines: Use E1399 for ultrasonic conductive coupling gel.

(3) Documentation Requirements:

(a) Submit the following with the prior authorization (PA) request:

(A) Documentation that supports the coverage criteria specified in this rule for the stimulator requested are met;

(B) Copies of x-ray and operative reports;

(b) For an electrical osteogenic stimulator, a Certificate of Medical Necessity (CMN) which has been completed, signed and dated by the treating physician may substitute for a written order if it contains all the required elements of an order;

(c) Additional medical records may be requested by DMAP;

(d) The client's medical records must reflect the need for the stimulator requested. The client's medical records include, but are not limited to, the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test/diagnostic reports.

(4) Table 122-0510

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0510 Electronic Stimulators

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0747	Osteogenesis stimulator, electrical, non- invasive, other than spinal applications	PA	PC	RT13			NF
One time payment per condition		E0748Osteogenesis stimulator, electrical,					
	noninvasive, spinal applications						
	One time payment per condition						
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	PA	PC	RT	13		NF
E1399	Durable medical equipment, misc.	PA					

410-122-0515 Neuromuscular Electrical Stimulator (NMES)

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) A neuromuscular electrical stimulator (NMES) uses electrodes to transmit an electrical impulse to the skin over selected muscle groups. There are two broad categories of NMES.

(A) NMES for Treatment of Muscle Atrophy:

(1) NMES devices in this category stimulate the muscle when the client is in a resting state to treat muscle atrophy.

(2) The Division of Medical Assistance Programs (DMAP) will cover NMES to treat muscle atrophy specific to disuse atrophy where nerve supply to the muscle is intact (including brain, spinal cord and peripheral nerves) and to treat other non-neurological reasons for disuse atrophy. Some examples would be casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins).

(B) NMES to Enhance Functional Activity of Neurologically Impaired Clients:

Specifically, DMAP will cover NMES used to improve the ability to walk in clients with Spinal Cord Injury (SCI).

(1) This type of NMES is commonly referred to as functional electrical stimulation (FES). FES devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.

(2) DMAP will only cover NMES/FES for SCI clients for walking, who meet the following criteria:

(i) Client has completed at least 32 physical therapy sessions, directly performed one-on-one with the physical therapist with the NMES/FES device over a trial period of three months, with the specific goal of using the NMES/FES device to achieve walking, not to reverse or retard muscle atrophy.

(I) Therapists with the sufficient skills to provide these services are only employed at inpatient hospitals; outpatient hospitals; comprehensive outpatient rehabilitation facilities; and outpatient rehabilitation facilities;

(II) The physician treating the client for SCI will use this trial period to properly evaluate the person's ability to use the NMES/FES frequently and for the long term; and

(ii) The client meets all of the following characteristics:

(I) Intact lower motor units (L1 and below) (both muscle and peripheral nerve);

(II) Muscle and joint stability for weight bearing at upper and lower extremities that demonstrates balance and control to maintain an upright support posture independently;

(III) Demonstrated brisk muscle contraction to NMES and sensory perception of electrical stimulation sufficient for muscle contraction;

(IV) High motivation, commitment and cognitive ability to use NMES/FES devices for walking;

(V) Can transfer independently and demonstrates independent standing tolerance for at least three minutes;

(VI) Demonstrated hand and finger function to manipulate controls;

(VII) At least six-month post recovery spinal cord injury and restorative surgery;

(VIII) Hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and

(IX) Demonstrated willingness to use the device long-term;

(3) NMES/FES for walking is not covered in an SCI client with any of the following:

(i) Cardiac pacemaker;

(ii) Severe scoliosis or severe osteoporosis;

(iii)Skin disease or cancer at area of stimulation;

(iv) Irreversible contracture;

(v) Autonomic dysflexia; or

(vi)Treatment of muscle weakness due to the following conditions (not all-inclusive):

Stroke; spinal cord injury; peripheral nerve injury; other central nervous system, spinal or peripheral nerve disease/condition affecting motor and/or sensory pathways to/from the muscles being stimulated;

(2) Documentation Requirements: Submit documentation that supports coverage criteria as specified in this rule are met.

(3) Procedure Codes:

(a) A4595, Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES) – Includes all supplies necessary for the effective use of the device - DMAP will purchase – Prior authorization (PA) required;

(b) E0745, Neuromuscular stimulator, electronic shock unit – DMAP will rent – Purchased after no more than 13 months of rental - PA required.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

410-122-0520 Glucose Monitors and Diabetic Supplies

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover medically appropriate diabetic supplies including home blood glucose monitors for clients with diabetes, including gestational diabetes who can better control their blood glucose levels by checking them and contacting their treating practitioner for advice and treatment, as appropriate;

(b) Coverage of home blood glucose monitors is limited to clients meeting all of the following conditions:

(A) The client has diabetes which is being treated by a practitioner; and

(B) The glucose monitor and related accessories and supplies have been ordered by a practitioner who is treating the client's diabetes; and

(C) The client or caregiver has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices; and

(D) The client or caregiver is capable of using the test results to assure the client's appropriate glycemic control; and

(E) The device is designed for home use;

(c) A home blood glucose monitor with special features (E2100 or E2101) may be covered for clients who meet the basic coverage criteria (1)(b)(A)-(E) of this rule; and

(A) For code E2100, the treating practitioner certifies that the client has a severe visual impairment (i.e., best corrected visual acuity of 20/200 or worse) requiring use of this special monitoring system; or

(B) For code E2101, the treating practitioner certifies that the client has an impairment of manual dexterity severe enough to require the use of this special monitoring system. Coverage of E2101 for a client with manual dexterity impairments is not dependent upon a visual impairment;

(d) If a glucose monitor is covered, lancets (A4259), blood glucose test reagent strips (A4253), glucose control solutions (A4256), and spring powered devices for lancets (A4258) may also be covered. Coverage limitations for these supplies is as follows:

(A) A4258 – only one spring powered device every six months;

(B) A4253 and A4259 – The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider of the test strips and lancets must maintain in its records the order from the treating practitioner. Before providing more test strips and lancets, the client must have nearly exhausted their supply. The amount of test strips and lancets covered are based on the needs of the client according to the following utilization guidelines:

(i) Up to 100 test strips and 100 lancets every three months for clients who are not currently being treated with insulin injections;

(ii) Up to 100 test strips and 100 lancets every month for clients who are currently being treated with insulin injections;

(iii) For amounts that exceed the utilization guidelines, the treating practitioner must have:

(I) Documented in the client's medical record the specific reason for the additional supplies for that particular client; and

(II) Seen the client and have evaluated their diabetes control within six months prior to ordering quantities that exceed the utilization guidelines; and

(III) Documented in the client's medical record, a specific narrative statement that adequately specifies the frequency at which the client is actually testing or a copy of the client's log; or there must be documentation in the DMEPOS provider's records, (e.g., a copy of the client's log) that the client is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the client is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months;

(e) DMEPOS providers must not dispense a quantity of supplies exceeding a client's expected utilization. DMEPOS providers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering practitioner that the atypical utilization is, in fact, warranted. Regardless of utilization, a DMEPOS provider must not dispense more than a three month quantity of glucose testing supplies at a time;

(f) Providers may contact the treating practitioner to renew an order; however, the request for renewal may only be made with the client's continued monthly use of testing supplies and only with the client's or caregiver's request to the DMEPOS provider for order renewal;

(g) An order refill does not have to be approved by the ordering practitioner; however, a client or their caregiver must specifically request refills of glucose monitor supplies before they are dispensed. The DMEPOS provider must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the client has "authorized" this in advance;

(h) Codes in this rule ordered by the practitioner on an "as needed" basis are not covered; (i) Purchase fee includes normal, low and high-calibrator solution/chips (A4256), a battery (A4233, A4234, A4235 or A4236) and a spring-powered lancet device (A4258).

