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March 2004

To: OMAP Durable Medical Equipment (DME) Service Providers

From: Joan Kapowich, Manager
OMAP Program and Policy

Joan M. Kapowich

Re: DME Administrative Rules, Revision 2

Effective: **April 1, 2004**

OMAP updated the DME rulebook by revising the following rules:

410-122-0030, 410-122-0040, 410-122-0060, 410-122-0080, 410-122-0180, 410-122-0190, 410-122-0200, 410-122-0202, 410-122-0203, 410-122-0205, 410-122-0209, 410-122-0210, 410-122-0340, 410-122-0365, 410-122-0375, 410-122-0380, 410-122-0525, 410-122-0540, 410-122-0560, 410-122-0580, 410-122-0620, 410-122-0625, 410-122-0660, 410-122-0700

OMAP revised 410-122-0200 to update the pulse oximeter rule and repealed rules 410-122-0105, 410-122-0120 and 410-122-0140 to remove unnecessary billing instructions. The remainder of rules listed above are amended to reflect technical changes, code updates and word clarification.

- If you are reading this letter on OMAP's website: (http://www.dhs.state.or.us/policy/healthplan/rules/), this administrative rulebook contains a complete set of rules for this program, including revision(s). Note: OMAP added page numbers, however each rule is numbered individually for easy replacement in the future.

- If you do not have web access and receive hardcopy of revisions, this letter is attached to the rule revisions to be used as replacements in your rulebook.

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

TR 533 4-04

DEPARTMENT OF HUMAN SERVICES, DEPARTMENTAL ADMINISTRATION AND MEDICAL ASSISTANCE PROGRAMS

DIVISION 122

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

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410-122-0000 Purpose

The Office of Medical Assistance Programs (OMAP) Administrative Rules for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are to be used in conjunction with the Oregon Health Plan Administrative Rules and the General Rules for OMAP. DMEPOS coverage for eligible clients is based on these rules which govern the provision and reimbursement for DMEPOS.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 3-1982, f. 1-20-82, ef. 2-1-82; AFS 41-1982, f. 4-29-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 in the North Salem, Woodburn, Dallas, McMinnville, Lebanon, Albany and Corvallis branch offices, ef. 6-30-82 in the balance of the state; AFS 6-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 13-1991, f. & cert. ef. 3-1-91; Renumbered from 461-024-0000; HR 9-1993, f. & cert. ef. 4-1-93; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01

410-122-0020 Prescription Requirement

(1) The purchase or rental on or after October 1, 2002, of durable medical equipment (DME) and supplies must have a proper written order signed by the prescribing practitioner. An original, fax, or electronic prescription is acceptable. A practitioner means 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. A prescription is also required if modifications are made to original durable medical equipment. Repairs, parts needed for repairs and replacement parts (e.g., batteries), do not require a prescription.

(2) The DME provider must obtain a prescription before providing the service. The prescription must be supported by documentation in the prescribing practitioner's records.

(3) The prescription must be dated, legible and specify the exact medical item or service required, the ICD-9-CM diagnosis codes, number of units, and length of time needed. The Office of Medical Assistance Programs (OMAP) defines a lifetime need as 99 months. Only the initial lifetime prescription is required, unless otherwise indicated by the prescribing practitioner, for the following items:

(a) Ventilators;

(b) Suction pumps and related supplies;

(c) Intermittent positive pressure breathing device;

(d) Continuous positive pressure airway (CPAP) device and related supplies;

(e) Respiratory assist device and related supplies;

(f) Medicare 15-month capped rentals (follow Medicare guidelines related to prescription requirements and certificates of medical necessity).

(4) A new prescription is required:

(a) Once a year for incontinent supplies, ostomy supplies, urological supplies, and some diabetic supplies, per Medicare guidelines;

(b) When there is a change in the order for the item;

(c) When an item is replaced; or

(d) When there is a change of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider.

(5) DME providers are responsible for retaining a copy of the prescription in their records.

(6) The DME provider may change a prescription by documenting the change on the prescription with the date, time, initials, and who provided the change.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
May 1, 2003

410-122-0030 Pricing

(1) The Office of Medical Assistance Programs (OMAP) will reimburse for the lowest level of service, which will meet the medical appropriateness.

(2) Rental fees include:

(a) Delivery;

(b) Training in the use of the equipment;

(c) Pick-up;

(d) Routine service, maintenance and repair;

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

(3) Purchase price includes delivery, assembly, adjustments, if needed, and training in the use of the equipment or supply.

(4) Repair of equipment includes pick-up and delivery. Travel time shall not be billed to OMAP or the client.

(5) OMAP payment will be based on either OMAP's maximum allowable rate or billed rate whichever is the lesser:

(a) Pricing for E1399 and K0108 is addressed respectively in section (6) and (7) of this rule;

(b) For situations involving Medicare, Third Party Resource (TPR) or Alternate Resource, see General rules OAR 410-120-1280 (Billing) and OAR 410-120-1340 (Payment).

(6) E1399:

(a) E1399 will be reimbursed at 80% (eighty percent) of the manufacturer's suggested retail price (MSRP) up to the maximum reimbursable amount of

$ 2,500. Total reimbursement is capped at $ 2,500 per item. See example in Table 122-0030-1;

(b) When no MSRP is available through manufacturer, provider (supplier or vendor or retailer) must submit one of the following to OMAP and specify price per individual piece of an item:

(A) Manufacturer's invoice; or

(B) Manufacturer's wholesale price; or

(C) Manufacturer's list price; or

(D) Acquisition cost (includes shipping); or

(E) Cost factor; or

(F) Manufacturer's bill to provider.

(c) When no MSRP is available, reimbursement will be calculated as manufacturer's invoice, wholesale price, list price, acquisition cost, cost factor or bill to provider, whichever is the lowest plus 20% (twenty percent) of the bill (invoice price or wholesale price or list price or acquisition cost or cost factor) up to the maximum reimbursable amount of $ 2,500. See example in Table 122-0030-2;

(d) If (6)(b) (A – F) are not available, provider must submit an "estimated price" of an item as expected by provider and stipulated between manufacturer and provider. Reimbursement will be calculated as estimated price plus 20% of estimated price up to the maximum reimbursable amount of $ 2,500 per line item;

(e) For an item billed at or above $100: When requesting prior authorization, provider (supplier or vendor or retailer) must submit a copy of manufacturer's invoice, wholesale price, list price, acquisition cost, cost factor, bill or estimated price to provider as expected from manufacturer, manufacturer's part number and item description. Depending on the case, OMAP may require item picture(s) from the provider;

(f) For an item billed with E1399, the provider may be requested to submit written verification of E1399 code through an organization such as SADMERC (Statistical Analysis Durable Medical Equipment Regional Carrier) or AOPA (American Orthotic & Prosthetic Association) when no specific HCPCS code is available for that item and item category is not specified in current OMAP - DME rules (OAR 410 Division 122 rules);

(g) When an item is specifically addressed as related to E1399 code in current OMAP - DME rules, OAR 410-122-0190, OAR 410-122-0208, OAR 410-122-0250, OAR 410-122-0365, OAR 410-122-0375 and OAR 410-122-0580, no SADMERC or AOPA clarification is required;

(h) Manufacturer's part number (MPN) is described in section 8 of this rule;

(i) When an item's MSRP is expected to be higher than $3,120 or manufacturer's bill or invoice cost plus 20% is expected to be higher than $2,500, provider must submit documentation showing less expensive alternative was considered by the prescriber. The prescriber must document the reason the less expensive alternative is not medically appropriate, expected hours per day usage of new equipment, hours of usage of current equipment, and if there is any expected change in outcome. The item will be reviewed by OMAP on a case by case basis.

(7) K0108:

(a) K0108 will be reimbursed at 80% (eighty percent) of MSRP up to the maximum reimbursable amount of $1,000. Total reimbursement is capped at $1,000 per item;

(b) When no MSRP is available through manufacturer, provider (supplier or vendor or retailer) must submit one of the following to OMAP and specify price per individual piece of an item:

(A) Manufacturer's invoice; or

(B) Manufacturer's wholesale price; or

(C) Manufacturer's list price; or

(D) Acquisition cost (includes shipping); or

(E) Cost factor; or

(F) Manufacturer's bill to provider.

(c) When no MSRP is available, reimbursement will be calculated as manufacturer's invoice, wholesale price, list price, acquisition cost, cost factor or bill to provider, whichever is the lowest plus 20% (twenty percent) of the bill (invoice price or wholesale price or list price or acquisition cost or cost factor) up to the maximum reimbursable amount of $1,000;

(d) If (7)(b) (A – F) above are not available provider must submit an "estimated price" of an item as expected by provider and stipulated between manufacturer and provider. Reimbursement will be calculated as estimated price plus 20% of estimated price up to the maximum reimbursable amount of $1,000 per item;

(e) When requesting prior authorization, provider (supplier or vendor or retailer) must submit a copy of manufacturer's invoice, wholesale price, list price, acquisition cost, cost factor, bill or estimated price to provider as expected from manufacturer, manufacturer's part number and item description. Depending on the case, OMAP may require item picture (s) from the provider;

(f) Manufacturer's part number (MPN) is described in section 8 of this rule;

(g) When an item's MSRP is expected to be higher than $1,250 or manufacturer's bill or invoice cost plus 20% is expected to be higher than $1,000, provider must submit documentation showing less expensive alternative was considered by the prescriber. The prescriber must document the reason the less expensive alternative is not medically appropriate, expected hours per day usage of new equipment, hours of usage of current equipment, and if there is any expected change in outcome. The item will be reviewed by OMAP on a case by case basis.

(8) Manufacturer Part Number (MPN)

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

(b) 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.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 0030-1

E1399 Example	MSRP	80% of MSRP	Maximum Reimbursement
1.	$100	$80	$80
2.	$3,200	$2,560	$2,500 because of cap

4-1-04

Table 0030-2

E1399 Example	Manufacturer's invoice	20% of invoice	Maximum reimbursement = invoice plus 20%
1	$2,000	$400	$2,400

4-1-04

410-122-0040 Prior Authorization of Payment

Prior Authorization of Payment

(1) Procedure codes in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) rules that indicate prior authorization (PA) is required are intended for fee-for-service clients only. Failure to obtain PA for a service as indicated in rule, is not reimbursable by the Office of Medical Assistance Programs. To determine PA requirements for clients enrolled in Managed Care Plans, contact the Plan for their policy governing PA.

(2) PA of payment is required for non-Medicare clients for DMEPOS. This is indicated by the notation, “PA required…”, immediately following the description of the procedure code, even if private insurance is billed first. PA is not required for Medicare clients except for services not covered by Medicare. When a client is in a skilled nursing facility (SNF) under a covered, Medicare part A stay, all services must be billed to Medicare by the SNF, except for customized prosthetic devices, therefore no prior authorization from OMAP is required for DMEPOS. Obtaining PA is the responsibility of the durable medical equipment provider.

(3) Prior authorization authorities for PA requests (or for changes to existing PA’s) are as follows:

(a) Services for clients identified on the Office of Medical Assistance Programs (OMAP) Medical Care ID as Medically Fragile Children's Unit clients are prior authorized by the Department of Human Service’s (DHS) Medically Fragile Children's Unit;

(b) Services for clients identified on the OMAP Medical Care ID as being enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program are prior authorized by the MCM contractor;

(c) Services for clients identified on the OMAP Medical Care ID as Children, Adults and Families (CAF) (formerly Adult and Family Services) (AFS) or State Office of Services for Children and Families (SOSCF) (formerly Children’s Services Division) (CSD) are prior authorized by OMAP. All required documentation must be submitted to OMAP.

(d) Most services for clients identified on the OMAP Medical Care ID as Seniors and People with Disabilities (SPD) (formerly Senior and Disabled Services Division) (SSD) are prior authorized by the local branch office designated on the OMAP Medical Care ID. All required documentation must be submitted to the local branch office designated on the OMAP Medical Care ID. Services for SPD clients authorized by OMAP only are noted throughout the DMEPOS rulebook immediately following the code description.

(4) DMEPOS providers must submit the PA request to the authorizing authority in writing via mail or fax. Postmark or fax dates will be used as the date of contact. Providers may use the OMAP 3122, or a reasonable facsimile which contains the same information, for the request.

(5) An authorization request for a service provided after the authorizing authority's normal working hours, must be received by the authorizing authority in writing within five working days from the initiation of service.

(6) PA does not guarantee eligibility or payment -- always check for the client's eligibility on the date of service.

(7) For clients determined eligible after services are provided, authorization may still be obtained if the PA would have been granted had eligibility been determined prior to service.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-122-0060 Medicare/Medical Assistance Program Services

Medicare/Medical Assistance Program Services

(1) For services provided to clients with both Medicare and Medical Assistance Program coverage, bill Medicare first, except when the item(s) is not covered by Medicare.

(2) Services not covered by Medicare should be billed directly to the Office of Medical Assistance Programs on an OMAP 505 with the appropriate two-digit Third Party Resource (TPR) code in field 9.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-122-0080 Coverage and Exclusions

Coverage and Exclusions

(1) Items will not be purchased by the Office of Medical Assistance Programs (OMAP) when less expensive alternatives are available which will substantially meet the need.

(2) Equipment which is primarily and customarily used for a non-medical purpose will not be approved for payment, although the item has some medically related use.

(3) OMAP does not cover items which primarily serve the following purpose:

(a) Convenience of client or caregiver;

(b) Cosmetic;

(c) Education;

(d) Equipment of questionable usefulness or questionable therapeutic value;

(e) New equipment of unproven value;

(f) Personal comfort;

(g) Transportation.

(4) Equipment and services not medically appropriate are excluded from coverage by OMAP (see "Medically Appropriate Services and Items" in the OMAP General Rules rulebook), also:

(a) Criteria as listed with individual codes is considered the medical appropriateness for that item; and

(b) If no criteria is listed or there are questions about the criteria, medical appropriateness is determined by OMAP;

(c) Unless stated otherwise, the number of units per month is limited by medical appropriateness.

(5) Equipment and supplies are not covered under some benefit packages (see General Rules – 410-120-1210).

(6) Equipment not covered for purchase, rent or repair by OMAP, includes, but is not limited to the following (or similar or related equipment):

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

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, metal-caged, total electric, water

Bedwetting prevention devices

Bladder stimulators (pacemakers)

Bracelets, medical alert

Car seats, standard infant

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

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)

Ramps, van, wheelchair

Reachers

Restraints

Scales, bath, diet

Sharp's 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 Procedure Codes

(1) The Office of Medical Assistance Programs (OMAP) rules for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are to be used in conjunction with HCPCS. When billing for durable medical equipment and supplies, use the procedure codes listed in the DMEPOS rules. When billing for orthotics and prosthetic equipment and supplies, use the American Orthotics and Prosthetic Association (AOPA) publication, prepared by the AOPA.

(2) Questions concerning the coding of items should be referred to the Medicare Statistical Analysis DMERC (SADMERC) Palmetto Government Benefits Administrators or the AOPA. Written verification of coding from SADMERC or AOPA will be accepted as true and correct, at OMAP's discretion.

(3) Any durable medical equipment needed during an inpatient hospital stay is paid as part of the inpatient reimbursement to the hospital and is therefore the responsibility of the hospital.

(4) For prior authorization (PA) contacts, see OAR 410-122-0040.

(5) Buy-ups are prohibited. "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. Refer to the OMAP General Rules for specific language on buy-ups. An Advanced Beneficiary Notice (ABN) constitutes a buy-up and is prohibited.