(2) Guidelines:

(a) Insulin-treated means that the client is receiving insulin injections to treat their diabetes. Insulin does not exist in an oral form and therefore patients taking oral medication to treat their diabetes are not insulin-treated;

(b) A severe visual impairment is defined as a best corrected visual acuity of 20/200 or worse;

(c) An order renewal is the act of obtaining an order for an additional period of time beyond that previously ordered by the treating practitioner;

(d) An order refill is the act of replenishing quantities of previously ordered items during the time period in which the current order is valid;

(e) A4256 describes control solutions containing high, normal, and low concentrations of glucose that can be applied to test strips to check the integrity of the test strips. This code does not describe the strip or chip which is included in a vial of test strips and which calibrates the glucose monitor to that particular vial of test strips;

(f) For glucose test strips (A4253), 1 unit of service = 50 strips. For lancets (A4259), 1 unit of service = 100 lancets;

(g) Blood glucose test or reagent strips that use a visual reading and are not used in a glucose monitor are not covered. Do not use code A4253 for these items;

(h) DMEPOS providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

(3) Documentation Requirements:

(a) For codes requiring prior authorization (PA), submit documentation which supports coverage criteria as specified in this rule are met;

(b) The order for home blood glucose monitors and/or diabetic testing supplies must include all of the following:

(A) All item(s) to be dispensed;

(B) The specific frequency of testing;

(C) The treating practitioner’s signature;

(D) The date of the treating practitioner's signature;

(E) A start date of the order - only required if the start date is different than the signature date;

(c) A new order must be obtained when there is a change in the testing frequency;

(d) For E2100 or E2101 in a client with impaired visual acuity, submit documentation which includes a narrative statement from the practitioner that indicates the client’s specific numerical visual acuity (e.g., 20/400) and that this result represents "best corrected" vision;

(e) For E2101 - clients with impaired manual dexterity, submit documentation which includes a narrative statement from the practitioner that indicates an explanation of the client’s medical condition necessitating the monitor with special features;

(f) When requesting quantities of supplies which exceed utilization guidelines as specified in (1)(d)(B)(i)-(ii)(e.g., more than 100 blood glucose test strips per month for insulin-dependent diabetes mellitus), submit documentation supporting the medical appropriateness for the higher utilization as specified in (1)(d)(B)(iii)(I)-(III) to the Medical Unit for PA;

(g) Documentation which supports coverage requirements for codes billed in this rule are met, must be kept on file by the DMEPOS provider and made available to DMAP on request;

(h) The ICD-9 diagnosis code describing the condition that necessitates glucose testing must be included on each claim for the monitor, accessories and supplies;

(i) If the client is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted;

(j) If the client is not being treated with insulin injections, the KS modifier must be added to the code for the monitor and each related supply on every claim submitted;

(k) DMEPOS providers are not prohibited from creating data collection forms in order to gather medically appropriate information; however, DMAP will not rely solely on those forms to prove the medical appropriateness of services provided.

(3) Procedure Codes – Table 122-0520

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0520 Diabetic Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
Equipment							
E0607	Home blood glucose monitor		PC			RP	
E2100	Blood glucose monitor with integrated voice synthesizers	PA	PC			RP	
E2101	Blood glucose monitor with integrated lancing/blood sample collection	PA	PC			RP	
Accessories/Supplies							
A4233	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each		PC				
A4234	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each		PC				
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each		PC				
A4236	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each		PC				
A4244	Alcohol or peroxide, per pint		PC				
A4245	Alcohol wipes, per box		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4250	Urine test or reagent strips or tablets, per 100 tablets or strips		PC				
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips ■ 1 unit = 50 strips		PC				
A4255	Platforms for home blood glucose monitor, 50 per box		PC				
A4256	Normal, low and high calibrator solution/chips ■ Replacement only, not billable with new blood glucose monitor		PC				
A4258	Spring-powered device for lancet, each		PC				
A4259	Lancets, per box of 100 ■ 1 unit = 100 lancets		PC				
S8490	Insulin syringes, any size ■ Includes needles ■ 100 syringes ■ 1 unit = 100 syringes		PC				

410-122-0525 External Insulin Infusion Pump

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover an external insulin infusion pump for the administration of continuous subcutaneous insulin for the treatment of diabetes mellitus when criterion (A) or (B) is met and criterion (C) or (D) is met:(A) C-peptide testing requirement:

(i) The C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method; or

(ii) For a client with renal insufficiency and a creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, a fasting C-peptide level is less than or equal to 200 per cent of the lower limit of normal of the laboratory's measurement method; and

(iii) A fasting blood sugar obtained at the same time as the C-peptide level is less than or equal to 225 mg/dl;

(B) Beta cell autoantibody test is positive;

(C) The client has:

(i) Completed a comprehensive diabetes education program; and

(ii) Been on a program of multiple daily injections of insulin (i.e., at least three injections per day), with frequent self-adjustments of insulin dose for at least six months prior to initiation of the insulin pump; and

(iii) Documented frequency of glucose self-testing an average of at least four times per day during the two months prior to initiation of the insulin pump, and meets one or more of the following criteria while on the multiple injection regimen:

(I) Glycosylated hemoglobin level (HbA1C) greater than 7 percent;

(II) History of recurring hypoglycemia;

(III) Wide fluctuations in blood glucose before mealtime;

(IV) Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL;

(V) History of severe glycemic excursions;

(D) The client has:

(i) Been on an external insulin infusion pump prior to enrollment in the medical assistance program, and;

(ii) Documented frequency of glucose self-testing an average of at least four times per day during the month prior to medical assistance program enrollment;

(b) For continued coverage of an external insulin pump and supplies, the client must be seen and evaluated by the treating physician at least every three months;

(c) The external insulin infusion pump must be ordered and follow-up care rendered by a physician who manages multiple clients on continuous subcutaneous insulin infusion therapy and who works closely with a team including nurses, diabetic educators, and dieticians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy;

(d) DMAP may cover supplies (including dressings) used with an external insulin infusion pump during the period of covered use of an infusion pump. These supplies are billed with codes A4221 and K0552;

(e) Code A4221 includes catheter insertion devices for use with external insulin infusion pump infusion cannulas and are not separately payable.

(f) A4221 is limited to one unit of service per week.

(2) Coding Guidelines:

(a) Code A4221 includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784);

(b) Code K0552 describes a syringe-type reservoir that is used with the external insulin infusion pump (E0784).

(3) Documentation Requirements:

(a) With the request for prior authorization (PA), the DMEPOS provider must submit medical justification which supports that the criteria in this rule are met;

(b) When billing and dispensing for an item in Table 122-0525, the DMEPOS provider must ensure that medical records corroborate that all criteria in this rule are met;

(c) The DMEPOS provider must keep medical records on file and make them available to DMAP on request.

(4) Table 122-0525

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0525 External Insulin Infusion Pump

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
Equipment							
E0784	External ambulatory infusion pump, insulin	PA	PC	RT	13	RP	NF
Supplies							
A4221	Supplies for maintenance of drug infusion catheter, per week	PA	PC				NF
K0552	Supplies for external drug infusion pump, syringe type, cartridge, sterile, each	PA	PC				NF
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each		PC				NF
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each		PC				NF
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each		PC				NF
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each		PC				NF
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each		PC				NF

410-122-0540 Ostomy Supplies: Colostomy, Illeostomy, Ureterostomy

(1) Indications and Coverage: The use of ostomy supplies are covered for clients with a surgically created opening (stoma) to divert urine, feces, or ilial contents to outside of the body.

(2) Documentation: The prescription, and documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider.

(3) Procedure Codes: Table 122-0540

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0540 Ostomy Supplies: Colostomy, Illeostomy, Ureterostomy

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4331	Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each		PC				
A4361	Ostomy face plate, each ■ May not bill for A4375, A4376, A4379, or A4380 at the same time		PC				
A4362	Skin barrier; solid, 4 x 4 or equivalent, standard wear, each		PC				
A4364	Adhesive, liquid or equal, any type, per oz.		PC				
A4365	Adhesive remover wipes, any type, 50 per box		PC				
A4366	Ostomy vent, any type, each		PC				
A4367	Ostomy Belt, each		PC				
A4369	Ostomy skin barrier, liquid (spray, brush, etc.), per oz		PC				
A4371	Ostomy skin barrier, powder, per oz.		PC				
A4372	Ostomy skin barrier, solid 4x4 or equivalent, with built-in convexity, each		PC				
A4373	Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each		PC				
A4375	Ostomy pouch, drainable, with faceplate attached, plastic, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each		PC				
A4377	Ostomy pouch, drainable, for use on faceplate, plastic, each		PC				
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each		PC				
A4379	Ostomy pouch, urinary, with faceplate attached, plastic, each		PC				
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each		PC				
A4381	Ostomy pouch, urinary, for use on faceplate, plastic, each		PC				
A4382	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each		PC				
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each		PC				
A4384	Ostomy faceplate equivalent, silicone ring, each		PC				
A4385	Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, without built-in convexity, each		PC				
A4387	Ostomy pouch, closed, with barrier attached, with built-in convexity (one piece), each		PC				
A4388	Ostomy pouch, drainable, with extended wear barrier attached (one piece), each		PC				
A4389	Ostomy pouch, drainable, with barrier attached, with built-in convexity (one piece), each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built- in convexity (one piece), each		PC				
A4391	Ostomy pouch, urinary, with extended wear barrier attached, without built-in convexity (one-piece), each		PC				
A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (one piece), each		PC				
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (one piece), each		PC				
A4394	Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce		PC				
A4395	Ostomy deodorant for use in ostomy pouch, solid, per tablet		PC				
A4396	Ostomy belt with peristomal hernia support		PC				
A4397	Irrigation supply, sleeve, each		PC				
A4398	Ostomy irrigation supply bag, each ■ May bill for A4399 at the same time		PC				
A4399	Ostomy irrigation supplies, cone/catheter, including brush ■ May bill for A4398 at the same time		PC				
A4402	Lubricant, per ounce ■ One unit of service = one oz		PC				
A4404	Ostomy ring, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4405	Ostomy skin barrier, non-pectin based, paste, per ounce		PC				
A4406	Ostomy skin barrier, pectin based, paste, per ounce		PC				
A4407	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each		PC				
A4408	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each		PC				
A4409	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each		PC				
A4410	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each		PC				
A4413	Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system) with filter, each		PC				
A4414	Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, 4 x 4 inches or smaller, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4415	Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4 x 4 inches, each		PC				
A4416	Ostomy pouch, closed, with barrier attached, with filter, each		PC				
A4417	Ostomy pouch, closed, with barrier attached, with filter, with built-in convexity, each		PC				
A4418	Ostomy pouch, closed; without barrier attached, with filter, each		PC				
A4419	Ostomy pouch, closed; for use on barrier with non-locking flange, with filter, (2-piece), each		PC				
A4420	Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each		PC				
A4421	Ostomy supply; miscellaneous	PA	PC				
A4422	Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each		PC				
A4423	Ostomy pouch, closed; for use on barrier with locking flange (2 piece), with filter, each		PC				
A4424	Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each		PC				
A4425	Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4426	Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each		PC				
A4427	Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each		PC				
A4428	Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each		PC				
A4429	Ostomy pouch, urinary, with barrier, attached, with built-in convexity, with faucet-type tap with valve (1 piece), each		PC				
A4430	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each		PC				
A4431	Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each		PC				
A4432	Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each						
A4433	Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each		PC				
A4434	Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4455	Adhesive remover or solvent (for tape, cement or other adhesive ■ One unit of service = one oz. of liquid or spray)		PC				
A5051	Ostomy pouch, closed; with barrier attached (1 piece), standard wear, each		PC				
A5052	Ostomy pouch, closed; without barrier attached (1 piece), each		PC				
A5053	Ostomy pouch, closed; for use on faceplate, each		PC				
A5054	Ostomy pouch, closed for use on barrier with flange (2 piece), each		PC				
A5055	Stoma cap, each		PC				
A5061	Ostomy pouch, drainable; with barrier attached (one piece), each		PC				
A5062	Ostomy pouch, drainable, without barrier attached (1 piece), each		PC				
A5063	Ostomy pouch, drainable, for use on barrier with flange (2 piece system), each		PC				
A5071	Ostomy pouch, urinary, with barrier attached (1 piece), each		PC				
A5072	Ostomy pouch, urinary, without barrier attached (1 piece), each		PC				
A5073	Ostomy pouch, urinary, for use on barrier with flange (2 piece), each		PC				
A5081	Continent device; plug for continent stoma, each		PC				
A5082	Catheter for continent stoma, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A5093	Ostomy accessory; convex insert, each		PC				
A5119	Skin barrier, wipes, box per 50		PC				
A5121	Skin barrier, solid, 6 x 6 or equivalent, each		PC				
A5122	Skin barrier, solid, 8 x 8 or equivalent, each		PC				
A5126	Adhesive or non-adhesive; disc or foam pad		PC				
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.		PC				

410-122-0560 Urological Supplies

(1) Indications and Limitations of Coverage and/or Medical Appropriateness:

(a) Urinary catheters and external urinary collection devices are covered when used to drain or collect urine for a client who has permanent urinary incontinence or permanent urinary retention;

(b) Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within three months. A determination that there is no possibility that the client's condition may improve sometime in the future is not required. If the medical record, including the judgment of the attending treating physician, indicates the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is considered met;

(c) For adults, Medicare coverage criteria must be met (see Medicare's website for coverage criteria);

(d) Supplies for intermittent irrigation of indwelling catheters may be covered when they are used on an as needed (non-routine) basis in the presence of acute obstruction of the catheter;

(e) Supplies for continuous irrigation of indwelling catheters may be covered if there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically necessary catheter changes;

(f) Reimbursement for more than 200 pairs of non-sterile gloves (A4927) per month is not payable by the Division of Medical Assistance Programs (DMAP).

(2) Documentation Requirements:

(a) Documentation of medical appropriateness which has been reviewed and signed by the treating physician must be kept on file by the durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) provider;

(b) Medical appropriateness for use of a greater quantity of supplies than the amounts specified in this policy must be documented in the client's medical record and kept on file by the DMEPOS provider;

(c) Documentation required in this policy must be available to DMAP on request.

(3) Table 122-0560.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065 1-1-07

Table 122-0560 Urological Services

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4217	Sterile water/saline, 500 ml.		PC				
A4310	Insertion tray without drainage bag and without catheter (accessories only) ■ Limited to one per month ■ Not covered for intermittent catheterization ■ Not covered at the same time as A4311, A4312, A4313, A4314, A4315, A4316, A4332, A4353, A4354		PC				
A4311	Insertion tray without drainage bag, with indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.) ■ Limited to one per month ■ Not covered for intermittent catheterization ■ Not covered at the same time as, A4310, A4312, A4313, A4314, A4315, A4316, A4332, A4338, A4340, A4344, A4346, A4351, A4352, A4353, A4354		PC				
A4312	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone ■ Limited to one per month for routine catheter maintenance ■ Not covered for intermittent catheterization		PC				

Table 122-0560 Urological Services

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
	■ Not covered at the same time as A4310, A4311, A4313, A4314, A4315, A4316, A4332, A4338, A4340, A4344, A4346, A4351, A4352, A4353, A4354, A5105						
A4313	Insertion tray without drainage bag with indwelling catheter, ~~f~~ Foley type, three-way for continuous irrigation		PC				
	■ Limited to one per month for routine catheter maintenance						
	■ Not covered for intermittent catheterization						
	■ Not covered at the same time as A4310, A4311, A4312, A4314, A4315, A4316, A4332, A4338, A4340, A4344, A4346, A4351, A4352, A4353, A4354						
A4314	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)		PC				
	■ Limited to one per month for routine catheter maintenance						
	■ Not covered for intermittent catheterization						
	■ Not covered at the same time as A4310, A4311, A4314, A4332, A4338, A4344, A4357						

Table 122-0560 Urological Services

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4315	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone ■ Not covered for intermittent catheterization ■ Not covered at the same time as A4310, A4312, A4332, A4344, A4354, A4357		PC				
A4316	Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation ■ Limited to one per month for routine catheter maintenance ■ Not covered for intermittent catheterization ■ Not covered at the same time as A4310, A4313, A4332, A4344, A4346, A4354, A4357		PC				
A4320	Irrigation tray with bulb or piston syringe, any purpose		PC				
A4322	Irrigation syringe, bulb or piston, each		PC				
A4326	Male external catheter specialty type with integral collection chamber, each		PC				
A4327	Female external urinary collection4 device, metal cup, each ■ Limited to one per week		PC				
A4328	Female external urinary collection device; pouch, each ■ Limited to one per day		PC				

Table 122-0560 Urological Services

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4331	Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each		PC				
A4332	Lubricant, individual sterile packet, for insertion of urinary catheter, each ■ Not covered for intermittent catheterization (A4351, A4352) ■ Not covered at the same time as A4310, A4311, A4312, A4313, A4314, A4315, A4316, A4353, A4354		PC				
A4333	Urinary catheter anchoring device, adhesive skin attachment, each ■ Limited to three per week		PC				
A4334	Urinary catheter anchoring device, leg strap, each ■ Limited to one per month		PC				
A4338	Indwelling catheter; Foley type, two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each ■ Limited to one per month for routine catheter maintenance ■ Not covered at the same time as A4311		PC				

Table 122-0560 Urological Services

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4340	Indwelling catheter; specialty type, e.g., coude, mushroom, wing, etc., each ■ Limited to one per month for routine catheter maintenance		PC				
A4344	Indwelling catheter Foley type, two-way, all silicone, each ■ Limited to one per month for routine catheter maintenance ■ Not covered at the same time as A4312, A4315		PC				
A4346	Indwelling catheter, Foley type, three-way for continuous irrigation, each ■ Limited to one per month for routine catheter maintenance ■ Not covered at the same time as A4313, A4316 ■ Limited to use for continuous irrigation of indwelling catheter		PC				
A4348	Male external catheter with integral collection compartment, extended wear, each		PC				
A4349	Male external catheter, with or without adhesive, disposable, each ■ Limited to 35 per month ■ Adhesive strips or tape are included in the allowable		PC				

Table 122-0560 Urological Services

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
	■ Not covered at the same time as K0572, K0573						
A4351	Intermittent urinary catheter; straight tip, each ■ Limited to one per week ■ Not covered at the same time as A4332, A4352 or A4353		PC				
A4352	Intermittent urinary catheter; coude (curved) tip, each ■ Limited to one per week ■ Not covered at the same time as A4332, A4351 or A4353		PC				
A4353	Intermittent urinary catheter with insertion supplies ■ Includes a catheter, lubricant, gloves, antiseptic solution, applicators, drape, and a tray or bag in a sterile package intended for single use ■ Limited to one per week ■ Not covered at the same time as A4310, A4332, A4344, A4351, A4352		PC				
A4354	Catheter insertion tray with drainage bag but without catheter ■ Not covered at the same time as A4310, A4314, A4315, A4316, A4332, A4357		PC				