(6) Equipment is considered purchased and becomes the property of the client, after 16 consecutive months of rental from the same provider or whenever the purchase price is reached. The rental period begins with the initial date of service and all rental charges apply to the purchase price:

(a) Consecutive months are defined as any period of continuous use where no more than a 60 day break occurs unless the item is for a Medicare/Medical Assistance Program client and is in the Medicare capped rental program, then continue to bill Medicare for maintenance, per Medicare’s schedule;

(b) Any needed repairs or maintenance after the 16th month of rental or OMAP purchase, whichever comes first, is the responsibility of OMAP, based on client eligibility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-122-0190 Equipment and Services Not Otherwise Classified

(1) Documentation must support that the procedure code billed is accurate and is appropriate.

(2) Medical appropriateness and prescription requirements also apply.

(3) The level of reimbursement should not be considered as a factor in the use of these procedure codes.

(4) Each item requested must be itemized with description and amount.

(5) Procedure Codes:

(a) A4335, Incontinence supply; miscellaneous (not covered for clients under three years of age)--PA required--the Office of Medical Assistance Programs (OMAP) will purchase:

(A) Limited to 360 units per month, based on medical appropriateness of any combination of products (i.e., adult diapers and inserts). Limitation is waived if documentation supporting increased medically appropriate usage is reviewed and prior authorized by the OMAP Medical Unit;

(B) Includes but is not limited to pad-in-pant systems.

(b) A4421, Ostomy supply; miscellaneous—PA required—OMAP will purchase;

(c) A4649, Surgical supply; miscellaneous, includes, but is not limited to antiseptic towelettes. Antiseptic towelettes are covered only for intermittent urinary catheterizations when other methods of cleansing are not available --PA required--OMAP will purchase;

(d) A6261, Wound filler, not elsewhere classified, gel/paste (1 unit of service = 1 fluid ounce)--PA required--OMAP will purchase;

(e) A6262, Wound filler, not elsewhere classified, dry form (1 unit of service = 1 gram)--PA required--OMAP will purchase;

(f) A9900, Miscellaneous DME supply, accessory, and/or service component of another HCPCS code - includes but is not limited to--PA required--OMAP will purchase:

(A) Dale(tm) tracheostomy tube holder;

(B) Dale(tm) tracheostomy tube holder for neonates/infants.

(g) E1399, Durable medical equipment, miscellaneous--PA required--OMAP will purchase, rent and repair - Item considered purchased after 16 months of rent - This code may be covered for payment from OMAP when client is a resident of a nursing facility, check when obtaining PA - For back-up equipment use modifier TW - includes but is not limited to:

(A) Use for walker gliders. Not covered for a client in a nursing facility;

(B) Use for oxymiser cannula. Not covered for clients in a nursing facility;

(C) Use for hydraulic bath tub lift. Not covered for clients in a nursing facility;

(D) Use for heavy duty or extra wide rehab shower/commode chair. Not covered for clients in a nursing facility;

(E) Use for routine maintenance for client-owned ventilator.

(i) Proof of manufacturer's suggested maintenance schedule must be submitted when requesting PA;

(ii) Bill E1340 for labor charges.

(F) Not used for:

(i) Wheelchair base;

(ii) Repairs.

(G) Use for gait belt:

(i) Indications and coverage. Gait belts are covered when:

(I) Client is 60 pounds or greater; and

(II) The care provider is trained in the proper use; and

(III) The client meets one of the following criteria: The client may be able to walk independently, but needs a minor correction of ambulation; or the client needs minimal or standby assistance to walk alone; or the client requires assistance with transfer.

(ii) Documentation:

(I) Documentation of medical appropriateness from the prescribing practitioner must be kept on file by the DME provider;

(II) Documentation must include documentation that the care provider is trained in proper use.

(h) L0999, Addition to spinal orthosis, not otherwise specified - PA required -- OMAP will purchase; Also covered for payment by OMAP when client is a resident of a nursing facility;

(i) L8239, Elastic support, not otherwise specified - PA required--OMAP will purchase; Also covered for payment by OMAP when client is a resident of a nursing facility.

(7) Repairs:

(a) Repairs to equipment which a client is purchasing or already owns are covered when necessary to make the equipment serviceable. 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 can be made for the amount of the excess;

(b) Technicians are DME 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;

(c) A written description of the nature of the repair and an itemization of the parts and labor time involved must be kept in the DME supplier's file;

(d) Documentation of medical appropriateness is only required if:

(A) The equipment was not provided by the repairing provider; or

(B) The client's medical condition has changed; or

(C) The client has other equipment of similar use (e.g., power and manual wheelchair).

(e) If equipment is sent to the manufacturer for repair or non-routine service, the manufacturer must itemize the invoice as to parts, labor time (documentation of start and stop time is not required), shipping and handling. Shipping and handling will not be reimbursed;

(f) E1340, Repair or non-routine service requiring the skill of a technician, labor component, per 15 minutes - OMAP will repair, Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned equipment;

(g) K0462, Temporary replacement for client-owned equipment being repaired, any type--PA required--OMAP will rent; Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned equipment:

(A) Use the price of the HCPCS code that corresponds to equipment being repaired;

(B) Use for client-owned equipment that is being repaired (e.g., wheelchair, hospital bed) or the replacement equipment (e.g., power chair being repaired and manual chair as replacement) whichever is least costly;

(C) Include the manufacturer, brand name, model name, and model number of the temporary replacement item;

(D) Limited to one month;

(E) Prescription not required.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-122-0200 Pulse Oximeter

(1) Indications and Limitations of Coverage. May be covered if the client has evidence of more than three desaturations below 88% per month and at least one of the following conditions exist:

(a) The client exhibits signs or symptoms of acute respiratory dysfunction;

(b) The client has chronic lung disease, chest trauma, severe cardiopulmonary disease, or neuromuscular disease involving the muscles of respiration;

(c) The client is on a ventilator and there is a need to adjust the ventilator settings, wean from the ventilator or to monitor for an acute change in condition;

(d) The client has a chronic condition resulting in hypoxemia and there is a need to assess supplemental oxygen requirements and/or a therapeutic regimen.

(e) The device must provide a printout which documents an adequate number of sampling hours, per cent of oxygen saturation and an aggregate of the results. This information must be reviewed and evaluated by the treating practitioner on a regular basis;

(f) Routine use of pulse oximetry monitoring is not covered (example: a patient with chronic, stable cardiopulmonary problems).

(2) Documentation. Submit the following documentation for review:

(a) A practitioner order that clearly specifies the medical appropriateness for pulse oximetry testing. The prescription must include a primary ICD-9-CM code that supports the medical appropriateness;

(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;

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

(d) In addition, an appropriate history and physical exam and progress notes must be available for review, upon request.

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

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

(3) Procedure Codes:

(a) A4606, Oxygen probe for use with client-owned oximeter device, replacement – PA required—The Office of Medical Assistance Programs (OMAP) will purchase;

(b) E0445, Oximeter device for measuring blood oxygen levels non-invasively, per month—PA required--OMAP will rent and repair - Item considered purchased after 16 months of rent. Quantity (units) is one on a given date of service;

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

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

4-1-04

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

(1) Indications and Coverage:

(a) Sleep Disordered Breathing -- Obstructive apnea, central apnea, mixed apnea, and sleep hypopnea syndrome. Covered if the polysomnogram indicates:

(A) An Apnea Hypopnea Index (AHI) > 10 per hour of sleep; and

(B) 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;

(C) Oxygen saturation related to an apneic or hypopneic event which is less than 90%.

(b) Upper airway resistance syndrome (UARS). Covered when both the following criteria are met:

(A) An arousal index > 15; and

(B) Significant excessive daytime sleepiness as defined by any of the following:

(i) Epworth sleepiness scale > 10; or

(ii) History of moderate or severe sleepiness; or

(iii) Multiple Sleep Latency Test (MSLT) with a mean sleep latency < 8.

(C) Definition of moderate and severe sleepiness per "Sleep-Related Breathing Disorders in Adults: Recommendations for Syndrome Definition and Measurement Techniques in Clinical Research; The Report of an American Academy of Sleep Medicine Task Force" published in Sleep, Volume 22. Number 5, 1999:

(i) "Moderate: Unwanted sleepiness or involuntary sleep episodes occur during activities that require some attention. Examples include uncontrollable sleepiness that is likely to occur while attending activities such as concerts, meetings, or presentations. Symptoms produce moderate impairment of social or occupational function.";

(ii) "Severe: Unwanted sleepiness or involuntary sleep episodes occur during activities that require more active attention. Examples include uncontrollable sleepiness while eating, during conversation, walking, or driving. Symptoms produce marked impairment in social or occupational function."

(2) Documentation:

(a) To be submitted with request for prior authorization (PA) and kept on file by the DME provider:

(A) Summary of events from the polysomnogram report performed in a certified sleep laboratory;

(B) Medical justification from the prescribing practitioner;

(C) Oxygen saturation reports, if required;

(D) Prescribing practitioner history and physical examination.

(b) To be submitted with the request for PA for purchase after the two-month rental period is completed;

(c) Proof of efficacy and compliance from the prescribing practitioner.

(3) Other:

(a) A two-month rental period is required for CPAP prior to purchase. Rental price starting with the initial date of service, regardless of payor, applies to purchase price;

(b) Clients currently using CPAP can continue to use without having to meet the new criteria.

(4) Procedure Codes:

(a) E0601, Continuous Airway Pressure Device (CPAP) -- PA required-- The Office of Medical Assistance Programs (OMAP) will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a nursing facility -- Item considered purchased after 16 months of rent;

(b) Accessories for CPAP:

(A) A7030, Full face mask used with positive airway pressure device, each—one per 12 months -- PA required-- OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility;

(B) A7031, Face mask interface, replacement for full face mask, each one per 12 months-- PA required -- OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility;

(C) A7032, Replacement cushion for nasal application device, each, two per month -- PA required -- OMAP will purchase, Also covered for payment by OMAP when client is a resident of a nursing facility;

(D) A7033, Replacement pillows for nasal application device, pair, two per month--PA required -- OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility;

(E) A7034, Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head straps, one per three months, -- PA required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(F) A7035, Headgear, used with positive airway pressure device -- one per six months, - PA required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(G) A7036, Chin strap, used with positive airway pressure device -- one per six months -- PA required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(H) A7037, Tubing, used with positive airway pressure device -- one per one month -- PA required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(I) A7038, Filter, disposable, used with positive airway pressure device -- two per one month, -- PA required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(J) A7039, Filter, non-disposable, used with positive airway pressure device -- one per six months, -- PA required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(K) A7044, Oral interface used with positive airway pressure device, each -- PA required -- OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility;

(L) A7046, Water chamber for humidifier, used with positive airway pressure device, replacement, each -- PA required -- OMAP will purchase -- Item considered purchased after 16 months of rent. Also covered for payment by OMAP when client is a resident of a nursing facility;

(M) E0561, Humidifier, non-heated, used with positive airway pressure device -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment by OMAP when client is a resident of a nursing facility;

(N) E0562, Humidifier, heated, used with positive airway pressure device -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment by OMAP when client is a resident of a nursing facility;

(O) S8186, Swivel adapter -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-122-0203 Oxygen and Oxygen Equipment

(1) Children (under age 21):

(a) Coverage Criteria: Prescribing practitioner must determine medical appropriateness;

(b) Documentation: DME providers must retain documentation of medical appropriateness from prescribing practitioner.

(2) Adults: Coverage Criteria:

(a) Home oxygen therapy is covered only if all of the following conditions are met:

(A) The treating prescribing 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

(B) The client's blood gas study meets the criteria stated below; and

(C) The qualifying blood gas study was performed by a prescribing practitioner or by a qualified provider or supplier of laboratory services; and

(D) 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 -- i.e., not during a period of acute illness or an exacerbation of their underlying disease; and

(E) Alternative treatment measures have been tried or considered and deemed clinically ineffective.

(b) Coverage of oxygen therapy is not available for the following conditions:

(A) Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments;

(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. There is no evidence that increased PO2 will improve the oxygenation of tissues with impaired circulation;

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

(E) Stationary oxygen as a backup for a concentrator is the responsibility of the oxygen provider.

(3) Laboratory Evidence:

(a) Group I:

(A) Coverage criteria includes any of the following:

(i) An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake); or

(ii) An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during sleep for a client who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake; or

(iii) A decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent 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 PO2 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 PO2 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.

(B) Initial coverage for clients meeting Group 1 criteria is limited to 12 months or the prescribing practitioner-specified length of need, whichever is shorter.

(b) Group II:

(A) Coverage -- criteria include the presence of:

(i) An arterial PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep, or during exercise (as described under Group 1 criteria); and

(ii) 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.

(B) Initial coverage for clients meeting Group II criteria is limited to three months or the prescribing practitioner specified length of need, whichever is shorter.

(c) Group III -- Home use of oxygen is presumed not medically appropriate for clients with arterial PO2 levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.

(d) Blood Gas Study:

(A) The qualifying blood gas study must be performed by a CLIA (Clinical Laboratory Improvement Amendments) certified laboratory. A supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. In addition, the qualifying blood gas study may not be paid for by any supplier. This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests;

(B) 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;

(C) For Initial Certifications, the blood gas study reported on the Certificate of Medical Necessity (CMN) or reasonable facsimile, must be the most recent study obtained 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;

(D) For clients initially meeting Group I criteria, the most recent blood gas study prior to the thirteenth month of therapy must be reported on the Recertification CMN;

(E) For clients initially meeting Group I criteria, if the estimated length of need on the Initial CMN is less than lifetime and the prescribing practitioner wants to extend coverage, a repeat blood gas study must be performed within 30 days prior to the date of the Revised Certification;

(F) For clients initially meeting Group II criteria, the most recent blood gas study which was performed between the 61st and 90th day following Initial Certification must be reported on the Recertification CMN;

(G) When a qualifying test is not obtained 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, coverage would resume beginning with the date of that test if that test meets Group I or II criteria;

(H) For clients initially meeting Group II criteria, if the estimated length of need on the Initial CMN is less than lifetime and the prescribing practitioner

wants to extend coverage, a repeat blood gas study must be performed within 30 days prior to the date of the Revised Certification;

(I) For any Revised CMN, the blood gas study reported on the CMN must be the most recent test performed prior to the Revised date;

(J) 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), only report the ABG PO2 on the CMN. If the ABG PO2 result is not a qualifying value, home oxygen therapy is not covered regardless of the oximetry test result;

(K) Oxygen Saturation (Oximetry) Tests -- Must not be performed by the DME supplier or anyone financially associated with or related to the DME supplier.

(4) Portable Oxygen Systems: A portable oxygen system is 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. If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system.

(5) Standby Oxygen: Oxygen PRN or oxygen as needed is not covered.

(6) Topical Oxygen: Oxygen for topical use is not covered.

(7) Documentation:

(a) Certificate of Medical Necessity (CMN) is a required documentation to support the medical indication;

(b) The Certificate of Medical Necessity (CMN) form for home oxygen is CMS form 484. This form is used for initial certification, recertification, and changes in the oxygen prescription. This form or other documentation of medical appropriateness must be reviewed and signed by the treating prescribing practitioner and kept on file by the DME provider;

(c) Initial CMN is required:

(A) Prior to billing; provider (supplier or vendor) shall keep documentation on file showing their communication with prescriber to obtain CMN prior to delivery;

(B) If more than 3 months pass between the “initial date” of the CMN or the time a CMN is completed and signed by the physician, and the item being ordered is delivered to client, a new completed and signed CMN is required;

(C) 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;

(D) When there has been a change in the client's condition that has caused a break in medical appropriateness 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, or hospice, but the client continued to need oxygen during that time;

(E) When the client initially qualified in Group II, repeat blood gas studies were not performed between the 61st and 90th day of coverage, but a qualifying study was subsequently performed. The initial date on this new CMN may not be any earlier than the date of the subsequent qualifying blood gas study;

(d) Recertification CMN is required:

(A) Three months after Initial Certification -- if oxygen test results on the Initial Certification are in Group II. The blood gas study reported must be the most recent study, which was performed between the 61st and 90th day following the Initial Date;

(B) 12 months after Initial Certification -- if oxygen test results on the Initial Certification are in Group I. The blood gas study reported must be the most recent blood gas study prior to the thirteenth month of therapy. This CMN also establishes lifetime.

(e) Revised CMN is required:

(A) When a portable oxygen system is added subsequent to Initial Certification of a stationary system. In this situation, there is no requirement for 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;

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

(C) When there is a new treating prescribing practitioner but the oxygen order is the same. In this situation, there is no requirement for a repeat blood gas study;

(D) If there is a new supplier, that supplier must obtain a new CMN. It would be considered a Revised CMN;

(E) Submission of a Revised CMN does not change the Recertification schedule specified above;

(F) 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.

(f) New Order Required: In the following situations, a new order must be obtained and kept on file by the supplier, but neither a new CMN nor a repeat blood gas study are required:

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

(i) Less than 1 LPM (Liters Per Minute);

(ii) 1-4 LPM;

(iii) Greater than 4 LPM.

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

(8) Oxygen users before March 1, 1991, will continue to receive services and are not subject to the above criteria.

(9) For client entering OMAP FFS (Fee-For-Service) from either Fully Capitated Health Plan (FCHP), Managed Care Organization (MCO / HMO / Health Plan), ASO (Administrative Service Organization), PCO (Physician Care Organization) or from non-OMAP FFS:

(a) An initial CMN must be obtained by provider (supplier or vendor), however the blood gas study on the initial CMN does not have to be obtained within 30 days prior to the initial date, but must be the most recent study obtained while the patient was either in the Fully Capitated Health Plan (FCHP), Managed Care Organization (MCO / HMO/ Health Plan), ASO (Administrative Service Organization), PCO (Physician Care Organization) or from non-OMAP FFS under the testing guideline specified in sections (3) through section (7) of this rule;

(b) Provider (supplier or vendor) must follow the requirement for recertification and revised CMN if that applies per section (7) of this rule.

(10) Procedure Codes:

(a) E1390 Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, per month -- the Office of Medical Assistance Programs (OMAP) will rent -- Covered for payment by OMAP if nursing facility resident uses more than 1,000 liters per day. All equipment and supplies needed for the operation of the concentrator are included in the rental fee;

(b) E1391 Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, per month -- the Office of Medical Assistance Programs (OMAP) will rent -- Covered for payment by OMAP if nursing facility resident uses more than 1,000 liters per day. All equipment and supplies needed for the operation of the concentrator are included in the rental fee;

(c) Oxygen enriching systems:

(A) E1405, Oxygen and water vapor enriching system with heated delivery -- OMAP will rent -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(B) E1406, Oxygen and water vapor enriching system without heated delivery -- OMAP will rent -- Also covered for payment by OMAP when client is a resident of a nursing facility.

(d) Compressed gas:

(A) E0424, Stationary compressed gaseous oxygen system, rental, per month; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing -- OMAP will rent;

(B) E0425, Stationary compressed gaseous system purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing -- OMAP will purchase -- OMAP will repair;

(C) E0430, Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing -- OMAP will purchase -- OMAP will repair;

(D) E0431, Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing, per month -- OMAP will rent;

(E) 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 = 1 unit -- OMAP will purchase;

(F) E0443, Portable oxygen contents, gaseous, (for use only with portable gaseous systems when no stationary gas or liquid system is used), one month supply = 1 unit -- OMAP will purchase.

(e) Liquid oxygen:

(A) E0434, Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing;

(B) E0435, Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor -- OMAP will purchase -- OMAP will repair;

(C) E0439, Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing, per month -- OMAP will rent;

(D) E0440, Stationary liquid system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing -- OMAP will purchase -- OMAP will repair;

(E) E0442, Oxygen contents, liquid, (for use with owned liquid stationary system or when both a stationary and portable liquid system are owned), one month supply = 1 unit -- OMAP will purchase;

(F) E0444, Portable oxygen contents, liquid, (for use only with portable liquid systems when no stationary gas or liquid system is used), one month supply = 1 unit -- OMAP will purchase.

(f) Oxygen supplies:

(A) E0455, Oxygen tent, excluding croup or pediatric tents, per month -- OMAP will rent;

(B) 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, E1405 or E1406 -- OMAP will purchase -- OMAP will rent and repair; Item considered purchased after 16 months of rent;

(C) 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 -- OMAP will purchase;

(D) 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 -- OMAP will purchase -- OMAP will rent and repair -- Item considered purchased after 16 months of rent;

(E) E0605, Vaporizer, room type -- OMAP will purchase;

(F) E1353, Regulator (yoke or other) -- OMAP will purchase -- OMAP will repair;

(G) E1355, Stand / rack for oxygen tank -- OMAP will purchase.

(11) Table 122-0203:

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 0203 Procedure Code

HCPCS	Purchase	Rental	Repair
E1390 E1391		X X	
E1405		X	
E1406		X	
E0424		X	
E0425	X		X
E0430	X		X
E0431		X	
E0441	X		
E0443	X		
E0434		X	
E0435	X		X
E0439		X	

Table 0203 continued:

Procedure Code HCPCS	Purchase	Rental	Repair
E0440	X		
E0442	X		
E0444	X		
E0455		X	
E0550	X	X	X
E0555	X		
E0560	X	X	X
E0605	X		
E1353	X		X
E1355	X		

4-1-04

410-122-0204 Nebulizer

(1) A4619 -- Face Tent -- the Office of Medical Assistance Programs (OMAP) will purchase.

(2) A7003, Administration set, with small volume nonfiltered pneumatic nebulizer, disposable -- Includes lid, jar and baffles, tubing, T-piece and mouth piece -- OMAP will purchase.

(3) A7004, Small volume nonfiltered pneumatic nebulizer, disposable -- Includes lid, jar and baffles -- OMAP will purchase.

(4) A7005, Administration set, with small volume nonfiltered pneumatic nebulizer, nondisposable -- Includes lid, jar and baffles, tubing, T-piece and mouth piece -- OMAP will purchase.

(5) A7006, Administration set, with small volume filtered pneumatic nebulizer -- Includes lid, jar and baffles, tubing, T-piece, mouth piece, and filter-- OMAP will purchase.

(6) A7010, Corrugated tubing, disposable, used with large volume nebulizer (1 unit of service = 100 feet) -- OMAP will purchase.

(7) A7011, Corrugated tubing, non-disposable, used with large volume nebulizer (1 unit of service = 10 feet) -- OMAP will purchase.

(8) A7012, Water collection device, used with large volume nebulizer -- OMAP will purchase.

(9) A7013, Filter, disposable, used with aerosol compressor -- OMAP will purchase.

(10) A7014, Filter, non-disposable, used with aerosol compressor or ultrasonic generator -- OMAP will purchase.

(11) A7015, Aerosol mask, used with DME nebulizer -- OMAP will purchase.

(12) A7016, Dome and mouthpiece, used with small volume ultrasonic nebulizer -- OMAP will purchase.

(13) A7017, Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen -- OMAP will purchase.

(14) A7018, Water, distilled, used with large volume nebulizer (1 unit of service = 1,000 ml) -- Not separately payable or billable with rented oxygen -- OMAP will purchase.

(15) A7020, Sterile water or sterile saline, 1,000 ml, used with large volume nebulizer -- Not separately payable or billable with rented oxygen -- OMAP will purchase.

(16) E0565, Compressor, air power source for equipment which is not self-contained or cylinder driven -- A pneumatic aerosol compressor which can be set for pressure above 30 psi at a flow rate of 6-8 liters/minute, and is capable of continuous operation -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

(17) E0570, Nebulizer, with compressor -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

(18) E0571, Aerosol compressor, battery powered, for use with small volume nebulizer -- A portable 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. OMAP will purchase.

(19) E0572, Aerosol compressor, adjustable pressure, light duty for intermittent use -- A pneumatic aerosol compressor which can be set for pressures above 30 psi at a flow rate of 6-8 liters/minute, but is capable only of intermittent operation -- OMAP will purchase.

(20) E0580, Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter -- OMAP will purchase.

(21) E0585, Nebulizer, with compressor and heater -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

(22) E1372, Immersion external heater for nebulizer -- Not covered with E0585 -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01

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. It 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 DME supplier. A DME supplier is not considered a qualified provider or supplier of these tests for purposes of this policy's coverage and payment guidelines. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests;

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

(3) Initial coverage criteria for E0470and E0471 devices (first three months):

(a) 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:

(A) Daytime hypersomnolence;

(B) Excessive fatigue;

(C) Morning headache;

(D) Cognitive dysfunction;

(E) Dyspnea, etc.

(b) A RAD (E0470, E0471) used to administer NPPRA therapy is covered for those clients with clinical disorder groups characterized as:

(A) Restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities); or

(B) Severe chronic obstructive pulmonary disease (COPD); or

(C) Central sleep apnea (CSA); or

(D) Obstructive sleep apnea (OSA) (E0470 only); and

(E) Who also meet the following criteria:

(i) Restrictive Thoracic Disorders:

(I) 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

(II) An arterial blood gas PaCO2, done while awake and breathing the client's usual FIO2, is >= 45 mm Hg; or

(III) Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the client's usual FIO2;

(IV) For progressive neuromuscular disease (only), maximal inspiratory pressures less than 60 cm/H2O or forced vital capacity is less than 50% predicted; and

(V) Chronic obstructive pulmonary disease does not contribute significantly to the client's pulmonary limitation;

(VI) If all above criteria are met, either a 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.

(ii) Severe COPD:

(I) An arterial blood gas PaCO2, done while awake and breathing the client's usual FIO2, is >= 52 mm Hg; and

(II) 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 FIO2 (whichever is higher); and

(III) Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out;

(IV) If all of the above criteria for clients with COPD are met, a E0470 device will be covered for the first three months of NPPRA therapy (see below for continued coverage after the initial three months). A E0471device will not be covered for a client with COPD during the first two months, because therapy with a 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 a E0471 device for COPD after two month's use of a E0470 device;

(V) If the above criteria are not met, then E0470 and E0471 are not covered.

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

(I) 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 FIO2; and

-significant improvement of the sleep-associated hypoventilation with the use of a E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the client's usual FIO2;

(II) If all above criteria are met, either a 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);

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

(iv) Obstructive Sleep Apnea (OSA):

(I) A complete facility-based, attended polysomnogram, has established the diagnosis of obstructive sleep apnea; and

(II) A single level device (E0601, Continuous Positive Airway Pressure Device (CPAP)) has been tried and proven ineffective;

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

(IV) A E0471 device is not medically appropriate if the primary diagnosis is OSA.

(c) Continued coverage beyond the first three months of therapy:

(A) Clients covered for the first 3 months of a E0470 or E0471 device must be re-evaluated to establish the medical appropriateness of continued coverage by the Office of Medical Assistance Programs (OMAP) 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 OMAP 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 OMAP to deny continued coverage as not medically appropriate;

(B) 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:

(i) 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

(ii) An Evaluation of Respiratory Assist Device (OMAP 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 at OMAP's website but OMAP does not furnish paper copies.

(C) If the above criteria are not met, continued coverage of a E0470 or E0471 device and related accessories will be denied as not medically appropriate;

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

(i) An arterial blood gas PaCO2, repeated no sooner than 61 days after initiation of compliant use of the E0470, done while awake and breathing the client's usual FIO2, still remains >= 52 mm Hg; and

(ii) A sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of a 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 FIO2 (whichever is higher); and

(iii) 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

(iv) An Evaluation of Respiratory Assist Device (OMAP 2461) completed by the client, no sooner than 61 days after initiation of the E0470 device.

(d) Coding Guidelines:

(A) For devices previously coded as K0532, after the effective date of this policy, code K0532 as E0470, and if the K0533 is being used with

a noninvasive interface to administer NPPRA therapy, code as E0471;

(B) For devices previously billed as K0194 (intermittent assist device with CPAP device, with humidifier), use codes E0470 and E0561 to continue billing after the effective date of this policy.

(e) Documentation:

(A) To be submitted with request for prior authorization (PA) and the original kept on file by the supplier:

(i) 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;

(ii) Summary of events from the polysomnogram, if required under indications and coverage;

(iii) Arterial blood gas results, if required under indications and coverage;

(iv) Sleep oximetry results, if required under indications and coverage;

(v) 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;

(vi) 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 (OMAP 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;

(D) Procedure Codes – Table 122-0205.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 0205 Procedure Codes

A7030	Full face mask used with positive airway pressure device, each—one per 12 months -- PA required -- OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility;
A7031	Face mask interface, replacement for full face mask, each one per 12 months-- PA required-- OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility;
A7032	Replacement cushion for nasal application device, each, two per month -- PA required -- OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility
A7033	Replacement cushion for nasal application device, pair-- PA required -- OMAP will purchase--Also covered for payment by OMAP when client is a resident of a nursing facility—Not separately covered with E0471
A7034	Nasal application device, used with positive airway pressure devise – PA required – OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility – 1 per 3 months
A7035	Headgear, used with positive airway pressure device – PA required–OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility – 1 per 6 months
A7036	Chin strap, used with positive airway pressure device – PA required–OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility – 1 per 6 months

A7037 Tubing, used with positive airway pressure device – PA required– OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility – 1 per 1 month

A7038 Filter, disposable, used with positive airway pressure device – PA required--OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility – 2 per 1 month

A7039 Filter, non-disposable, used with positive airway pressure device – PA required-- OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility – 1 per 6 months

A7044 Oral, interface used with positive airway pressure device, each – PA required–OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility – 1 per 6 months

A7046 Water chamber for humidifier, used with positive airway pressure device, replacement, each—PA required--OMAP will purchase. Also covered for payment by OMAP when client is a resident of a nursing facility—1 per 6 months

E0470 Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive 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 required—OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility—Item considered purchased after 16 months of rent

E0471 Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist

device with continuous positive airway pressure device)—PA required —OMAP will rent. Also covered for payment by OMAP when client is a resident of a nursing facility

The rental fee includes all equipment, supplies, services (including respiratory therapy services) and training necessary for the effective use of the RAD.

E0561 Humidifier, non-heated, used with positive airway pressure device – PA required– OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility – Item considered purchased after 16 months of rent

E0562 Humidifier, heated, used with positive airway pressure device – PA required–OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility – Item considered purchased after 16 months of rent

S8186 Swivel adapter – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility.

4-1-04

410-122-0206 IPPB

E0500, IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source -- the Office of Medical Assistance Programs (OMAP) 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 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
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01

410-122-0207 Respiratory Supplies

(1) A4608, Transtracheal oxygen catheter, each -- the Office of Medical Assistance Programs (OMAP) will purchase.

(2) A4614, Peak Expiratory Flow Meter, hand-held -- OMAP will purchase.

(3) A4615, Cannula, nasal -- OMAP will purchase.

(4) A4616, Tubing (oxygen), per foot -- OMAP will purchase.

(5) A4617, Mouthpiece -- OMAP will purchase.

(6) A4620, Variable concentration mask -- OMAP will purchase.

(7) A4627, Spacer, bag or reservoir, with/without mask, for use with metered dose inhaler -- OMAP will purchase.

(8) A4712 Water, sterile, for injection, per 10 ml -- OMAP will purchase.