Table 122-0560 Urological Services

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4355	Irrigation tubing set for continuous bladder irrigation through a three-way indwelling Foley catheter, each		PC				
A4356	External urethral clamp or compression device (not to be used for a catheter clamp), each ■ Limited to one per three months		PC				
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each ■ Limited to two per month ■ Not covered at the same time as A4314, A4315, A4316, A4354, A5102		PC				
A4358	Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each ■ For clients who are ambulatory, up in a chair or wheelchair bound ■ Limited to two per month ■ Not covered at the same time as A5105, A5112, A5113, A5114		PC				
A4359	Urinary suspensory without leg bag, each ■ Not covered at the same time as A5105		PC				
A4402	Lubricant, per ounce		PC				
A4927	Gloves, non-sterile, per 100 ■ Limited to 200 pair per month		PC				

Table 122-0560 Urological Services

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4930	Gloves, sterile, per pair ■ For sterile catheter technique only		PC				
A5102	Bedside drainage bottle, with or without tubing, rigid or expandable, each ■ Limited to two per six months ■ Not covered at the same time as A4357		PC				
A5105	Urinary suspensory; with leg bag, with or without tube ■ Not covered at the same time as A4358, A4359, A5112, A5113, A5114		PC				
A5112	Urinary leg bag; latex ■ Limited to one per month ■ For clients who are ambulatory, up in a chair or wheelchair bound ■ Not covered at the same time as A4358, A5113, A5114		PC				
A5113	Leg strap; latex, replacement only, per set ■ Not covered at the same time as A4112, A4358, A5105		PC				
A5114	Leg strap; foam or fabric, replacement only, per set ■ Not covered at the same time as A4358, A5105, A5112		PC				

Table 122-0560 Urological Services

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.		PC				
A5200	Percutaneous catheter/tube anchoring device, adhesive skin attachment		PC				

410-122-0580 Bath Supplies

(1) Indications and Coverage – A rehab shower/commode chair is covered when all of the following criteria are met:

(a) Client is unable to use a standard shower chair/bench due to a musculoskeletal condition;

(b) Client has positioning, trunk stability or neck support needs that a standard shower chair/bench cannot provide;

(c) The home (shower) can accommodate a rehab/shower chair; and,

(d) Less costly alternatives have been considered and ruled out.

(2) Documentation:

(a) The prescription and medical justification for the equipment must be kept on file by the DME supplier. The prescribing practitioner's records must contain information which supports the medical appropriateness of the item ordered.

(b) Documentation of MSRP must be kept on file by the DME supplier.

(c) For a rehab/shower chair, submit documentation to support the above criteria, including a list of equipment available for client's use.

(3) Table 122-0580

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0580 Bath Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0160	Sitz type bath or equipment, portable, used with or without commode		PC				
E0161	Sitz type bath or equipment, portable, used with or without commode with faucet attachments		PC				
E0162	Sitz bath chair	*	PC	RT			
E0240	Bath/shower chair, with or without wheels,any size						
	* - By report (submit invoice and shipping charges for payment review)						
E0241	Bathtub wall rail, each		PC				
E0242	Bathtub rail floor base		PC				
E0243	Toilet rail, each		PC				
E0245	Tub stool or bench		PC				
E0246	Transfer tub rail attachment		PC				
E0247	Transfer bench for tub or toilet with or without commode opening		PC				
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening		PC				
E0705	Transfer board or device, any type, each		PC	RT			

Code	Description	PA	PC	RT	MR	RP	NF
E1399	Durable medical equipment, miscellaneous, includes but is not limited to: ■ Rehab shower/commode chair; and ■ Other medically appropriate ONLY accessories for a rehab shower/commode chair such as: ◆ Elevating and/or swing away footrest ◆ Swing away arm rests ◆ Non-corrosive construction ◆ Padded seat ◆ Wheeled Adjustable head immobilized ◆ Reclining back ◆ Braking system ◆ Leg and/or restraint belt	PA	PC	RT		RP	

410-122-0590 Patient Lifts

(1) Indications and Coverage -- A lift is covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the client would be bed confined.

(2) A sling or seat for a client lift may be covered as an accessory when ordered as a replacement for the original equipment item.

(3) E0621 is included in the allowance for E0630 when provided at the same time.

(4) Procedure Codes:

(a) E0621 -- Sling or seat, client lift, canvas or nylon – the Office of Medical Assistance Programs (OMAP) will purchase – Prior authorization (PA) required;

(b) E0630 -- Client lift, hydraulic with seat or sling (considered purchased after 13 months of rental) – OMAP will purchase, rent or repair – PA required;

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-122-0600 Toilet Supplies

(1) The Division of Medical Assistance Programs (DMAP) may consider coverage for commodes when:

(a) The client is physically incapable of utilizing regular toilet facilities. This would occur when the client is confined to:

(A) A single room; or

(B) One level of the home environment and there is no toilet on that level; or

(C) The home and there are no toilet facilities in the home;

(b) Extra-wide/heavy-duty commodes may be covered when(A) The client weighs 300 pounds or more and meets the conditions of coverage for commodes;

(c) Only bariatric commodes coded as E1399 (durable medical equipment, miscellaneous) may be covered for a client residing in a nursing facility, subject to service limitations of DMAP rules, when all of the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric commode has been assigned code E1399 by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC);

(2) Documentation Requirements:

(a)Documentation must include the practitioner's order, the client's height and weight and information supporting the medical appropriateness for the commode dispensed;

(b) For codes requiring prior authorization (PA), submit documentation which supports conditions of coverage are met as specified in this rule.

(3) Procedure Codes – Table 122-0600.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0600 Toilet Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0163	Commode chair – stationary with fixed arms		PC	RT	13	RP	
E0164	Commode chair, mobile with fixed arms		PC	RT	13	RP	
E0165	Commode chair, stationary, with detachable arms ■ Covered if necessary to facilitate transferring the client ■ Covered if the client has a body configuration that requires extra width		PC	RT	13	RP	
E0166	Commode chair, mobile, with detachable arms ■ Covered if necessary to facilitate transferring the client ■ Covered if the client has a body configuration that requires extra width		PC	RT	13	RP	
E0167	Pail or pan for use with commode chair ■ Replacement only ■ Not covered at same time as E0163, E0164, E0165, E0166		PC				
E0168	Commode chair, extra-wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each ■ Width of 23 inches or more and/or capable of supporting clients who weigh 300 pounds or more	PA	PC	RT	13	RP	

Code	Description	PA	PC	RT	MR	RP	NF
E0244	Raised toilet seat		PC				
E0275	Bedpan, standard metal or plastic		PC				
E0276	Bedpan, fracture metal or plastic		PC				
E0325	Urinal, male, jug-type, any material		PC				
E0326	Urinal, female, jug-type, any material		PC				
E1399	Bariatric commode coded as E1399 by SADMERC	PA	PC	RT	13	RP	NF

410-122-0620 Miscellaneous Supplies

Procedure Codes – Table 122-0620.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0620 Miscellaneous Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4206	Syringe with needle, sterile 1cc, each ■ Also used for.3cc or.5cc sterile syringe with needle		PC				
A4207	Syringe with needle, sterile, 2cc, each		PC				
A4208	Syringe with needle, sterile, 3cc, each		PC				
A4209	Syringe with needle, sterile, 5cc or greater, each		PC				
A4213	Syringe, sterile, 20cc or greater, each		PC				
A4215	Needle only, sterile, any size, each		PC				
A4244	Alcohol or peroxide, per pint		PC				
A4245	Alcohol wipes, per box		PC				
A4246	Betadine or phisohex solution, per4 pint		PC				
A4247	Betadine or iodine swabs/wipes, per box		PC				
A4250	Urine test or reagent strips or tablets (100 tablets or strips)		PC				
A4320	Irrigation tray with bulb or piston syringe, any purpose		PC				
A4322	Irrigation syringe, bulb or piston, each		PC				
A4330	Perianal fecal collection pouch with adhesive, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope		PC				
A4663	Blood pressure cuff only		PC				
A4670	Automatic blood pressure monitor ■ Covered only if no one in residence is available to safely and accurately use or assist with standard blood pressure equipment and client or caregiver must be able to demonstrate ability to use equipment and correctly interpret results	PA	PC				
E0191	Heel or elbow protector, each		PC				
E0370	Air pressure elevator for heel		PC				
E0701	Helmet with face guard and soft interface materials, prefabricated		PC				NF
S8265	Haberman feeder for cleft lip/palate		PC				
V5266	Battery for use in hearing device ■ Limited to 60 batteries per calendar year		PC				NF

410-122-0625 Surgical Dressing

Procedure Codes -- Table 122-0625.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0625 Surgical Dressing