(9) 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 -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

(10) E0606, Postural drainage board -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

(11) J7051, Sterile saline or water, up to 5 ml each -- OMAP will purchase.

(12)S8185, Flutter device -- OMAP will purchase.

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

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

410-122-0208 Suction Pumps

(1) Coverage Criteria:

(a) Use of a home model suction machine is covered for a client who has difficulty raising and clearing secretions secondary to:

(A) Cancer or surgery of the throat; or

(B) Dysfunction of the swallowing muscles; or

(C) Unconsciousness or obtunded state; or

(D) Tracheostomy; or

(E) Neuromuscular conditions.

(b) Suction catheters are disposable supplies and are covered with a medically appropriate rented, purchased or owned suction pump. Sterile catheters are only covered for tracheostomy suctioning. Oropharyngeal and upper tracheal areas are not sterile and catheters can be reused if properly cleansed and/or disinfected;

(c) 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;

(d) When a suction pump 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;

(e) Suction device will be purchased for individual use by a person in a nursing facility when the person is permanently on one of the following:

(A) Volume ventilator;

(B) Chest shell;

(C) Chest wrap;

(D) Negative pressure ventilator.

(f) Use E1399 for suction pump used with a nasogastric tube.

(2) Documentation: 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:

(a) A4323, Sterile saline irrigation solution, 1,000 ml -- covered when used to clear a suction catheter after tracheostomy suctioning - not covered for clearing an oropharyngeal suction catheter -- OMAP will purchase;

(b) A4609, Tracheal suction catheter, closed system, for less than 72 hours of use, each -- OMAP will purchase

(c) A4610, Tracheal suction catheter, closed suction, for 72 or more hours of use, each -- OMAP will purchase;

(d) A4624, Tracheal suction catheter, any type, other than closed system, each -- the Office of Medical Assistance Programs (OMAP) will purchase;

(e) A4628, Oropharyngeal suction catheter, each -- OMAP will purchase;

(f) A7000, Canister, disposable, used with suction pump, each -- OMAP will purchase;

(g) A7001, Canister, non-disposable, used with suction pump, each -- OMAP will purchase;

(h) A7002, Tubing, used with suction pump, each -- OMAP will purchase;

(i) E0600, Respiratory suction pump, home model, portable or stationary, electric -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a nursing facility when the client is permanently on one of the following: a volume ventilator, chest shell, chest wrap or negative pressure ventilator -- Item considered purchased after 16 months of rent;

(j) E2000, Gastric suction pump, home model, portable or stationary, electric -- OMAP will purchase or rent. Item considered purchased after 16 months of rent.

(4) Table 0208:

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-01-03

Table 0208 Procedure Code

HCPCS	Purchase	Rental	Repair
A4323	X		
A4609	X		
A4610	X		
A4624	X		
A4628	X		
A7000	X		
A7001	X		
A7002	X		
E0600	X	X	X
E2000	X	X	

10-01-03

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 DME supplier. The prescribing practitioner's records must contain information which supports the medical appropriateness of the item ordered.

(3) Procedure Codes:

(a) A4481, Tracheostomy filter, any type, any size, each -- the Office of Medical Assistance Programs (OMAP) will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(b) A4483, Moisture exchanger, disposable -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(c) A4623, Tracheostomy, inner cannula -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(d) 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 -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility. One tracheostomy care kit per day is covered for two weeks following an open surgical tracheostomy;

(e)A4626, Tracheostomy cleaning brush, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(f)A4629, Tracheostomy care kit for established tracheostomy contains one tube brush, two pipe cleaners, two cotton tip applicators, 30" twill tape, two 4x4 sponges; OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility. One tracheostomy care kit per day is considered necessary for routine care of a tracheostomy, starting with post-operative day 15;

(g)A7501, Tracheostoma valve, including diaphragm, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(h)A7502, Replacement diaphragm/faceplate for tracheostoma valve, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(i) A7503, Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(j)A7504, Filter for use in a tracheostoma heat and moisture exchange system, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(k)A7505, Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(l)A7506, Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(m) A7507, Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(n) A7508, Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(o) A7509, Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(p) A7520, Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each—OMAP will purchase—Also covered for payment by OMAP when client is a resident of a nursing facility;

(q) A7521, Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each—OMAP will purchase—Also covered for payment by OMAP when client is a resident of a nursing facility;

(r) A7522, Trachestomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each—OMAP will purchase—Also covered for payment by OMAP when client is a resident of a nursing facility;

(s) A7524, Tracheostoma stent/stud/button, each—OMAP will purchase—Also covered for payment by OMAP when client is a resident of a nursing facility;

(t) A7525, Tracheostomy mask, each—OMAP will purchase—Also covered for payment by OMAP when client is a resident of a nursing facility;

(u) A7526, Tracheostomy tube/collar, each—OMAP will purchase—Also covered for payment by OMAP when client is a resident of a nursing facility;

(v) S8189, Tracheostomy supply, not otherwise classified -- Prior authorization required by OMAP -- OMAP will purchase -- Also

covered for payment by OMAP when client is a resident of a nursing facility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-122-0210 Ventilators

(1) The hospital discharge planner, case manager, or prescribing practitioner should call the DME provider directly. The DME provider will fax or mail the request for prior authorization (PA).

(2) The DME provider is responsible for providing written medical justification within the first 30 days to continue authorization for further services.

(3) If written justification is not received, there will be no further authorization.

(4) The following criteria will be used to determine payment:

(a) Documentation of being unable to wean from ventilator or unable to wean from use at night; or

(b) Documentation that alternate means of ventilation were used without success; or

(c) Client ready for discharge is currently on a ventilator and has been on the ventilator more than ten days.

(5) A back-up battery, generator, and resuscitation bag will be provided, if necessary.

(6) The allowable rental fee for the ventilator is to include all equipment, supplies, services and training necessary for the effective use of the ventilator.

(7) Routine maintenance is included in the rental fee.

(8) All respiratory therapy services needed are included in the rental fee.

(9) The ventilator provider must supply 24-hour emergency coverage.

(10) An emergency telephone number must be available 24-hours day from the ventilator provider.

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

(12) The following criteria will be used to determine payment for a back-up ventilator:

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

(b) Documentation supports medical appropriateness; or

(c) The client needs to be transported frequently with portable ventilator, and their ventilator is not a portable model; or

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

(13) Back-up ventilator:

(a) A back-up ventilator will be reimbursed at half the allowable rate;

(b) For back-up ventilator, use modifier TW -- back-up equipment;

(c) Back-up ventilator users before April 1, 1992, will continue to receive services and are not subject to the above criteria.

(14) Procedure Codes – Table 122-0210.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 0210 Procedure Codes

A4611	Battery, heavy duty; replacement for client-owned ventilator – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility
A4612	Battery, cables; replacement for client-owned ventilator – OMAP will purchase – Also covered for payment by OMAP when client is a resident in nursing facility
A4613	Battery charger; replacement for client-owned ventilator – OMAP will purchase – OMAP will repair – Also covered for payment by OMAP when client is a resident in a nursing facility
A4618	Breathing circuits, for client-owned ventilator – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility
E0450	Volume ventilator; stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube) – PA required – OMAP will rent – Also covered for payment by OMAP when client is a resident in a nursing facility
E0454	Pressure ventilator with pressure control, pressure support and flow triggering features -- PA required – OMAP will rent – Also covered for payment by OMAP when client is a resident in a nursing facility
E0461	Volume ventilator, stationary or portable, with back-up rate feature used with non-invasive interface -- PA required– OMAP will rent – Also covered for payment by OMAP when client is a resident in a nursing facility
E0457	Chest shell (cuirass) – PA required – OMAP will rent, purchase and repair – Also covered for payment by

	OMAP when client is a resident in a nursing facility – Item considered purchased after 16 months of rent
E0459	Chest wrap – PA required– OMAP will purchase, rent and repair – Item considered purchased after 16 months of rent – Also covered for payment by OMAP when client is a resident in a nursing facility
E0460	Negative pressure ventilator; portable or stationary – PA required – OMAP will rent – Also covered for payment by OMAP when client is a resident in a nursing facility
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) – PA required-- OMAP will rent – Also covered for payment by OMAP when client is a resident in a nursing facility.
S8999	Resuscitation bag – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

410-122-0220 Pacemaker Monitor

(1) E0610, Pacemaker monitor, self-contained, checks battery depletion, includes audible and visible check systems -- the Office of Medical Assistance Programs (OMAP) will purchase -- Also covered for payment by OMAP 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 -- OMAP will purchase -- Also covered for payment by OMAP 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
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 9-1993 f. & cert. ef. 4-1-93; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01

410-122-0240 APNEA Monitor

(1) All necessary training to utilize services, including CPR training, is included in the rental fee.

(2) Indications and coverage:

(a) The following conditions will be considered for initial approval for a maximum of six months:

(A) A sibling has died from SIDS;

(B) Symptomatic apnea due to neurological impairment;

(C) Craniofacial malformation likely to cause symptomatic apnea.

(b) The following conditions will be considered for initial approval for a maximum of three months:

(A) Symptomatic apnea of prematurity;

(B) Observation of apparent life-threatening event (ALTE);

(C) Receiving home oxygen (not a universal requirement, full-term infant usually does not require).

(c) The authorization may be extended if documentation is submitted to support one of the following conditions:

(A) Continues to have real alarms documented by memory monitor;

(B) Upper respiratory infection when monitoring was scheduled to be discontinued (will be extended for two weeks, no memory monitor required).

(3) Documentation: The following documentation must be submitted for initial authorization of an apnea monitor:

(a) Diagnosis and statement of medical appropriateness from the prescribing practitioner; and

(b) Copies of hospital records documenting medical appropriateness; and/or

(c) Copies of sleep studies or apnea monitor with recording feature reports; and/or

(d) Documentation of ALTE from log, nursing notes or doctor's progress records.

(4) Multi-Channel Sleep Study:

(a) Indications and coverage:

(A) Sleep study must be medically appropriate;

(B) A sleep study is not required to discontinue use of an apnea monitor.

(b) Documentation: The following documentation must be submitted for initial authorization of a sleep study:

(A) Diagnosis and statement of medical appropriateness from the prescribing practitioner; and/or

(B) Copies of hospital records documenting medical appropriateness and diagnosis.

(5) Apnea Monitor, with recording feature:

(a) Indications and coverage:

(A) May be substituted for up to three months of prolonged apnea monitoring;

(B) Needed to support continuation of apnea monitoring beyond initial limits;

(C) May be substituted for apnea monitoring to determine frequency of real alarms.

(b) Documentation: The following documentation must be submitted for initial authorization of an apnea monitor with recording feature:

(A) Diagnosis and statement of medical appropriateness from the prescribing practitioner; and

(B) Copies of hospital records documenting medical appropriateness; and/or

(C) Documentation of ALTE from log, nursing notes or prescribing practitioner's progress records.

(6) Apnea Monitor Codes: Table 0240.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

Table 0240 Apnea Monitor Codes

A4556	Electrodes (e.g., apnea monitor) per pair – Prior authorization (PA) required by the Office of Medical Assistance Programs (OMAP) – OMAP will purchase
A4557	Lead wires (e.g., apnea monitor) per pair – PA required by OMAP – OMAP will purchase
A4558	Conductive paste or gel – PA required by OMAP – OMAP will purchase
E0619	Apnea Monitor with recording feature – PA required by OMAP – OMAP will rent.
E0618	Apnea monitor without recording feature (includes client cable) – PA required by OMAP – OMAP will rent

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) Electric Breast Pump codes:

(a) E0602, Breast pump, manual, any type -- Office of Medical Assistance Programs (OMAP) will purchase;

(b) E0603, Breast pump, electric (AC and/or DC), any type, per day -- OMAP will rent -- Prior authorization required by OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02

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) Documentation: An order for the breast prosthesis, which shows the type of prosthesis, and which is signed and dated by the treating prescribing practitioner, must be kept on file by the supplier. An ICD-9-CM diagnosis code which describes the condition which necessitates the breast prosthesis must be present on each order for a breast prosthesis or related item.

(3) Procedure Codes: Table 0255.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02

Table 0255Procedure Codes

A4280 Adhesive skin support attachment for use with external breast prosthesis, each – The Office of Medical Assistance Programs (OMAP) will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

Used when billing for an adhesive skin support that attaches an external breast prosthesis directly to the chest wall

L8000 Breast prosthesis, mastectomy bra – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

Four per year

L8001 Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

L8002 Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

L8015 External breast prosthesis garment, with mastectomy form, post mastectomy – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

A camisole type undergarment with polyester fill used post mastectomy.

An external breast prosthesis garment, with mastectomy form is covered for use in the postoperative period prior to

a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis.

L8020 Breast prosthesis, mastectomy form – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

One per year per side

L8030 Breast prosthesis, silicone or equal – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

One per year per side

L8035 Custom breast prosthesis, post mastectomy, molded to client model – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

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.

L8039 Breast prosthesis, not otherwise classified – Prior authorization required by OMAP – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

410-122-0260 Home Uterine Monitoring

(1) The prescribing practitioner or Durable Medical Equipment (DME) provider may fax or mail the request for prior authorization (PA).

(2) 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.

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

(4) 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.

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

(6) S9001, Uterine Home Monitoring, with or without associated nursing services -- PA required by OMAP -- OMAP will rent.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01

410-122-0280 Heating/Cooling Accessories

Procedure Codes for Heating/Cooling Accessories: Table 280.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 9-1993 f. & cert. ef. 4-1-93; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01

Table 280 Procedure Codes for Heating/Cooling Accessories:

A4265	Paraffin, per pound – The Office of Medical Assistance Programs (OMAP) will purchase
E0200	Heat lamp without stand (table model) includes bulb or infrared element – OMAP will purchase – OMAP will rent – Item considered purchased after 16 months of rent
E0205	with stand – OMAP will purchase – OMAP will rent – Item considered purchased after 16 months of rent
E0210	Electric heat pad – standard – OMAP will purchase
E0215	moist – OMAP will purchase
E0217	Water circulating heat pad with pump, OMAP will purchase, rent, repair – Items considered purchased after 16 months of rent
E0220	Hot water bottle – OMAP will purchase
E0230	Ice cap or collar – OMAP will purchase
E0235	Paraffin bath unit portable (without paraffin) – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent
E0236	Pump for water circulating pad – OMAP will purchase – OMAP will rent – repair – Item considered purchased after 16 months of rent
E0238	nonelectric – OMAP will purchase
E0249	Pad for water circulating heat unit – OMAP will purchase

410-122-0300 Light Therapy

(1) A4633, Replacement bulb/lamp for ultraviolet light therapy system, each -- OMAP will purchase.

(2) E0691, Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less -- Prior authorization required by OMAP -- OMAP will purchase -- OMAP will rent -- OMAP will repair. Item considered purchased after 16 months of rent.

(3) E0692, Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel -- Prior authorization required by OMAP -- OMAP will purchase -- OMAP will rent -- OMAP will repair. Item considered purchased after 16 months of rent.

(4) E0693, Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel -- Prior authorization required by OMAP -- OMAP will purchase -- OMAP will rent -- OMAP will repair. Item considered purchased after 16 months of rent.

(5) E0694, Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection--Prior authorization required by OMAP -- OMAP will purchase -- OMAP will rent -- OMAP will repair. Item considered purchased after 16 months of rent.

(6) S9098, Home visit, phototherapy services (e.g., bili-lite), including equipment rental, nursing services blood draw, supplies, and other services, per diem, per day -- OMAP will rent.

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

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

410-122-0320 Manual Wheelchair Base

(1) Indications and Coverage:

(a) The purchase, rental, or modification of a manual wheelchair is covered when all of the following criteria are met:

(A) The client's condition is such that without the use of a wheelchair the client would be bed-confined or confined to a non-mobile chair; and

(B) The client is not functionally ambulatory and the wheelchair is necessary to function within the home.

(b) The Office of Medical Assistance Programs (OMAP) will not pay for backup chairs. Only one wheelchair will be maintained, rented, repaired, purchased or modified for each client to meet the medical appropriateness; however, if a client's current wheelchair no longer meets the medical appropriateness or repair to the wheelchair exceeds replacement cost, a new wheelchair may be authorized. If a client has a wheelchair that meets his/her medical needs regardless of who has obtained it, OMAP will not provide another chair;

(c) One month's rental of a wheelchair is covered if a client-owned wheelchair is being repaired;

(d) Living quarters must be able to accommodate requested wheelchair. OMAP will not be responsible for adapting the living quarters to accommodate the wheelchair;

(e) Backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, wheelchair gloves, and upgrades to allow performance of leisure or recreational activities are not covered;

(f) Wheelchair "poundage" (lbs) represents the weight of the usual configuration of the wheelchair without front riggings;

(g) Do not use E1399 for manual wheelchair base;

(h) Reimbursement for wheelchair codes includes all labor charges involved in the assembly and delivery of the wheelchair and all adjustments for three months after date the client takes delivery. Reimbursement also includes emergency services, education and on-going assistance with use of the wheelchair for three months after the client takes delivery.

(i) Nursing Facility:

(A) Use the correct base code for manual wheelchairs provided to clients in nursing facilities. The only wheelchairs covered in a nursing facility have been uniquely constructed, substantially modified, manual wheelchair for a specific person residing in a nursing facility;

(B) The wheelchair is considered customized when the unique seating, arm rests, leg rests and/or head rests, in combination, make it virtually impossible to meet another person's positioning needs in the wheelchair. Examples include, but are not limited to a pindot seating system, foam in place seating system, or other molded-to-client systems;

(C) The frame for the wheelchair base does not have to be customized or changed to meet the definition of a customized wheelchair in a nursing facility;

(D) Documentation must clearly describe the unique modification to the wheelchair and the custom seating system. Pictures of the client, measurements of body contour and completion of the OMAP 3125 by an impartial evaluator are required.

(E) When billing, use modifier U1 -- Nursing Facility wheelchair.

(2) Documentation:

(a) Documentation of medical appropriateness which has been reviewed and signed by the treating prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(b) Submit list of all DME available or being used to meet the client's needs when requesting prior authorization (PA);

(c) Submit Wheelchair and Seating Prescription and Justification form (OMAP 3125) or reasonable facsimile, with recommendations for most appropriate equipment. This must be submitted by physical therapist, occupational therapist, prescribing practitioner, or registered nurse, when requesting a PA. The evaluation must include client's functional ambulation status in their customary environment. This is not required when using K0001, K0002 or K0003 if no modifications are required;

(3) Procedure Codes:

(a) E1161 Manual adult size wheelchair, includes tilt-in-space --PA required--OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent. Also covered for payment by OMAP when client is a resident of a nursing facility, if it meets nursing facility criteria:

(A) Indications and coverage for tilt-in space: clients must meet the criteria for a wheelchair (manual or powered), plus the following:

(i) Dependent for transfers; and

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

(iii) Plan of care must address the need to change position at frequent intervals and not be left in the tilt position most of the time; and

(iv) One of the following:

(I) High risk of skin breakdown;

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

(III) Hyper/hypotonia;

(IV) Requires frequent change of position with poor upright sitting.

(B) Documentation -- must support the above criteria.

(b) K0001, Standard Wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment by OMAP when client is a resident of a nursing facility, if it meets nursing facility criteria: Weight >36 lbs; seat width 16" (narrow), 18" (adult); seat depth 16"; seat height >= 19" and ? 21"; back height -- non-adjustable 16"-17"; arm style -- fixed or detachable; footplate extension 16"-21"; footrests -- fixed or swingaway detachable;

(c) K0002, Standard Hemi (low seat) Wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent; also covered for payment by OMAP when client is a resident of a nursing facility, if it meets nursing facility criteria:

(A) Weight >36 lbs; seat width 16" (narrow), 18" (adult); seat depth 16"; seat height 17"-18"; back height -- non-adjustable 16"-17"; arm style -- fixed or detachable; footplate extension -- 14"-17"; footrests -- fixed or swingaway detachable;

(B) Covered when the client requires a lower seat height (17"-18") because of short stature or to enable the client to place his/her feet on the ground for propulsion.

(d) K0003, Lightweight Wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent; also covered for payment by OMAP when client is a resident of a nursing facility, if it meets nursing facility criteria:

(A) Weight < 36 lbs; seat width 16" or 18"; seat depth 16"; seat height >= 17" and < 21"; back height -- non-adjustable 16"-17"; arm height -- fixed height, detachable; footplate extension 16"-21"; footrests -- fixed or swingaway detachable;

(B) Covered when a client cannot functionally self-propel in a standard wheelchair using arms and/or legs and the client can and does self-propel in a lightweight wheelchair.

(e) K0004, High Strength, Lightweight Wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment by OMAP when client is a resident of a nursing facility, if it meets nursing facility criteria:

(A) Lifetime warranty on side frames and cross braces; weight < 34 lbs; seat width 14", 16" or 18"; seat depth 14" (child), 16" (adult); seat height >= 17" and < 21"; back height -- sectional or adjustable 15"-19'; arm style -- fixed or detachable; footplate extension 16"-21"; footrests -- fixed or swingaway detachable;

(B) Covered when a client:

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

(ii) The activities may cause permanent damage to a standard or lightweight chair; or

(iii) When a client requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair; and

(iv) Spends at least two hours per day in the wheelchair.

(f) K0005, Ultralightweight Wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment by OMAP when client is a resident of a nursing facility, if it meets nursing facility criteria. Lifetime warranty on side frames and cross braces; weight < 30 lbs; adjustable rear axle position; seat width 14", 16", or 18"; seat depth 14" (child), 16" (adult); seat height >= 17" and < 21"; arm style -- fixed or detachable; footplate extension 16"-21"; footrests -- fixed or swingaway detachable;

(g) K0006, Heavy Duty Wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent; Also covered for payment by OMAP when client is a resident of a nursing facility, if it meets nursing facility criteria:

(A) Seat width 18", seat depth 16" or 17"; seat height >19" and < 21"; back height -- non-adjustable 16"-17"; arm style -- fixed height, detachable; footplate extension 16"-21"; footrests -- fixed or swingaway detachable; reinforced back and seat upholstery; can support client weighing >250 pounds or the client has severe spasticity;

(B) Covered if the client weighs more than 250 pounds, has severe spasticity, or has a mental/physical diagnosis that warrants a heavy-duty chair (e.g., has a history of damaging equipment due to diagnosis).

(h) K0007, Extra Heavy Duty Wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment by OMAP when client is a resident of a nursing facility, if it meets nursing facility criteria:

(A) Seat width 18"; seat depth 16" or 17"; seat height >19" and < 21"; Back height -- non-adjustable 16"-17"; arm style -- fixed height, detachable; footplate extension 16"-21"; footrests -- fixed or swingaway detachable; reinforced back and seat upholstery; can support client weighing >300 pounds;

(B) Covered if the client weighs more than 300 pounds, has severe spasticity or has a mental/physical diagnosis that warrants a heavy duty chair (e.g., has a history of damaging equipment due to diagnosis).

(i) K0009, Other Manual Wheelchair/Base, PA required -- OMAP will purchase, rent, and repair -- Item considered purchased after 16 months of rent:

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

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 18-1994(Temp), f. & cert. ef. 4-1-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. l2-30- 94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

410-122-0325 Motorized/Power Wheelchair Base

(1) Indications and Coverage:

(a) The purchase, rental, or modification of a power wheelchair is covered when all of the following criteria are met:

(A) The client without the use of the wheelchair would be bed confined or confined to a non-mobile chair; and

(B) The client is not ambulatory or not functionally ambulatory and the wheelchair is necessary to function within the home; and

(C) The client has severe weakness of the upper extremities due to a neurological, respiratory or muscular disease/condition; and

(D) The client is unable to operate a manual wheelchair; and

(E) The client is capable of safely operating the controls for the power wheelchair; and

(F) The client's condition is such that the requirement for a power wheelchair will be long-term (at least six months).

(b) The Office of Medical Assistance Programs (OMAP) will not pay for backup wheelchairs. Only one wheelchair will be maintained, rented, repaired, purchased or modified for each client to meet the medical appropriateness; however, if a client's current wheelchair no longer meets the medical appropriateness or repair to the wheelchair exceeds replacement costs, a new wheelchair may be authorized. If a client has a wheelchair that meets his/her medical needs regardless of who has obtained it, OMAP will not provide another chair;

(c) One month's rental of a wheelchair is covered if a client-owned wheelchair is being repaired;

(d) Living quarters must be able to accommodate requested wheelchair. OMAP will not be responsible for adapting the living quarters to accommodate the wheelchair;

(e) Backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, wheelchair gloves, head lights, tail lights, and upgrades to allow performance of leisure or recreational activities are not covered;

(f) Wheelchair "poundage" (lbs.) represents the weight of the usual configuration of the wheelchair without front riggings;

(g) Do not use E1399 for motorized/power wheelchair base;

(h) Reimbursement for wheelchair codes includes all labor charges involved in the assembly and delivery of the wheelchair and all adjustments for three months after date the client takes delivery. Reimbursement also includes emergency services, education and on-going assistance with use of the wheelchair for three months after the client takes delivery;

(i) Codes K0010 - K0014 are not used for manual wheelchairs with add-on power packs. Use the appropriate code for the manual wheelchair base provided (K0001 - K0009) and codes K0460 or K0461 for the add-on power packs.

(2) Documentation:

(a) Documentation of medical appropriateness which has been reviewed and signed by the treating prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(b) Submit list of all DME available or being used to meet the client's needs when requesting prior authorization (PA);

(c) Submit Wheelchair and Seating Prescription and Justification form (OMAP 3125) or reasonable facsimile, with recommendations for most appropriate equipment. This must be submitted by physical therapist, occupational therapist, prescribing practitioner, or

registered nurse, when requesting a PA. The evaluation must include client's functional ambulation status in their customary environment.

(3) K0010, Standard-weight frame motorized/power wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent: Seat width 14"-18"; seat depth 16"; seat height >= 19" and ¾ 21"; back height -- sectional 16" or 18"; arm style -- fixed height, detachable; footplate extension 16"-21"; footrests -- fixed or swingaway detachable.

(4) K0011, Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent: Seat width 14"-18"; seat depth 16"; seat height >= 19" and ¾ 21"; back height -- sectional 16" or 18"; arm style -- fixed height, detachable; footplate extension 16"-21"; footrests -- fixed or swingaway detachable.

(5) K0012, Lightweight portable motorized/power wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent: Seat width 14"-18"; seat depth 16"; seat height ¾ 19" and >= 21"; back height -- sectional 16" or 18"; arm style -- fixed height, detachable; footplate extension 16"-21"; footrests -- fixed or swingaway detachable; weight < 80 lbs. without battery; folding back or collapsible frame.

(6) K0014, Other motorized/power wheelchair base -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent:

(a) Use in addition to K0108 for power recline or tilt-in space;

(b) Use for pediatric motorized/power wheelchair base.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02

410-122-0330 Power-Operated Vehicle

(1) Indications and Coverage:

(a) The purchase, rental, or modification of a power-operated vehicle (POV) is covered when all of the following criteria are met:

(A) A physician specializing in the practice of physiatry, orthopedics neurology or rheumatology must provide a clinical evaluation of the client's medical and physical condition and a prescription for the vehicle. A prescription from the client's prescribing practitioner is acceptable if it is determined that a specialist is not reasonably accessible (e.g., more than 1 day's round trip from the client's home) or the client's condition precludes such travel;

(B) The client without the use of a POV would be bed confined or confined to a non-mobile chair;

(C) The client is unable to operate a manual wheelchair;

(D) The client is capable of safely operating the controls for the POV;

(E) The client can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV; and

(F) The POV can be operated inside the home;

(G) Living quarters must be able to accommodate requested POV. the Office of Medical Assistance Programs (OMAP) will not be responsible for adapting the living quarters to accommodate the POV;

(H) Allowance for a 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.

(b) One month's rental of a POV is covered if a client-owned POV is being repaired. OMAP will not pay for backup chairs. Only one wheelchair or POV will be rented or purchased to meet the medical

need. Replacement parts for a client owned POV, should be billed using the specific wheelchair accessory HCPCS. Use K0108 if a specific code does not exist.

(2) Documentation:

(a) Documentation of medical appropriateness which has been reviewed and signed by the evaluating prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(b) Submit list of all DME available or being used to meet the client's needs when requesting prior authorization (PA);

(c) The elements of a clinical evaluation should detail (not all inclusive):

(A) Current limitations of ambulation;

(B) Lower and upper extremity body strength;

(C) Other medical conditions that potentially impact operation of a manual wheelchair or POV, such as sensory defects, cardiopulmonary limitations, or rheumatologic disease; and

(D) Intended use and expected benefit of the POV;

(E) Physical limitations should be objective and quantitative; and

(F) Client's functional ambulation status in their customary environment.

(d) E1230, Power operated vehicle (3 or 4 wheel non-highway) -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Includes the cost of the initial batteries and battery charger.

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

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02

410-122-0340 Wheelchair Options/Accessories

(1) Indications and Coverage:

(a) Covered if client meets the criteria for wheelchair. An option/accessory is not covered if its primary benefit is to allow the client to perform leisure or recreational activities;

(b) The options/accessories are necessary for the client to perform one or more of the following actions:

(A) Function in the home;

(B) Perform instrumental activities of daily living.

(c) Use K0108 for replacement wheelchair parts if no other code is appropriate; (d) Use of pressure mapping device for specialized seating and positioning is included in the price of the wheelchair base, accessories or options.

(2) Documentation: Documentation of medical appropriateness which has been filled out, signed, and dated by the treating prescribing practitioner (for example, CMN) must be kept on file by the DME provider.

(3) Arm of Chair:

(a) E0973,Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each—the Office of Medical Assistance Programs will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent: covered if the client requires an arm height that is different than what is available using non-adjustable arms and the client spends at least two hours per day in the wheelchair;

(b) K0015, Detachable, non-adjustable height armrest, each -- the Office of Medical Assistance Programs (OMAP) will purchase, rent and repair. Also covered for payment by OMAP when client is a

resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) K0017, Detachable, adjustable height armrest, base, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the client requires an arm height that is different than that available using non-adjustable arms and the client spends at least two hours per day in the wheelchair;

(d) K0018, Detachable, adjustable height armrest, upper portion, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the client requires an arm height that is different than that available using non-adjustable arms and the client spends at least two hours per day in the wheelchair;

(e) K0019, Arm pad, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(f) K0020, Fixed, adjustable height armrest, pair -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the client requires an arm height that is different than that available using non adjustable arms and the client spends at least two hours per day in the wheelchair;

(g) K0106, Arm trough, each—OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent.

(4) Back of Chair:

(a) E0966, Manual wheelchair accessory, headrest extension, each-PA required—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(b) E0971, Anti-tipping device, wheelchair-- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) E0974, Manual wheelchair accessory, anti-rollback device, each-- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(d) E0982, Wheelchair accessory, back upholstery, replacement only, each—OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(A) Included in the allowance for a heavy duty or extra heavy-duty wheelchair;

(B) Not medically appropriate if used in conjunction with other manual wheelchair bases;

(i) Covered if used with a power wheelchair base and;

(ii) The client weighs more than 200 pounds.