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4450	Tape, non-waterproof, per 18 square inches		PC				
A4452	Tape, waterproof, per 18 square inches		PC				
A4462	Abdominal dressing holder, each		PC				
A4927	Gloves, non-sterile, per 100 ■ Limited to 200 pair per month		PC				
A4930	Gloves, sterile, per pair, limited to sterile procedure only		PC				
A6010	Collagen based wound filler, dry form, per gram of collagen		PC				
A6011	Collagen based wound filler, gel/paste, per gram of collagen		PC				
A6021	Collagen dressing, pad size 16 sq. in. or less, each		PC				
A6022	Collagen dressing, pad size more than 16 sq. in., but less than or equal to 48 sq. in., each		PC				
A6023	Collagen dressing, pad size more than 48 sq. in., each		PC				
A6024	Collagen dressing, wound filler, per 6 in.		PC				
A6025	Gel sheet for dermal or epidermal application, (e.g., silicone, hydro-gel, other), each		PC				
A6154	Wound pouch, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6196	Alginate dressing, wound cover, pad size 16 sq. inches or less, each dressing		PC				
A6197	Alginate dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing		PC				
A6198	Alginate dressing, wound cover, pad size more than 48 sq. inches, each dressing		PC				
A6199	Alginate dressing, wound filler ■ One unit of service = six inches		PC				
A6200	Composite dressing, pad size 16 sq. inches or greater, but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6201	Composite dressing, pad size more than 16 sq. inches, but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6202	Composite dressing, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6203	Composite dressing, pad size 16 sq. inches or less, with any size adhesive border, each dressing		PC				
A6204	Composite dressing, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6205	Composite dressing, pad size more than 48 sq. inches, with any size adhesive border, each dressing		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6206	Contact layer, 16 sq. inches, or less, each dressing		PC				
A6207	Contact layer, more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing		PC				
A6208	Contact layer, more than 48 sq. inches, each dressing		PC				
A6209	Foam dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6210	Foam dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6211	Foam dressing, wound cover, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6212	Foam dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing		PC				
A6213	Foam dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6214	Foam dressing, wound cover, pad size more than 48 sq. inches, with any size adhesive border, each dressing		PC				
A6215	Foam dressing, wound filler ■ One unit of service = one gram		PC				
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6217	Gauze, non-impregnated, non-sterile,		PC				
A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6219	Gauze, non-impregnated, non-sterile, pad size 16 sq. inches, or less, with any size adhesive border, each dressing		PC				
A6220	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6221	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. inches, with any size adhesive border, each dressing		PC				
A6222	Gauze, impregnated with other than water, normal saline, or hydro-gel, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6223	Gauze, impregnated with other than water, normal saline, or hydro-gel, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6224	Gauze, impregnated with other than water, normal saline, or hydro-gel, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6231	Gauze, impregnated, hydro-gel, for direct wound contact, pad size 16 sq. inches or less, each dressing		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6232	Gauze, impregnated, hydro-gel, for direct wound contact, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing		PC				
A6233	Gauze, impregnated, hydro-gel, for direct wound contact, pad size more than 48 sq. inches, each dressing		PC				
A6234	Hydrocolloid dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6235	Hydrocolloid dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6236	Hydrocolloid dressing, wound cover, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6237	Hydrocolloid dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing		PC				
A6238	Hydrocolloid dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6239	Hydrocolloid dressing, wound cover, pad size more than 48 sq. inches, with any size adhesive border, each dressing		PC				
A6240	Hydrocolloid dressing, wound filler, paste ■ One unit of service = one ounce		PC				
A6241	Hydrocolloid dressing, wound filler, dry form		PC				

Code	Description	PA	PC	RT	MR	RP	NF
	■ One unit of service = one gram						
A6242	Hydro-gel dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6243	Hydro-gel dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6244	Hydro-gel dressing, wound cover, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6245	Hydro-gel dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing		PC				
A6246	Hydro-gel dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6247	Hydro-gel dressing, wound cover, pad size more than 48 sq. inches, with any size adhesive border, each dressing		PC				
A6248	Hydro-gel dressing, wound filler, gel		PC				
	■ One unit of service = one fluid ounce						
A6251	Specialty absorptive dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6252	Specialty absorptive dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6253	Specialty absorptive dressing, wound cover, pad size more than 48 sq. inches without adhesive border, each dressing		PC				
A6254	Specialty absorptive dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing		PC				
A6255	Specialty absorptive dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6256	Specialty absorptive dressing, wound cover, pad size more than 48 sq. inches with any size adhesive border, each dressing		PC				
A6257	Transparent film, 16 sq. inches or less, each dressing		PC				
A6258	Transparent film, more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing		PC				
A6259	Transparent film, more than 48 sq. inches, each dressing		PC				
A6261	Wound filler, not elsewhere classified, gel/paste ■ One unit of service = one fluid ounce	PA	PC				
A6262	Wound filler, not elsewhere classified, dry form ■ One unit of service = one gram	PA	PC				
A6266	Gauze, impregnated, other than water or normal saline, or zinc paste, any width		PC				

Code	Description	PA	PC	RT	MR	RP	NF
	■ One unit of service = one linear yard)						
A6402	Gauze, non-impregnated, sterile, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6403	Gauze, non-impregnated, sterile, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6404	Gauze, non-impregnated, sterile, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6407	Packing strips, non-impregnated, up to 2 inches in width, per linear yard		PC				
A6410	Eye pad, sterile, each		PC				
A6411	Eye pad, non-sterile, each		PC				
A6512	Eye patch, occlusive, each		PC				
A6441	Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard		PC				
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard		PC				
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard		PC				
A6444	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per yard		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6445	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard		PC				
A6446	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard		PC				
A6447	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard		PC				
A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard		PC				
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard		PC				
A6452	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard		PC				
A6453	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard		PC				
A6454	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard		PC				
A6455	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven width greater than or equal to three inches and less than five inches, per yard		PC				
A7040	One way chest drain valve		PC				
A7041	Water seal drainage container and tubing for use with implanted chest tube		PC				

410-122-0630 Incontinent Supplies

(1) Incontinent supplies may be covered for urinary or fecal incontinence as follows:

(a) Category I Incontinent Supplies –

For up to 220 units (any code or product combination in this category) per month, unless documentation supports the medical appropriateness for a higher quantity;

(b) Category II Underpads:

(A) Disposable underpads (T4541 and T4542): For up to 100 units (any combination of T4541 and T4542) per month, unless documentation supports the medical appropriateness for a higher quantity, up to a maximum of 150 units per month;

(B) Reusable/washable underpads: (T4537 and T4540) For up to eight units (any combination of T4537 and T4540) in a 12 month period;

(C) Category II Underpads are separately payable only with Category I Incontinent Supplies;

(D) T4541 and T4542 are not separately payable with T4537 and T4540 for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for eight reusable/washable underpads on a given date of service, a client would not be eligible for disposable underpads for the subsequent 12 months.

(c) Category III Washable Protective Underwear:

(A) For up to 12 units in a 12 month period;

(B) Category III Washable Protective Underwear are not separately payable with Category I Incontinent Supplies for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for 12 units of T4536 on a given date of service, a client would not be eligible for Category I Incontinent Supplies for the subsequent 12 months.

(2) Incontinent supplies are not covered:

(a) For nocturnal enuresis; or

(b) For children under the age of three.

(3) A provider may only submit A4335 when there is no definitive Healthcare Common Procedure Coding System (HCPCS) code that meets the product description.

(4) Documentation requirements: Submit the following documentation for review:

(a) For all categories, the medical reason and condition causing the incontinence; and

(b) When a client is using urological or ostomy supplies at the same time as codes specified in this rule, information which clearly corroborates the overall quantity of supplies needed to meet bladder and bowel management is medically appropriate.

(5) Quantity specification:

(a) For prior authorization (PA) and reimbursement purposes, a unit count for Category I – III codes is considered as single or individual piece of an item and not as multiple quantity;

(b) If an item quantity is listed as number of boxes, cases or cartons, the total number of individual pieces of that item contained within that respective measurement (box, case or carton) must be specified in the unit column on the PA request. See table 122-0630-2;

(c) For gloves (Category IV Miscellaneous), 100 gloves equal one unit.

(9)Table 122-0630-1

(10)Table 122-0630-2

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0630-1 Incontinent Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
CATEGORY I – Incontinent Supplies							
A4335	Incontinence supply; miscellaneous	PA	PC				
T4521	Adult-sized disposable incontinence product, brief/diaper, small, each	PA	PC				
T4522	Adult-sized disposable incontinence product, brief/diaper, medium, each	PA	PC				
T4523	Adult-sized disposable incontinence product brief/diaper, large, each	PA	PC				
T4524	Adult-sized disposable incontinence product, brief/diaper, extra large, each	PA	PC				
T4525	Adult-sized disposable incontinence product, protective underwear/pull-on, small size, each	PA	PC				
T4526	Adult-sized disposable incontinence product, protective underwear/pull-on, medium size, each	PA	PC				
T4527	Adult-sized disposable incontinence product, protective underwear/pull-on, large size, each	PA	PC				
T4528	Adult-sized disposable incontinence product, protective underwear/pull-on, extra large size, each	PA	PC				
T4529	Pediatric-sized disposable incontinence product, brief/diaper, small/medium, each	PA	PC				

Table 122-0630-1 Incontinent Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
T4530	Pediatric-sized disposable incontinence product, brief/diaper, large, each	PA	PC				
T4531	Pediatric-sized disposable incontinence product, protective underwear/pull-on, small/medium size, each	PA	PC				
T4532	Pediatric-sized disposable incontinence product, protective underwear/pull-on, large size, each	PA	PC				
T4533	Youth-sized disposable incontinence product, brief/diaper, each	PA	PC				
T4534	Youth-sized disposable incontinence product, protective underwear/pull-on, each	PA	PC				
T4535	Disposable liner/ shield/ guard/ pad/ undergarment, for incontinence, each ■ Including but not limited to: pant liner, insert, insert pad, shield, pad, guard, booster pad, or belt-less undergarment	PA	PC				
T4538	Diaper service, reusable diaper, each diaper	PA	PC				

Table 122-0630-1 Incontinent Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
CATEGORY II – Underpads							
T4537	Incontinence product, protective underpad, reusable, bed size, each	PA	PC				
T4540	Incontinence product, protective underpad, reusable, chair size, each	PA	PC				
T4541	Incontinence product, disposable, large, each (more than 394 square inches)	PA	PC				
T4542	Incontinence product, disposable, small, each (less than or equal to 394 square inches)	PA	PC				
CATEGORY III – Washable Protective Underwear							
T4536	Incontinence product, protective underwear/pull-on, reusable,any size, each	PA	PC				
CATEGORY IV - Miscellaneous							
A4927	Gloves, non-sterile, per 100 (50 pairs) ■ Limited to 4 units (200 pairs) per month ■ Covered only when directly related to usage of incontinent supplies		PC				

Table 122-0630-2 Incontinent Supplies

How to count units/pieces when requesting prior authorization (PA) – *Sample*

Container description	Individual pieces (count)	Units considered for PA
1 box of diapers	10	10
1 box of gloves	100 pieces (50 pairs)	100 gloves = 1 unit

410-122-0640 Eye Prostheses

(1) Indications and Coverage:

(a) An eye prosthesis is indicated for a client (adult or child) with absence or shrinkage of an eye due to birth defect, trauma or surgical removal;

(b) Polishing and resurfacing will be allowed on a yearly basis;

(c) Replacement is covered every five years with extensions allowed when documentation supports medical appropriateness for more frequent replacement.

(2) Documentation: Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider.

(3) Procedure Codes – Table 122-0640.
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0640 Eye Prostheses

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
V2623	Prosthetic eye, plastic, custom		PC				NF
V2624	Polishing/Resurfacing of ocular prosthesis		PC				NF
V2625	Enlargement of ocular prosthesis		PC				NF
V2626	Reduction of ocular prosthesis		PC				NF
V2627	Scleral cover shell		PC				NF
V2628	Fabrication and fitting of ocular conformer		PC				NF
V2629	Prosthetic eye, other type		PC				NF

410-122-0660 Orthotics and Prosthetics

(1) Indications and Coverage:

(a) All of the orthotic and prosthetic “L” codes and any temporary “S” or “K” codes have been removed from the rules except for:

(A) OAR 410-122-0470 Supports and Stockings;

(B) OAR 410-122-0255 External Breast Prosthesis, and;

(C) OAR 410-122-0680 Facial Prosthesis.

(b) Use the current HCPCS Level II Guide for current codes and descriptions;

(c) For adults, follow Medicare current guidelines for determining coverage;

(d) For children, the prescribing practitioner must determine and document medical appropriateness.

(2) Prior Authorization is required for the following codes:

(a) L1499;

(b) L2999;

(c) L3649;

(d) L3999;

(e) L5999;

(f) L7499;

(g) L8499;

(h) L9900.

(3) Codes Not Covered -- Table 122-0660.

(4) Reimbursement:

(a) The hospital is responsible for reimbursing the provider for orthotics and prosthetics provided on an inpatient basis;

(b) Evaluations, office visits, fittings and materials are included in the service provided;

(c) Evaluations will only be reimbursed as a separate service when the provider travels to a client's residence to evaluate the client's need;

(d) All covered orthotic and prosthetic codes are also covered if client resides in a nursing facility except:

(A) L1500;

(B) L1510, and;

(C) L1520.

(e) Use type of service "J' when billing for a tracheostomy speaking valve (L8501). See Division 129, Speech-Language Pathology, Audiology and Hearing Aid Services for rule information.

Table 122-0660

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0660 Orthotics and Prosthetics

Codes Not Covered

L1844	L5781	L6881	L7030	L7364
L2750	L5782	L6882	L7035	L7366
L2780	L5822	L6920	L7040	L7367
L3031	L5824	L6925	L7045	L7368
L3251	L5828	L6930	L7170	L7500
L5610	L5830	L6935	L7180	
L5613	L5847	L6940	L7185	L7900
L5614	L5848	L6945	L7186	L8510
L5722	L5980	L6950	L7190	L8511
L5724	L6025	L6955	L7191	L8512
L5726	L6310	L6960	L7260	L8513
L5728	L6360	L6965	L7261	L8514
L8010	L6638	L6970	L7266	L8614
L8500	L6646	L6975	L7272	L8619
L8505	L6648	L7015	L7274	
L8507	L6825	L7020	L7360	
L5780	L6875	L7025	L7362	

410-122-0678 Dynamic Adjustable Extension/Flexion Device

Procedure Codes – Table 122-0678

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0678 Dynamic Adjustable Extension/Flexion Device

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E1800	Dynamic adjustable elbow extension/flexion device, includes soft interface material		PC	RT	13		NF
E1802	Dynamic adjustable forearm pronation/supernator device, includes soft interface material		PC	RT	13		NF
E1805	Dynamic adjustable wrist extension/flexion device, includes soft interface material		PC	RT	13		NF
E1810	Dynamic adjustable knee extension/flexion device, includes soft interface material		PC	RT	13		NF
E1815	Dynamic adjustable ankle extension/flexion device, includes soft interface material		PC	RT	13		NF
E1820	Replacement soft interface material, dynamic adjustable extension/flexion device		PC				NF
E1825	Dynamic adjustable finger extension/flexion device, includes soft interface material		PC	RT	13		NF
E1830	Dynamic adjustable toe extension/flexion device, includes soft interface material		PC	RT	13		NF
E1840	Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material		PC	RT	13		NF

410-122-0680 Facial Prostheses

(1) Indications and Coverage:

(a) Covered when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect;

(b) Adhesives, adhesive remover and tape used in conjunction with a facial prosthesis are covered. Other skin care products related to the prosthesis, including but not limited to cosmetics, skin cream, cleansers, etc., are not covered;

(c) The following services and items are included in the allowance for a facial prosthesis:

(A) Evaluation of the client;

(B) Pre-operative planning;

(C) Cost of materials;

(D) Labor involved in the fabrication and fitting of the prosthesis;

(E) Modifications to the prosthesis made at the time of delivery of the prosthesis or within 90 days thereafter;

(F) Repair due to normal wear or tear within 90 days of delivery;

(G) Follow-up visits within 90 days of delivery of the prosthesis.

(d) Modifications to a prosthesis that occur more than 90 days after delivery of the prosthesis and that are required because of a change in the client's condition are covered;

(e) Repairs are covered when there has been accidental damage or extensive wear to the prosthesis that can be repaired. If the expense for repairs exceeds the estimated expense for a replacement prosthesis, no payments can be made for the amount of the excess;

(f) Follow-up visits which occur more than 90 days after delivery and which do not involve modification or repair of the prosthesis are non-covered services;

(g) Replacement of a facial prosthesis is covered in cases of loss or irreparable damage or wear or when required because of a change in the client's condition that cannot be accommodated by modification of the existing prosthesis;

(h) When a prosthesis is needed for adjacent facial regions, a single code must be used to bill for the item, whenever possible. For example, if a defect involves the nose and orbit, this should be billed using the hemi-facial prosthesis code and not separate codes for the orbit and nose. This would apply even if the prosthesis is fabricated in two separate parts.

(2) Documentation: The following must be submitted for prior authorization (PA):

(a) An order for the initial prosthesis and/or related supplies which is signed and dated by the ordering prescribing practitioner must be kept on file by the prosthetist/supplier and submitted with request for PA;

(b) A separate prescribing practitioner order is not required for subsequent modifications, repairs or replacement of a facial prosthesis;

(c) A new prescribing practitioner order is required when different supplies are ordered;

(d) A photograph of the prosthesis and a photograph of the client without the prosthesis must be retained in the supplier's record and must be submitted with the PA request;

(e) When code L8048 is used for a miscellaneous prosthesis or prosthetic component, the authorization request must be accompanied by a clear description and a drawing/copy of photograph of the item provided and the medical appropriateness;

(f) Requests for replacement, repair or modification of a facial prosthesis must include an explanation of the reason for the service;

(g) When replacement involves a new impression/moulage rather than use of a previous master model, the reason for the new impression/moulage must be clearly documented in the authorization request.