(e) E1226, Manual wheelchair accessory, fully reclining back, each—OMAP will purchase, rent and repair. Also covered for payment by OAMP when client is a resident of a nursing facility—Item considered purchased after 16 month of rent;

(A) Covered if the client spends at least two 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;

(v) Client needs to rest in a recumbent position two or more times during the day and transfer between wheelchair and bed is very difficult.

(B) Use for fully reclining back which is manually operated.

(f) K0023, Solid back insert, planar back, single density foam, attached with straps -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent -- A prefabricated back seating module which is incorporated into a wheelchair base;

(g) K0024, Solid back insert, planar back, single density foam, with adjustable hook-on hardware -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent -- A prefabricated back seating module which is incorporated into a wheelchair base.

(5) Seating Systems:

(a) Item is individually made for a client using:

(A) A plaster model of the client;

(B) A computer-generated model of the client (CAD-CAM technology); or

(C) Detailed measurements of the client used to create a curved foam custom fabricated component.

(b) Not used for seating components that are ready made but subsequently modified to fit an individual client;

(c) Indications and Coverage: Seating systems are covered when:

(A) The client has a significant spinal deformity and/or severe weakness of the trunk muscles; and

(B) The client's need for prolonged sitting tolerance, postural support to permit functional activities, or pressure reduction cannot be met adequately by a prefabricated seating system; and

(C) The client is expected to be in the wheelchair at least two hours per day.

(d) K0115, Seating systems, back module, posterior-lateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(e) K0116, Seating systems, combined back and seat module, custom fabricated for attachment to wheelchair base. A one-piece system including both back and seat component -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility.

(6) Seat:

(a) E0962, 1"cushion, for wheelchair, any type -- OMAP will purchase;

(b) E0963, 2"cushion, for wheelchair, any type -- OMAP will purchase;

(c) E0964, 3"cushion, for wheelchair, any type -- OMAP will purchase;

(d) E0965, 4"cushion, for wheelchair, any type -- OMAP will purchase;

(e) E0981, Wheelchair accessory, seat upholstery, replacement only, each—OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(f) E0985, Wheelchair accessory, seat lift mechanism,--PA required-OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(g) E0992, Manual wheelchair accessory, solid seat insert—OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(A) Includes hardware;

(B) Covered when the client spends at least two hours per day in the wheelchair.

(h) E2201, Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(i) E2202, Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches-- OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent

(j) E2203, Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(k) E2204, Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(l) E2340, Power wheelchair accessory, nonstandard seat frame width, 20-23 inches--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(m) E2341, Power wheelchair accessory, nonstandard seat frame width, 24-27 inches--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(n) E2342, Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(o) E2343, Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing

facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(p) K0056, Seat height < 17" or > 21"for a high strength, lightweight or ultralightweight wheelchair -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent. Covered only if the ordered item is at least 2"greater than or less than a standard option and the client's dimensions justify the need.

(7) Footrest/Legrest:

(a) E0951, Heel loop/holder, with or without ankle strap, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) E0952, Toe loop/holder, each—OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(c) E0990, Wheelchair accessory, elevating leg rest, complete assembly, each—OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

Use for the repair or replacement of an elevating leg rest for a client-owned wheelchair; Covered if the client has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee, has significant edema of the lower extremities that requires having an elevating leg rest or criteria for a reclining back option are met, and the client has a wheelchair with a reclining back.

(d) E0995, Wheelchair accessory, calf rest/pad, each—OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(e) E1020, Residual limb support system for wheelchair -- OMAP will purchase, rent, and repair -- Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(f) K0037, High mount flip-up footrest, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(g) K0038, Leg strap, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(h) K0039, Leg strap, H style, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(i) K0040, Adjustable angle foot-plate, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(j) K0041, Large size foot-plate, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(k) K0042, Standard size foot-plate, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a

resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(l) K0043, Footrest, lower extension tube, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(m) K0044, Footrest, upper hanger bracket, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(n) K0045, Footrest, complete assembly -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(o) K0046, Elevating leg rest, lower extension tube, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the client has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee, has significant edema of the lower extremities that requires having an elevating leg rest, or criteria for a reclining back option are met, and the client has a wheelchair with a reclining back;

(p) K0047, Elevating leg rest, upper hanger bracket, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the client has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee, has significant edema of the lower extremities that requires having an elevating leg rest, or criteria for a reclining back option are met, and the client has a wheelchair with a reclining back;

(q) K0050, Ratchet assembly -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(r) K0051, Cam release assembly, footrest or leg rest, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(s) K0052, Swing-away, detachable footrests, each, replacement -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent. Included in allowance for the wheelchair base;

(t) K0053, elevating footrests, articulating (telescoping), each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the client has a musculoskeletal condition, or the presence of a cast or brace which prevents 90 degree flexion at the knee, has significant edema of the lower extremities that requires having an elevating leg rest, or criteria for a reclining back option are met;

(u) K0195, elevating leg rests, pair (for use with capped rental wheelchair base) -- OMAP will rent-- Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair. Covered if the client has a musculoskeletal condition, or the presence of a cast or brace which prevents 90 degree flexion at the knee, has significant edema of the lower extremities that requires having an elevating leg rest, or criteria for a reclining back option are met.

(8) Hand rims Without Projections:

(a) K0059, Plastic coated hand rim, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0060, Steel hand rim, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) K0061, Aluminum hand rim, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent.

(9) Hand rims with Projections:

E0967, Manual wheelchair accessory, hand rim with projections, each—OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent.

(10) Rear Wheels:

(a) K0064, Zero pressure tube (flat free inserts), any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0065, Spoke protectors, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) K0066, Solid tire, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident

of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(d) K0067, Pneumatic tire, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent -- If both a pneumatic tire and pneumatic tire tube are provided on the same date, bill both K0067 and K0068;

(e) K0068, Pneumatic tire tube, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent -- If both a pneumatic tire and pneumatic tire tube are provided on the same date, bill both K0067 and K0068;

(f) K0069, Rear wheel assembly, complete, with solid tire, spokes or molded, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(g) K0070, Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent.

(11) Front Casters:

(a) K0071, Front caster assembly, complete, with pneumatic tire, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0072, Front caster assembly, complete, with semi-pneumatic tire, each -- OMAP will purchase, rent and repair. Also covered for

payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) K0073, Caster pin lock, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(d) K0074, Pneumatic caster tire, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(e) K0075, Semi-pneumatic caster tire, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(f) K0076, Solid caster tire, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(g) K0077, Front caster assembly, complete, with solid tire, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(h) K0078, Pneumatic caster tire tube, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent.

(12) Wheel Lock:

(a) E0961, Manual wheelchair accessory,wheel lock brake extension (handle),each -- OMAP will purchase, rent and repair. Also covered

for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) E0974,Manual wheelchair accessory,anti-rollback device, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the client able to propel self and needs the device because of ramps;

(c) K0081, Wheel lock assembly, complete, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent.

(13) Batteries/Chargers for Motorized/Power Wheelchair:

(a) E2360, Power wheelchair accessory, 22 NF non-sealed lead acid battery, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair. Separately payable from the purchased wheelchair base;

(b) E2361, Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair. Separately payable from the purchased wheelchair base;

(c) E2362 , Power wheelchair accessory, Group 24 non-sealed lead acid battery, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair. Separately payable from the purchased wheelchair base;

(d) E2363, Power wheelchair accessory, Group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) -- OMAP will purchase -- Also covered for payment by OMAP when client is a

resident of a nursing facility if supplied for client-owned wheelchair. Separately payable from the purchased wheelchair base;

(e) E2364, Power wheelchair accessory, U-1 non-sealed lead acid battery, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair. Separately payable from the purchased wheelchair base;

(f) E2365, Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair. Separately payable from the purchased wheelchair base;

(g) E2366, Power wheelchair accessory, Battery charger, single mode, for use with only one battery type, sealed or non-sealed, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(A) Covered if criteria for a power wheelchair are met;

(B) There will be no additional allowance if a dual mode charger is used;

(C) A battery charger is included in the allowance for a power wheelchair base (K0010-K0014);

(D) A battery charger should be billed separately only when it is a replacement.

(14) Motorized/Power Wheelchair Parts:

(a) E1002, Wheelchair accessory, power seating system, tilt only—PA required—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if

supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(b) E1003, Wheelchair accessory, power seating system, recline only, without shear reduction—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(c) E1004, Wheelchair accessory, power seating system, recline only, with mechanical shear reduction—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(d) E1005, Wheelchair accessory, power seating system, recline only, with power shear reduction—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(e) E1006, Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(f) E1007, Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(g) E1008, Wheelchair accessory, power seating system ,combination tilt and recline, with power shear reduction—PA required-- OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if

supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(h) E1010, Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, each—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(i) E2320, Power wheelchair accessory, hand or chin control interface, remote joystick or touchpad, proportional, including all related electronics, and fixed mounting hardware—PA required—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(j) E2321, Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(k) E2322, Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(l) E2323, Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(m) E2324, Power wheelchair accessory, chin cup for chin control interface--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(n) E2325, Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(o) E2326, Power wheelchair accessory, breath tube kit for sip and puff interface—PA required—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(p) E2327, Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware--PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(q) E2328, Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware—PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(r) E2329, Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware—PA required--

OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(s) E2330, Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware-PA required--OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(t)) K0090, Rear wheel tire for power wheelchair, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(u) K0091, Rear wheel tire tube other than zero pressure for power wheelchair, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(v) K0092, Rear wheel assembly for power wheelchair, complete, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(w) K0093, Rear wheel zero pressure tire tube (flat free insert) for power wheelchair, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(x) K0094, Wheel tire for power base, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(y) K0095, Wheel tire tube other than zero pressure for each base, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(z) K0096, Wheel assembly for power base, complete, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(aa) K0097, Wheel zero pressure tire tube (flat free insert) for power base, any size, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(bb) K0098, Drive belt for power wheelchair -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(cc) K0099, Front caster for power wheelchair, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent.

(15) Shock absorbers:

(a) E1015, Shock absorber for manual wheelchair, each -- OMAP will purchase, rent and repair -- PA required. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for

client-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) E1016, Shock absorber for power wheelchair, each -- OMAP will purchase, rent and repair -- PA required. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) E1017, Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each -- PA required -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(d) E1018, Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair -- OMAP will purchase, rent and repair -- PA required. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent.

(16) Miscellaneous Accessories:

(a) E0950, Wheelchair accessory, tray, each—the Office of Medical Assistance Programs will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—

(b) E0955, Wheelchair accessory, headrest, cushioned, prefabricated, including fixed mounting hardware, each- OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair;

(c) E0956, Wheelchair accessory, lateral trunk or hip support, prefabricated, including fixed mounting hardware, each—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair;

(d) E0957, Wheelchair accessory, medial thigh support, prefabricated, including fixed mounting hardware, each—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair;

(e) E0958, Manual wheelchair accessory, one-arm drive attachment, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the client propels the chair himself/herself with only one hand and the need is expected to last at least six months;

(f) E0959, Manual wheelchair accessory, each, adapter for amputee, each—OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(g) E0960, Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware— OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(h) E0972, Wheelchair accessory, transfer board or device, each, -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(i) E0978, Wheelchair accessory, safety belt/pelvic strap, each-- OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(j) E0983, Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(k) E0984, Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(l) E0986, Manual wheelchair accessory, push-rim activated power assist—PA required—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(m) E1028, Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(n) E1029, Wheelchair accessory, ventilator tray, fixed—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(o) E1030, Wheelchair accessory, ventilator tray, gimbaled—PA required—OMAP will purchase, rent and repair—Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair—Item considered purchased after 16 months of rent;

(p) K0104, Cylinder tank carrier, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a

resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(q) K0105, IV hanger, each -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent;

(r) K0108, Wheelchair component or accessory, not otherwise specified -- Prior authorization (PA) required -- OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned wheelchair -- Item considered purchased after 16 months of rent:

(A) Each item requested must be itemized with a clear description of item, manufacturer, model name number, Manufacturer's Suggested Retail Price (MSRP) and price;

(B) For option or accessories in which coverage rules have not been explicitly defined, the prescribing practitioner's order must include the item and a statement describing why that feature is medically appropriate in the particular client;

(C) Used for but not limited to:

(i) Nonstandard seat dimensions that do not fall under specific codes;

(ii) Accessories or options for a new wheelchair and replacement parts for a wheelchair being repaired;

(iii) Thigh abduction pommels;

(iv) Seat backs or cushions that do not fall under specific codes;

(v) Non-joystick control devices;

(vi Upgraded electronics;

(vii) Custom fabricated seat component when billing for a two-piece seating system (use K0115 for the custom fabricated back component);

(viii) Nonstandard seat height that does not fall under specific codes, (e.g., 16"height);

(ix) Roho mini max for wheelchair back;

(s) K0452, Wheelchair bearings, any type -- OMAP will purchase -- also covered for payment by OMAP when client is a resident of a nursing facility, if supplied for client-owned wheelchair..

(17) Pressure Pads:

(a) E0176, Air pressure pad or cushion, non-positioning -- PA required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(b) E0178, Gel or gel-like pressure pad or cushion, non-positioning -- PA required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(c) E0179, Dry pressure pad or cushion, non-positioning -- OMAP will purchase;

(d) E0192, Low pressure and positioning equalization pad for wheelchair -- PA required -- OMAP will purchase and repair -- Also covered for payment by OMAP when client is a resident of a nursing facility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

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) Documentation:

(a) An order for the cane or crutch which is signed by the prescribing practitioner must be kept on file by the supplier. The prescribing practitioner's records must contain information which supports the medical appropriateness of the item ordered;

(b) A white cane for a visually impaired client is considered to be a self-help item and is not covered by the Office of Medical Assistance Programs (OMAP). Table 0360.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

Table 0360 Canes

A4636	Replacement, handgrip, cane, crutch or walker, each – OMAP will purchase
A4637	Replacement, tip, cane, crutch, walker, each – OMAP will purchase
E0100	Cane, includes canes of all materials, adjustable or fixed, with tips – OMAP will purchase
E0105	quad or three prong, includes canes of all materials, adjustable or fixed, with tips – OMAP will purchase – OMAP will rent – Item considered purchased after 16 months of rent

Crutches

A4635	Underarm pad, crutch, replacement, each – OMAP will purchase
A4636	Replacement, handgrip, cane, crutch or walker, each – OMAP will purchase
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent
E0111	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips – OMAP will purchase – OMAP

will rent – Item considered purchased after 16 months of rent

E0113 Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip – OMAP will purchase – OMAP will rent – Item considered purchased after 16 months of rent

E0114 Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

E0116 Crutch, underarm, other than wood, adjustable or fixed, each, with pad, tip and handgrip – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

E0117 Crutch, underarm, articulating, spring assisted, each -- OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

E0153 Platform attachment, forearm, crutch, each – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

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 Office of Medical Assistance Programs (OMAP) 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) An order which has been signed and dated by the prescribing practitioner;

(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 (OMAP 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) List of all DME owned or available for client's use.

(4) A gait belt is covered when a client weighs 60 lbs. or more, the care provider is trained in the proper use, and the client can walk independently, but needs a minor correction of ambulation, or, needs minimal or standby assistance to walk alone, or, requires assistance with transfer. Use code E1399.