(3) Procedure Codes – Table 122-0680.
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

Table 122-0680 Facial Prostheses

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4364	Adhesive liquid, or equal, any type, per ounce		PC				NF
A4365	Adhesive remover wipes, any type, per box of 50		PC				NF
L8040	Nasal prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores all or part of the nose ■ It may include the nasal septum	PA	PC				NF
L8041	Mid-facial prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores part or all of the nose plus significant adjacent facial tissue/structures, but does not include the orbit or any intra-oral maxillary component ■ Adjacent facial tissue/structures include one or more of the following: ◆ Soft tissue of the cheek, ◆ Upper lip, or ◆ Forehead	PA	PC				NF
L8042	Orbital prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores the eyelids and the hard and soft tissue of the orbit ■ It may also include the eyebrow	PA	PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
	■ This code does not include the ocular prosthesis component						
L8043	Upper facial prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores the orbit plus significant adjacent facial tissue/structures, but does not include the nose or any intra-oral maxillary component ■ Adjacent facial tissue/structures include one or more of the following: soft tissue of the cheek or forehead ■ This code does not include the ocular prosthesis component	PA	PC				NF
L8044	Hemi-facial prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores part or all of the nose plus the orbit plus significant adjacent facial tissue/structures, but does not include any intra-oral maxillary component ■ This code does not include the ocular prosthesis component	PA	PC				NF
L8045	Auricular prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores all or part of the ear	PA	PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
L8046	Partial facial prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores a portion of the face but which does not specifically involve the nose, orbit or ear	PA	PC				NF
L8047	Nasal septal prosthesis provided by a non-physician ■ A removable superficial prosthesis which occludes a hole in the nasal septum but which does not include superficial nasal tissue	PA	PC				NF
L8048	Unspecified maxillofacial prosthesis, provided by a non physician ■ Used for a facial prosthesis that is not described by a specific code, L8040-L8047 ■ Used for any materials used for modification or repairs or for a component which is used to attach prosthesis to a bone-anchored implant or to an internal prosthesis (e.g., maxillary obturator) ■ Not to be used for implanted prosthesis anchoring components	PA	PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
L8049	Repair or modification of maxillofacial prosthesis, labor component, 15-minute increments provided by a non-physician ■ Use for time used for laboratory modification or repair and prosthetic evaluation services associated with repair or modification, only after 90 days from the date of delivery of the prosthesis ■ Evaluation not associated with repair or modification is not covered	PA				RP	NF

410-122-0700 Negative Pressure Wound Therapy Pumps

(1) Indications and Limitations of Coverage and Medical Appropriateness – Initial Coverage: The Division of Medical Assistance Programs (DMAP) may cover a negative pressure wound therapy (NPWT) pump and supplies on a monthly basis for up to four months on the most recent covered wound when either criterion (a) or (b) is met:

(a) Ulcers and wounds in the home setting or nursing facility:

(A) The client has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology;

(B) A complete wound therapy program described by criterion (i) and criteria (ii), (iii), or (iv), as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT:

(i) For all ulcers or wounds, the wound therapy program must include a minimum of all of the following general measures, which have either been addressed, applied, or considered and ruled out prior to application of NPWT:

(I) Documentation in the client's medical record of evaluation, care, and wound measurements by a licensed medical professional;

(II) Application of dressings to maintain a moist wound environment;

(III) Debridement of necrotic tissue if present;

(IV) Evaluation of and provision for adequate nutritional status;

(ii) For Stage III or IV pressure ulcers:

(I) Appropriate turning and positioning of the client;

(II) Use of a Group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see 410-122-0400 Pressure Reducing Support Surfaces). If the ulcer is not on the trunk or pelvis, a Group 2 or 3 support surface is not required; and

(III) Appropriate management of the client's moisture and incontinence;

(iii) For neuropathic (for example, diabetic) ulcers:
(I) The client has been on a comprehensive diabetic management program, and;

(II) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities;

(iv) For venous insufficiency ulcers:

(I) Compression bandages and/or garments have been consistently applied, and;

(II) Leg elevation and ambulation have been encouraged;

(b) Ulcers and wounds encountered in an inpatient setting:

(A) An ulcer or wound as described in subsection (1)(a) is encountered in the inpatient setting and, after wound treatments described in subsection (1)(a) have been tried or considered and ruled out, NPWT is initiated because the treating physician considers it the best available treatment option;

(B) The client has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical appropriateness for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the client that will not allow for healing times achievable with other topical wound treatments);

(c) In either situation described in subsection (1)(b), NPWT will be covered when treatment continuation is ordered beyond discharge to the home setting;

(d) If criterion in subsection (1)(a) or (1)(b) above is not met, the NPWT pump and supplies are not covered;

(e) NPWT pumps (E2402) must be capable of accommodating more than one wound dressing set for multiple wounds on a client. A request for more than one NPWT pump per client for the same time period is not covered;

(f) For the purposes of this rule, a licensed health care professional may be a physician, physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or physical therapist (PT). The practitioner must be licensed to assess wounds and/or administer wound care.

(2) Indications and Limitations of Coverage and Medical Appropriateness – Continued Coverage: For wounds and ulcers described in subsection (1)(a) or (1)(b), for clients placed on an NPWT pump and supplies, DMAP will only approve continued coverage when the licensed medical professional does all the following duties:

(a) On a regular basis:

(A) Directly assesses the wound(s) being treated with the NPWT pump; and

(B) Supervises or directly performs the NPWT dressing changes;

(b) On at least a monthly basis, documents changes in the ulcer's dimensions and characteristics.

(3) Coverage for a NPWT pump and supplies ends when any of the following occur:

(a) Criteria in section (2) are not met;

(b) The treating physician determines that adequate wound healing has occurred for NPWT to be discontinued;

(c) Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound;

(d) Four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using an NPWT pump in the treatment of the most recent wound. Coverage beyond four months will be given individual consideration based upon required additional documentation;

(e) Equipment or supplies are no longer being used for the client, whether or not by the physician's order.

(4) DMAP will not cover NPWT pump and supplies if one or more of the following are present:

(a) Necrotic tissue with eschar in the wound, if debridement is not attempted;

(b) Untreated osteomyelitis within the vicinity of the wound;

(c) Cancer present in the wound;
(d) The presence of a fistula to an organ or body cavity within the vicinity of the wound.

(5) DMAP will only cover NPWT pumps and their supplies that have been specifically designated as being qualified for use of HCPCS codes E2402, A6550 and A7000 via written instructions from the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

(6) DMAP covers a maximum of 15 dressing kits (A6550) per wound per month, unless there is documentation that the wound size requires more than one dressing kit for each dressing change.

(7) DMAP covers a maximum of 10 canister sets (A7000) per month, unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day). For high-volume exudative wounds, a stationary pump with the largest capacity canister must be used. DMAP does not cover excess use of canisters related to equipment failure (as opposed to excessive volume drainage).

(8) Guidelines:

(a) Equipment:

(A) Negative pressure wound therapy (NPWT) is the controlled application of subatmospheric pressure to a wound. Specifically, an electrical pump (described in the definition of code E2402) intermittently or continuously conveys subatmospheric pressure through connecting tubing to a specialized wound dressing (described in the descriptor of HCPCS code A6550). The dressing includes a resilient, open-cell foam surface dressing, sealed with an occlusive dressing that is meant to contain the subatmospheric pressure at the wound site and thereby promote wound healing. Drainage from the wound is collected in a canister (described in the definition of HCPCS code A7000);

(B) Code E2402 describes a stationary or portable NPWT electrical pump which provides controlled subatmospheric pressure that is designed for use with NPWT dressings, (A6550) to promote wound healing. Such an NPWT pump is capable of being selectively switched between continuous and intermittent modes of operation and is controllable to adjust the degree of subatmospheric pressure conveyed to the wound in a range from 25 to greater than or equal to 200 mm Hg subatmospheric pressure. The pump can sound an audible alarm when desired pressures are not being achieved (that is, where there is a leak in the dressing

seal) and when its wound drainage canister (A7000) is full. The pump is designed to fill the canister to full capacity;

(b) Supplies:

(A) Code A6550 describes a dressing set which is used in conjunction with a stationary or portable NPWT pump (E2402), and contains all necessary components, including but not limited to a resilient, open-cell foam surface dressing, drainage tubing, and an occlusive dressing which creates a seal around the wound site for maintaining subatmospheric pressure at the wound;

(B) Code A7000 describes a canister set which is used in conjunction with a stationary or portable NPWT pump (E2402) and contains all necessary components, including but not limited to a container, to collect wound exudate. Canisters may be various sizes to accommodate stationary or portable NPWT pumps;

(c) The staging of pressure ulcers used in this rule is as follows:

(A) Stage I - Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II - Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III - Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV - Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

(9) Documentation Requirements: Submit the following information with the prior authorization request:

(a) For Initial Coverage:

(A) A statement from the attending physician which describes the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care as specified in subsection (1)(a);

(B) From the treating clinician, history, previous treatment regimens (if applicable), and current wound management for which an NPWT pump is being requested to include the following:

(i) Changes in wound conditions, including precise, quantitative measurements of wound characteristics (wound length and width (surface area), and depth), quantity of exudates (drainage), presence of granulation and necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.);

(ii) Dated photographs of ulcers or wounds with specific location(s) identified within the last 30 days;

(iii) Length of sessions of use;

(iv) Dressing types and frequency of change;

(v) Wound healing progress;

(b) For Continued Coverage:

(A) Progress notes from the attending physician within the last 30 days;

(B) Updated wound measurements and what changes are being applied to effect wound healing including information specified in paragraph (9) (a) (B);

(c) For both initial and continued coverage of an NPWT pump and supplies, any other medical records that corroborate that all criteria in this rule are met;

(d) When requesting quantities of supplies greater than those specified in this rule as the usual maximum amounts, include documentation supporting the medical appropriateness for the higher utilization.

(10) Table 122-0700

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0700 Negative Pressure Wound Therapy Pumps

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories	PA	PC				NF
A7000	Canister, disposable, used with suction pump, each		PC				NF
E2402	Negative pressure wound therapy electrical pump, stationary or portable	PA		RT			NF

410-122-0720 Pediatric Wheelchairs

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a pediatric wheelchair 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) entirely; places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a 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 MRADL;

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

(C) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for use of the pediatric wheelchair that is being requested;

(D) Use of a pediatric wheelchair will significantly improve the client's ability to move within the home to the areas customarily used for their MRADL so that the client can complete these MRADLs within a reasonable time frame;

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

(F) The client has either:

(i) Sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the requested pediatric wheelchair in the home, during a typical day. Proper assessment of upper extremity function should consider limitations of strength, endurance, range of motion, coordination, presence of pain, and deformity or absence of one or both upper extremities; or

(ii) A caregiver who is available, willing, and able to provide assistance with the wheelchair;

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

(A) When the wheelchair 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 pediatric wheelchair will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home, a pediatric wheelchair 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 a pediatric wheelchair 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 pediatric wheelchair;

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

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

(c) A pediatric tilt-in space wheelchair (E1231- E1234) may be covered when a client:

(A) Is dependent for transfers; and

(B) Spends a minimum of four hours a day continuously in a wheelchair; and

(C) The plan of care addresses the need to change position at frequent intervals and the client is not left in the tilt position most of the time; and

(D) Has one of the following:

(i) High risk of skin breakdown;

(ii) Poor postural control, especially of the head and trunk;

(iii) Hyper/hypotonia;

(iv) Need for frequent changes in position and has poor upright sitting;

(d) DMAP does not reimburse for another wheelchair if the 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. DMAP does not reimburse for adapting living quarters;

(f) DMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves;

(g) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair, as well as support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education, and ongoing assistance with the use of the wheelchair;

(h) A Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) may be covered when:

(i) The coverage criteria for a PWC (see 410-122-0325, Motorized/Power Wheelchair Base) are met; and

(ii) The client is expected to grow in height; and

(iii) Either of the following criteria is met:

(I) The Group 2 Single Power Option in 410-122-0325, Motorized/Power Wheelchair Base, (2)(a)(C)(i)(I) and (2)(a)(C)(i)(II); or

(II) Multiple Power Options in 410-122-0325, Motorized/Power Wheelchair Base, (2)(a)(D)(i)(I) and (2)(a)(D)(i)(II);

(iv)The delivery of a PWC must be within 120 days following completion of the face-to-face examination with the physician;

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

(j) A pediatric wheelchair for use only outside the home is not covered;

(k) For more information on coverage criteria regarding repairs and maintenance, see 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing.

(2) Coding Guidelines:

(a) For individualized wheelchair features that are medically appropriate to meet the needs of a particular client, use the correct codes for the wheelchair base, options and accessories (see 410-122-0340 Wheelchair Options/Accessories);

(b) For wheelchair frames that are modified in a unique way to accommodate the client, submit the code for the wheelchair base used and submit the modification with code K0108 (wheelchair component or accessory, not otherwise specified);

(c) Wheelchair "poundage" (pounds) represents the weight of the usual configuration of the wheelchair with a seat and back, but without front riggings;

(d) A manual wheelchair with a seat width and/or depth of 14” or less is considered a pediatric size wheelchair and is billed with codes E1231-E1238 or E1229;

(e) A power wheelchair (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;

(f) Pediatric seating system codes E2291 – E2294 may only be billed with pediatric wheelchair base codes;

(g) Contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) regarding correct coding. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation Requirements:

(a) Wheelchair and Seating Justification and Prescription form (DMAP 3125):

(A) DMEPOS providers must submit this form or a reasonable facsimile for purchase and modifications of all pediatric wheelchairs;

(B) Information must include, but is not limited to:

(i) Medical justification, needs assessment, prescription, and specifications for the wheelchair, completed by a physical therapist, occupational therapist or treating physician. The person who provides this information must have no direct or indirect financial relationship, agreement or contract with the durable medical

equipment, prosthetics, orthotics and supplies (DMEPOS) provider requesting authorization; and

(ii) Client identification and rehab technology supplier identification information which may be completed by the DMEPOS provider; and

(iii) Signature and date by the treating physician and physical or occupational therapist.

(C) If the information on this form includes all the elements of an order, the provider may submit the completed form in lieu of an order;

(b) Additional Documentation:

(A) Information from a physical therapist, occupational therapist or treating physician that specifically indicates:

(i) The 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;

(B) Pertinent information from a physical therapist, occupational therapist or treating physician about the following elements that support coverage criteria are met for a pediatric wheelchair; 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, pediatric wheelchair, POV, or power wheelchair 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 a wheelchair or power mobility device;

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

(C) Documentation from a physical therapist, occupational therapist or treating physician that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home since DMAP determines coverage of a wheelchair solely by the client's mobility needs within the home, even though a client who qualifies for coverage of a pediatric wheelchair may use the wheelchair outside the home; and

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

(E) 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; and

(F) For the home assessment, prior to or at the time of delivery of the wheelchair, 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 wheelchair. This 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

(G) All Healthcare Common Procedure Coding System (HCPCS) codes, including the base, options and accessories, whether prior authorization (PA) is required or not, that will be separately billed; and

(c) A written order by the treating physician, identifying the specific type of pediatric wheelchair needed. If the order does not specify the type requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific pediatric wheelchair that is being ordered and any options and accessories requested. The DMEPOS provider may enter the items on this order. This order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority; and

(d) For a PWC request: See 410-122-0325, Motorized/Power Wheelchair Base for documentation requirements; and

(e) Any additional documentation that supports indications of coverage are met as specified in this policy; and

(f) The above documentation must be kept on file by the DMEPOS provider; and

(g) Documentation that the coverage criteria have been met must be present in the client's medical records and this documentation must be made available to DMAP on request; and

(h) For PWC's furnished on a rental basis with dates of services prior to October 1, 2006, use code E1239 as appropriate.

(4) Table 122-0720

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 122-0720 Pediatric Wheelchairs

For the code legend see OAR 410-122-0182

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E1011	Modification to pediatric wheelchair, width adjustment package (not to be dispensed with initial chair)	PA	PC	RT	13	RP	*
E1014	Reclining back, addition to pediatric wheelchair	PA	PC	RT	13	RP	*
E1025	Lateral thoracic support, non contoured, for pediatric wheelchair, each (includes hardware)	PA	PC	RT	13	RP	*
E1026	Lateral thoracic support, contoured, for pediatric wheelchair, each (includes hardware)	PA	PC	RT	13	RP	*
E1027	Lateral/anterior support, for pediatric wheelchair, each includes hardware)	PA	PC	RT	13	RP	*
E1229	Wheelchair, pediatric size not otherwise specified	PA	PC	RT	13	RP	*
E1231	Wheelchair pediatric size, tilt-in space, rigid, adjustable, with seating system	PA	PC	RT	13	RP	*
E1232	Wheelchair pediatric size, tilt-in space, folding, adjustable, with seating system	PA	PC	RT	13	RP	*
E1233	Wheelchair pediatric size, tilt-in space, rigid, adjustable, without seating system	PA	PC	RT	13	RP	*

For the code legend see OAR 410-122-0182

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
E1234	Wheelchair pediatric size, tilt-in space, folding, adjustable, without seating system	PA	PC	RT	13	RP	*
E1235	Wheelchair pediatric size, rigid, adjustable, with seating system	PA	PC	RT	13	RP	*
E1236	Wheelchair pediatric size, folding, adjustable, with seating system	PA	PC	RT	13	RP	*
E1237	Wheelchair pediatric size, rigid, adjustable, without seating system	PA	PC	RT	13	RP	*
E1238	Wheelchair pediatric size, folding, adjustable, without seating system	PA	PC	RT	13	RP	*
E2291	Back, planar, for pediatric size wheelchair including fixed attaching hardware	PA	PC				
E2292	Seat, planar, for pediatric size wheelchair including fixed attaching hardware	PA	PC				
E2293	Back, contoured, for pediatric size wheelchair, including fixed attaching hardware	PA	PC				
E2294	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	PA	PC				

For the code legend see OAR 410-122-0182

* *May be covered for a client-owned wheelchair when coverage criteria in this rule are met*

Code	Description	PA	PC	RT	MR	RP	NF
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	PA	PC	RT	13	RP	*
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	PA	PC	RT	13	RP	*