(5) Procedure Codes:

(a) E0638, Standing frame system, any size, with or without wheels Prior authorization required --OMAP will purchase , rent and repair if the following criteria are met:

(A) The client must be sequentially evaluated by a physical therapist or occupational therapist to make certain they are able to tolerate and obtain medical benefit from standing positioner;

(B) The client must be following a therapy program initially established by physical or occupational therapist;

(C) The weight of client must not exceed manufacturer's weight capacity;

(D) The client has demonstrated compliance with other programs;

(E) The client has demonstrated ability to utilize independently or with caregiver;

(F) The client has demonstrated successful trial period in monitored setting;

(G) The client does not have access to equipment from another source;

(H) The home must be able to accommodate the equipment;

(I) Not covered:

(i) Electric mobility option

(b) E1399, Durable medical equipment, miscellaneous, includes, but is not limited to: Sidelyer (includes accessories)—PA required--OMAP will purchase and repair--Covered if the following criteria are met:

(A) The client has contractures that are capable of being reduced or fixed contractures; or

(B) The client has positioning and support needs that cannot be met with other positioning devices; or

(C) Positioning is needed to prevent reflux during feeding; and

(D) Must be sequentially evaluated by a physical or occupational therapist to make certain able to tolerate and obtain medical benefit; and

(E) Must be following a therapy program initially established by a physical or occupational therapist; and

(F) The caregiver and/or family are capable of using the equipment appropriately; and

(G) The home must be able to accommodate the equipment.

(c) E1399, Durable medical equipment, miscellaneous, includes, but is not limited to: Custom positioner –PA required--OMAP will purchase and repair:

(A) Labor is included in the purchase price;

(B) Not used for positioners that are ready-made and subsequently modified to fit an individual client;

(C) The positioner is considered customized when it is virtually impossible to meet another person's positioning needs in the equipment;

(D) Custom positioner is covered if the following criteria are met:

(i) The configuration of the client's body cannot be supported by commercially available positioners due to size, orthopedic deformities, physical deformities or pressure ulcers;

(ii) Must be sequentially evaluated by a physical or occupational therapist to make certain able to tolerate and obtain medical benefit;

(iii) Must be following a therapy program initially established by a physical or occupational therapist;

(iv) The home must be able to accommodate the equipment;

(v) The caregiver and/or family are capable of using the equipment appropriately.

(d) E1399, Durable medical equipment, miscellaneous, includes, but is not limited to: Prone stander, supine stander or board -- PA required-- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Covered if the following criteria are met:

(A) The client must be sequentially evaluated by a physical therapist or occupational therapist to make certain able to tolerate and obtain medical benefit from standing positioner;

(B) The client must be following a therapy program initially established by physical or occupational therapist;

(C) The weight of client must not exceed manufacturer's weight capacity;

(D) The client has demonstrated compliance with other programs;

(E) The client has demonstrated ability to utilize independently or with caregiver;

(F) The client has demonstrated successful trial period in monitored setting;

(G) The client does not have access to equipment from another source; and

(H) The home must be able to accommodate the equipment.

(e) E1399, Durable medical equipment, miscellaneous, includes, but is not limited to: Accessories for standing frame—PA required--OMAP will purchase and repair -- Covered if the following criteria are met:

(A) Cannot be successfully positioned in equipment without specified accessories;

(B) The client must be sequentially evaluated by a physical therapist or occupational therapist to make certain able to tolerate and obtain medical benefit from standing positioner;

(C) The client must be following a therapy program initially established by physical or occupational therapist;

(D) The weight of client must not exceed manufacturer's weight capacity;

(E) The client has demonstrated compliance with other programs;

(F) The client has demonstrated ability to utilize independently or with caregiver;

(G) The client has demonstrated successful trial period in monitored setting;

(H) The client does not have access to equipment from another source;

(I) The home must be able to accommodate the equipment.

(6) Criteria for Specific Accessories:

(a) Back support:

(A) Needed for balance, stability, or positioning assistance;

(B) Has extensor tone of the trunk muscles;

(C) Does not have trunk stability to support themselves while being raised or while completely standing.

(b) Tall back:

(A) The client is over 5'11"tall;

(B) The client has no trunk control at all and needs additional support;

(C) The client has more involved need for assistance with balance, stability, or positioning.

(c) Hip guides:

(A) Lacks motor control and/or strength to center hips;

(B) Has asymmetrical tone which causes hips to pull to one side;

(C) Spasticity;

(D) Low tone or high tone;

(E) Need for balance, stability, or positioning assistance.

(d) Shoulder retractor or harness:

(A) Cannot maintain erect posture without support due to lack of motor control or strength;

(B) Kyphosis;

(C) Presence of strong flex or tone.

(e) Lateral supports:

(A) Lacks trunk control to maintain lateral stability;

(B) Has scoliosis which requires support;

(C) Needs a guide to find midline.

(f) Head rest:

(A) Lacks head control and cannot hold head up without support;

(B) Has strong extensor thrust pattern that requires inhibition.

(g) Independent adjustable knee pads:

(A) Has severe leg length discrepancy;

(B) Has contractures in one leg greater than the other.

(h) Actuator handle extension:

(A) No caregiver; and

(B) 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:

(A) Has increased tone which pulls arms backward so hands cannot come to midline;

(B) Tone, strength, or control is so poor arms hang out to side and backward, causing pain and risking injury;

(C) For posture.

(j) Tray: Positioning that cannot be met by other accessories;

(k) Abductors: Reduce tone for alignment to bear weight properly;

(l) Sandals (shoe holders):

(A) Dorsiflexion of the foot or feet;

(B) Planar flexion of the foot or feet;

(C) Eversion of the foot or feet;

(D) Safety.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-122-0375 Walkers

(1) Indications and coverage:

(a) A standard walker (E0130, E0135, E0140, E0141, E0143) is covered if both of the following criteria are met:

(A) When prescribed by a prescribing 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 a 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) Use E1399 for glide-type brakes replacement;

(d) Follow Medicare's coding guidelines from the latest version of the CIGNA Supplier Manual.

(2) Documentation: An order for the walker which is signed by the prescribing practitioner 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, including height and weight.

(3) Table 122-0375.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 375

A4636	Replacement, handgrip, cane, crutch or walker, each – The Office of Medical Assistance Programs (OMAP) will purchase
A4637	Replacement, tip, cane, crutch, walker, each – OMAP will purchase
E0130	Walker, rigid (pick-up), adjustable or fixed height – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent
E0135	Walker, folding (pick-up), adjustable or fixed height – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent
E0140	Walker, with trunk support, adjustable or fixed height, any type—OMAP will purchase, rent and repair—Item considered purchased after 16 months of rent
E0141	Walker, rigid, wheeled, adjustable or fixed height– OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent
E0143	Walker, folding, wheeled, adjustable or fixed height – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent
E0144	Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent
E0147	Walker, heavy duty, multiple braking system, variable wheel resistance– OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

Meets the criteria for a standard walker.

Covered for clients who are unable to use a standard walker due to obesity, severe neurologic disorders or other condition causing the restricted use of one hand.

Capable of supporting clients who weigh greater than 350 pounds.

E0148 Walker, heavy duty, without wheels, rigid or folding, any type, each – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

Meets the criteria for a standard walker.

For clients who weigh more than 300 pounds.

May be fixed height or adjustable height.

E0149 Walker, heavy duty, wheeled, rigid or folding, any type, each – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

Meets the criteria for a standard walker.

For clients who weigh more than 300 pounds.

May be fixed height or adjustable height.

E0154 Platform attachment, walker, each – OMAP will purchase – OMAP will repair and rent – Item considered purchased after 16 months of rent

E0155 Wheel attachment, rigid pick-up walker, per pair – OMAP will purchase and repair

E0156 Seat attachment, walker – OMAP will purchase – OMAP will repair

E0157 Crutch attachment, walker, each – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

E0158 Leg extensions for a walker, per set of four – for clients 6' tall or more – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

E0159 Brake attachment for wheeled walker replacement, each – OMAP will purchase, rent, repair. Item considered purchased after 16 months of rent.

E1399 Walker, child sized– Prior authorization (PA) required by OMAP – OMAP will purchase, rent and repair – Also covered for payment by OMAP when client is a resident of a nursing facility – Item considered purchased after 16 months of rent

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.

For client less than 56" tall.

4-1-04

410-122-0380 Hospital Beds

(1) Fixed Height Hospital Bed:

(a) Indications and Coverage:

(A) A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment;

(B) Covered if indications (i), (ii), (iii), or (iv) are met, and indication (v) is met:

(i) A client who requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month;

(ii) A client who requires, for alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;

(iii) A client who 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;

(iv) A client who requires traction equipment which can only be attached to a hospital bed;

(v) The client's level of functioning can only be met with a hospital bed.

(b) Documentation:

(A) Documentation of medical appropriateness which 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) A CMN is acceptable documentation for clients with both Medicare and Medical Assistance Program coverage. It is not acceptable documentation for clients with Medical Assistance Program coverage only;

(C) 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) Procedure Codes:

(A) E0250, Hospital Bed, fixed height, with any type side rails, with mattress -- PA required beginning the third month -- OMAP will purchase, rent and repair—Item considered purchased after 16 months or rent;

(B) E0251, Hospital Bed, fixed height, with any type side rails, without mattress -- PA required beginning the third month -- OMAP will purchase, rent and repair—Item considered purchased after 16 months of rent;

(C) E0290, Hospital Bed, fixed height, without side rails, with mattress -- PA required beginning the third month -- OMAP will purchase, rent and repair--Item considered purchased after 16 months of rent;

(D) E0291, Hospital Bed, fixed height, without side rails, without mattress -- PA required beginning the third month-- OMAP will purchase, rent and repair—Item considered purchased after 16 months of rent.

(2) Hospital Beds -- Variable Height:

(a) Indications and Coverage:

(A) A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments;

(B) Covered if indications (i), (ii), (iii), or (iv) are met, and indication (v) and (vi) are met:

(i) A client who requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month;

(ii) A client who requires, for alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;

(iii) A client who 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;

(iv) A client who requires traction equipment which can only be attached to a hospital bed;

(v) The 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;

(vi) The client's level of functioning can only be met with a hospital bed.

(b) Documentation:

(A) Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be submitted with the request for PA and kept on file by the DME provider;

(B) A CMN is acceptable documentation for clients with both Medicare and Medical Assistance Program coverage. It is not acceptable documentation for clients with Medical Assistance Program coverage only;

(C) 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) Procedure Codes

(A) E0255, Hospital bed, variable height (Hi-Lo), with any type side rails, with mattress -- PA required beginning the third month--OMAP will purchase, rent and repair—Item considered purchased after 16 months of rent;

(B) E0256, Hospital bed, variable height (Hi-Lo), with any type side rails, without mattress -- PA required beginning the third month--OMAP will purchase, rent and repair – Item considered purchased after 16 months of rent;

(C) E0292, Hospital bed, variable height (Hi-Lo), without side rails, with mattress -- PA required beginning the third month-- OMAP will purchase, rent and repair Item considered purchased after 16 months of rent;

(D) E0293, Hospital bed, variable height (Hi-Lo), without side rails, without mattress -- PA required beginning the third month--OMAP will purchase, rent and repair – Item considered purchased after 16 months of rent.

(3) Hospital Beds -- Semi-Electric:

(a) Indications and Coverage:

(A) A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments;

(B) A semi-electric bed is covered if indications (i), (ii), (iii), or (iv) are met and indications (v), (vi), and (vii) are met:

(i) A client who requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month;

(ii) A client who requires, for alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;

(iii) A client who 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;

(iv) A client who requires traction equipment which can only be attached to a hospital bed;

(v) The client requires frequent changes in body position and/or has an immediate need for a change in body position;

(vi) The client is capable of operating the controls;

(vii) The client's level of functioning can only be met with a hospital bed.

(b) Documentation:

(A) Documentation of medical appropriateness which has been reviewed, signed and dated by the prescribing practitioner must be submitted with the request for PA and kept on file by the DME provider;

(B) A CMN is acceptable documentation for clients with both Medicare and Medical Assistance Program coverage. It is not acceptable documentation for clients with Medical Assistance Program coverage only;

(C) 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;

(D) Document the reasons why a variable height bed does not meet the needs of the client.

(c) Procedure Codes:

(A) E0260, Hospital Bed, semi-electric (head and foot adjustment), with any type side rails, with mattress -- PA required beginning the

third month -- OMAP will purchase, rent and repair—Item considered purchased after 16 months of rent;

(B) E0261,Hospital Bed, semi-electric (head and foot adjustment), with any type side rails, without mattress -- PA required beginning the third month-- OMAP will purchase, rent and repair – Item considered purchased after 16 months of rent;

(C) E0294, Hospital Bed, semi-electric (head and foot adjustment) without side rails, with mattress -- PA required beginning the third month--OMAP will purchase, rent and repair – Item considered purchased after 16 months of rent;

(D) E0295, Hospital Bed, semi-electric (head and foot adjustment) without side rails, without mattress -- PA required beginning the third month-- OMAP will purchase, rent and repair — Item considered purchased after 16 months of rent.

(4) Heavy-Duty and Extra Heavy-Duty Bed -- Indications and Coverage:

(a) A heavy-duty bed is covered if indications, (A), (B), (C) or (D) and (E), (F), (G), and (H) are met:

(A) A client who requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month;

(B) A client who requires, for alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;

(C) A client who 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 most have been tried and failed;

(D) A client who requires traction equipment which can only be attached to a hospital bed;

(E) The client requires frequent changes in body position and/or has an immediate need for a change in body position;

(F) The client is capable of operating the controls;

(G) The client weighs more than 350 pounds;

(H) The client's level of functioning can only be met with a hospital bed.

(b) Documentation:

(A) Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be submitted with the request for PA and kept on file by the DME provider;

(B) A CMN is acceptable documentation for clients with both Medicare and Medical Assistance Program coverage. It is not acceptable documentation for clients with Medical Assistance Program coverage only;

(C) 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;

(D) Documentation must include height and weight.

(c) Procedure Codes:

(A) 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-- PA required beginning the third month--OMAP will purchase, rent and repair—Item considered purchased after 16 months of rent;

(B) E0302, Hospital bed, extra heavy duty, extra wide,with weight capacity greater than 600 pounds, with any type side rails, without

mattress,--PA required beginning the third month -- OMAP will purchase, rent and repair—Item considered purchased after 16 months of rent;

(C) 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—PA required beginning the third month OMAP will purchase, rent and repair—Item considered purchased after 16 months of rent;

(D) E0304, Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress-- PA required beginning the third - OMAP will purchase, rent and repair—Item considered purchased after 16 months of rent.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-122-0400 Pressure Reducing Support Surfaces

(1) Definitions:

(a) Mattress Overlay -- Device designed to be placed on top of a standard hospital or home mattress;

(b) Mattress Replacement -- Device that takes the place of the standard hospital or home mattress;

(c) Bottoming Out -- The finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. This bottoming out criterion should be tested with the client in the supine position with the head flat, in the supine position with the head slightly elevated (no more than 30 degrees) and in the sidelying position;

(d) The staging of pressure ulcers used in this policy is as follows:

(A) Stage 1 -- Nonblanchable erythema of intact skin;

(B) Stage 2 -- Partial thickness skin loss involving epidermis and/or dermis;

(C) Stage 3 -- Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia;

(D) Stage 4 -- Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures.

(e) Home -- Adult foster care, assisted living facility, residential care facilities, and private residence.

(2) Group 1:

(a) Indications and Coverage:

(A) Covered if the client meets:

(i) Criterion (1); or

(ii) Criterion (2) or (3) and at least one of criteria (4) through (7):

(I) 1 -- Completely immobile (e.g., client cannot make changes in body position without assistance);

(II) 2 -- Limited mobility (e.g., client cannot independently make changes in body position significant enough to alleviate pressure);

(III) 3 -- Any stage pressure ulcer on the trunk or pelvis;

(IV) 4 -- Impaired nutritional status;

(V) 5 -- Fecal or urinary incontinence;

(VI) 6 -- Altered sensory perception;

(VII) 7 -- Compromised circulatory status.

(B) The client must also have a care plan established by the prescribing practitioner or other licensed health care practitioner directly involved in the client's care, which must include the following:

(i) Education of the client and caregiver on the prevention and/or management of pressure ulcers;

(ii) Regular assessment by a nurse, prescribing practitioner or other licensed health care practitioner;

(iii) Appropriate turning and positioning, including instruction and frequency intervals;

(iv) Appropriate wound care (for stage II, III or IV ulcer);

(v) Appropriate management of moisture/incontinence;

(vi) Nutritional assessment and intervention consistent with the overall plan of care.

(C) Client does not bottom out.

(b) Documentation: Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider and submitted with the prior authorization (PA) request;

(c) Procedure Codes:

(A) A4640, Replacement pad for use with medically appropriate alternating pressure pad owned by client. An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 2.5" or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling and air pressure provide adequate client lift, reduces pressure, and prevents bottoming out. The Office of Medical Assistance Programs (OMAP) will purchase and repair. Also covered for payment by OMAP when client is a resident of a nursing facility;

(B) E0180, Pressure pad, alternating with pump. OMAP will purchase, rent and repair. Item considered purchased after 16 months of rent -- An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 2.5" or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling, and air pressure provide adequate client lift, reduce pressure and prevents bottoming out;

(C) E0181, Pressure pad, alternating with pump, heavy duty. OMAP will purchase, rent and repair. Item considered purchased after 16 months of rent -- An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and inflated cell height of the air

cells through which air is being circulated is 2.5" or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling, and air pressure provide adequate client lift, reduce pressure and prevents bottoming out;

(D) E0182, Pump for alternating pressure pad. Must generate enough pressure to maintain at least 2.5"depth in chambers and has appropriate frequency of air cycling. OMAP will purchase, rent and repair. Item considered purchased after 16 months of rent;

(E) E0184, Dry pressure mattress -- OMAP will purchase and rent. Item considered purchased after 16 months of rent. PA required by OMAP:

(i) Nonpowered pressure reducing mattress;

(ii) Foam height of 5" or greater, and foam with a density and other qualities that provide adequate pressure reduction, durable waterproof cover, can be placed directly on a hospital bed frame.

(F) E0185, Gel or gel-like pressure pad for mattress, standard mattress length and width -- PA required by OMAP. OMAP will purchase, rent, and repair. Item considered purchased after 16 months of rent:

(i) Gel or gel-like layer with a height of 2" or greater;

(ii) Nonpowered pressure reducing mattress overlay.

(G) E0186, Air pressure mattress. Total height of 5" or greater, durable waterproof cover and can be placed directly on a hospital bed frame. Nonpowered pressure reducing mattress. OMAP will purchase, rent, and repair. Item considered purchased after 16 months of rent. PA required by OMAP;

(H) E0187, Water pressure mattress. Total height of 5" or greater, durable waterproof cover and can be placed directly on a hospital bed frame. Nonpowered pressure reducing mattress. OMAP will

purchase, rent, and repair. Item considered purchased after 16 months of rent -- PA required by OMAP;

(I) E0188, Synthetic sheepskin pad -- OMAP will purchase;

(J) E0189, Lambs wool sheepskin pad -- OMAP will purchase;

(K) E0196, Gel pressure mattress. Total height of 5" or greater, durable waterproof cover and can be placed directly on a hospital bed frame. Nonpowered pressure reducing mattress. OMAP will purchase and rent. Item considered purchased after 16 months of rent. PA required by OMAP;

(L) E0197, Air pressure pad for mattress, standard mattress length and width. Composed of interconnected air cell that is inflated with an air pump with cell height of 3" or greater. PA required by OMAP -- OMAP will purchase, rent and repair. Item considered purchased after 16 months of rent;

(M) E0198, Water pressure pad for mattress, standard mattress length and width -- OMAP will purchase, rent, and repair. Item considered purchased after 16 months of rent -- PA required by OMAP:

(i) Filled height of 3" or greater;

(ii) Nonpowered pressure reducing mattress overlay.

(N) E0199, Dry pressure pad for mattress, standard mattress length and width -- OMAP will purchase and rent:

(i) Base thickness of 2" or greater and peak height of 3" or greater if it is a convoluted overlay or an overall height of at least 3"if it is a nonconvoluted overlay and foam with a density and other qualities that provide adequate pressure reduction and durable waterproof cover;

(ii) Nonpowered pressure reducing mattress overlay.

(3) Group 2:

(a) These services are covered in a home setting and nursing facilities. Group 2 items are covered if the client meets:

(A) Criterion (1) and (2) and (3); or

(B) Criterion (4); or

(C) Criterion (5) or (6):

(i) 1 -- Multiple stage II pressure ulcers located on the trunk or pelvis;

(ii) 2 -- Client has been on a comprehensive ulcer treatment program for at least 30 consecutive days which has included the use of an appropriate group I support surface;

(iii) 3 -- The ulcers have worsened or remained the same over the last 30 days;

(iv) 4 -- Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis;

(v) 5 -- Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days). All other criteria is waived for this condition;

(vi) 6 -- 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 comprehensive ulcer treatment described in (2) above should generally include:

(A) Education of the client and caregiver on the prevention and/or management of pressure ulcers;

(B) Regular assessment by a nurse, prescribing practitioner, or other licensed health care practitioner (usually at least weekly for a client with a stage III or IV ulcer);

(C) Appropriate turning and positioning;

(D) Appropriate wound care (for a stage II, III or IV ulcer);

(E) Appropriate management of moisture/incontinence;

(F) Nutritional assessment and intervention consistent with the overall plan of care.

(c) Other Coverage Issues -- In addition to indications and coverage, the client must meet the following:

(A) The client is confined to a bed or chair as a result of severely limited mobility;

(B) In the home setting, a willing and trained adult caregiver is available to assist the client with activities of daily living, fluid balance, skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management of the pressure reducing support surface;

(C) A prescribing practitioner must coordinate the home treatment regimen, which will include the use of other treatment modalities, where applicable, including, but not limited to nursing care, appropriate nutrition, and the creation of a tissue-growth environment:

(i) The allowable rental fee includes all equipment, supplies, and service appropriate for the effective use of the support surface;

(ii) Not covered for the prevention of pressure ulcers or pain control.

(d) Documentation:

(A) If the client is in a nursing facility, the following information must be submitted with the initial written request:

(i) A prescribing practitioner prescription;

(ii) The resident care manager evaluation describing the underlying condition (diagnosis, prognosis, rehabilitation potential and nutritional status) as well as a comprehensive assessment and evaluation of the individual after conservative treatment with other pressure reducing products or methods has been tried without success. A statement of goals for stepping down the intensity of support therapy is required;

(iii) A summary of a nutritional assessment by a registered dietician within the last 90 days including client's height and weight;

(iv) Prealbumin and total lymphocyte count values within the last 60 days;

(v) Written description of pressure ulcers. This should include: numbers, locations, sizes and stages;

(vi) Dated photographs of pressure ulcers;

(vii) Pressure ulcers on extremities must have documentation of the reason why pressure cannot be relieved by other methods. This simply means that the medical appropriateness for special pressure reducing products must be proven and documented.

(B) Documentation if the client is not in a nursing facility -- The following information must be submitted with the initial written report:

(i) A prescribing practitioner prescription;

(ii) ICD-9-CM diagnosis(es) submitted by the prescribing practitioner;

(iii) An evaluation done by licensed health professionals describing the underlying condition (diagnosis, prognosis, rehabilitation potential and nutritional status) as well as comprehensive assessment and

evaluation of the individual after conservative treatment with other pressure reducing products or methods has been tried without success;

(iv) A summary of a nutritional assessment by a licensed health professional within the last 90 days;

(v) Client's height and weight, may approximate if unable to obtain;

(vi) Prealbumin and total lymphocyte count values within the last 60 days;

(vii) Written description of pressure ulcers. This should include: numbers, locations, sizes and stages;

(viii) Dated photographs of pressure ulcers;

(ix) Pressure ulcer on extremities must have documentation of the reason why pressure cannot be relieved by other methods. This simply means that the medical appropriateness for special pressure reducing products must be proven and documented;

(x) The client is receiving skilled wound care nursing services either through a home health agency or through the private duty nurse program;

(xi) Copy of care plan which is client specific and includes but is not limited to the following:

(I) Education of the client and caregiver on the prevention and/or management of pressure ulcers;

(II) The number of hours per 24-hour period that the pressure reducing support surface will be utilized;

(III) Regular assessment by a registered nurse, prescribing practitioner, or other licensed health care practitioner within their scope of practice;

(IV) Turning and positioning;

(V) Wound care (for a stage II, III, or IV ulcer);

(VI) Management of moisture/incontinence;

(VII) Nutritional intervention;

(VIII) Any contributing factors, such as mobility status, impaired sensory perception, circulatory status, etc.;

(IX) Treatment must include healing;

(X) Documentation that a trained caregiver is willing and able to assist or supervise in carrying out the prescribed treatment regimen and to support the use and management of the pressure reducing support surface.

(xii) If the client has had a recent myocutaneous flap or skin graft:

(I) Copy of the operative report;

(II) Copy of the care plan.

(xiii) The payment of pressure reducing support surfaces will not be renewed if:

(I) Assessed as being a low risk for further breakdown; or

(II) Care plan goals are not being met.

(e) At review -- Submit:

(A) Dated photographs of pressure ulcers;

(B) Copies of skin flow sheets;

(C) Copies of any pertinent notes in the progress records;

(D) Copies of records supporting changes in laboratory values or nutritional status;

(E) Written description of pressure ulcers by nurse, prescribing practitioner, or other licensed health care practitioner, including numbers, locations, sizes, and stages;

(F) Copy of current care plan.

(f) Procedure Codes:

(A) E0193, Powered air flotation bed (low air loss therapy), per month -- PA required by OMAP -- OMAP will rent -- OMAP will repair. Item considered purchased after 16 months of rent -- Also covered for payment by OMAP when client is a resident of a nursing facility. A semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress 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 mattress;

(ii) Inflated cell height of the air cells through which air is being circulated is five inches or greater;

(iii) 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 client lift, reduce pressure and prevent bottoming out;

(iv) A surface designed to reduce friction and shear;

(v) Can be placed directly on a hospital bed frame;

(vi) Use also for 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 in 3.5" 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 provide adequate client lift, reduce pressure, and prevent bottoming out;

(IV) A surface designed to reduce friction and shear.

(B) E0277, Powered pressure reducing mattress, air, per month. OMAP will rent -- OMAP will repair. Item considered purchased after 16 months of rent -- PA required by OMAP -- Also covered for payment by OMAP when client is a resident if a nursing facility. 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:

(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;

(ii) Inflated cell height of the air cells through which air is being circulated is five inches or greater;

(iii) 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 client lift, reduce pressure, and prevent bottoming out;

(iv) A surface designed to reduce friction and shear;

(v) Can be placed directly on a hospital bed frame;

(vi) Use also for 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 3.5 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 provide adequate client lift, reduce pressure and prevent bottoming out;

(IV) A surface designed to reduce friction and shear.

(C) E0371 -- Non-powered advanced pressure-reducing overlay for mattress, standard mattress length and width, per month -- PA required by OMAP -- OMAP will rent -- OMAP will repair. Item considered purchased after 16 months of rent -- Also covered for payment by OMAP when client is a resident of a nursing facility -- 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;

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage for Group 2 support surfaces.

(D) E0372, Powered air overlay for mattress, standard mattress length and width, per month -- PA required by OMAP -- OMAP will rent -- Also covered for payment by OMAP when client is a resident of a nursing facility -- 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 3.5 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;

(iv) A surface designed to reduce friction and shear.

(E) E0373, Non-powered, advanced pressure-reducing mattres PA required by OMAP -- OMAP will purchase, rent, and repair. Item considered purchased after 16 months of rent -- Also covered for payment by OMAP when client is a resident of a nursing facility. An advanced non-powered 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;

(v) Can be placed directly on a hospital bed frame.

(4) Group 3 -- Air-fluidized beds are not covered.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02

410-122-0420 Hospital Bed Accessories

(1) Frames, Traction Devices, etc.:

(a) E0840, Traction frame, attached to headboard, cervical traction -- the Office of Medical Assistance Programs (OMAP) will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(b) E0850, Traction stand, free-standing, cervical traction -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(c) E0855, Cervical traction equipment not requiring additional stand or frame -- OMAP will purchase, rent, and repair -- item considered purchased after 16 months of rent;

(d) E0860, Traction equipment, overdoor, cervical -- OMAP will purchase;

(e) E0870, Traction frame, attached to footboard, extremity traction (e.g., Buck's) -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(f) E0880, Traction stand, free-standing, extremity traction, (e.g., Buck's) -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(g) E0890, Traction frame, attached to footboard, pelvic traction -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(h) E0900, Traction stand, free-standing, pelvic traction (e.g., Buck's) -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(i) E0920, Fracture frame, attached to bed, includes weights -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(j) E0930, Fracture frame, free-standing, includes weights -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(k) E0941, Gravity assisted traction device, any type -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(l) E0942, Cervical head harness/halter -- OMAP will purchase;

(m) E0943, Cervical pillow -- OMAP will purchase;

(n) E0944, Pelvic belt/harness/boot -- OMAP will purchase;

(o) E0945, Extremity belt/harness -- OMAP will purchase;

(p) E0946, Fracture frame, dual with cross bars, attached to bed (e.g., Balken, 4-poster) -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(q) E0947, Fracture frame, attachments for complex pelvic traction -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(r) E0948, Fracture frame, attachments for complex cervical traction -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

(2) Mattresses:

(a) E0271, Mattress, inner spring (replacement for client owned hospital bed) -- OMAP will purchase;

(b) E0272, Mattress, foam rubber (replacement for client owned hospital bed) -- OMAP will purchase.

(3) Rails:

(a) E0305, Bedside rails, half length, for use with hospital or non-hospital bed -- OMAP will purchase -- OMAP will rent -- Item considered purchased after 16 months of rent.

(b) E0310, Bedside rails, full length, for use with hospital or non-hospital bed -- OMAP will purchase -- OMAP will rent -- Item considered purchased after 16 months of rent.

(4) Trapeze Bars:

(a) Indications and Coverage: Trapeze bars are indicated when 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) Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider;

(c) E0910, Trapeze bars, a.k.a. client helper, attached to bed, complete with grab bar -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent:

(A) Not covered when used on a non-hospital bed;

(B) 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.

(d) E0940, Trapeze bar, free-standing, complete with grab bar -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. When prescribed, it must meet the same criteria as the attached equipment and the client must not be renting or own a hospital bed.

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

April 1, 2003 Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

410-122-0470 Supports and Stockings

(1) Cosmetic support panty hose (i.e., Leggs®, No Nonsense®, etc.) are not covered.

(2) Procedure Codes -- Table 0470.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

Table 0470

A4565	Slings – OMAP will purchase
L0120	Cervical, flexible non-adjustable (foam collar) – OMAP will purchase
L0210	Thoracic rib belt – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility
L8300	Trusses single with standard pad – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility
L8310	Trusse, double – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

Elastic Supports

L8100	Gradient compression stocking, below knee, 18-30 mm Hg., each – OMAP will purchase – Also covered for payment by OMAP if client is a resident of a nursing facility
L8110	below knee, 30-40 mm Hg., each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility
L8120	below knee, 40-50 mm Hg., each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility
L8130	thigh length, 18-30 mm Hg, each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8140 thigh length, 30-40 mm Hg, each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8150 thigh length, 40-50 mm Hg, each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8160 full length/chap style, 18-30 mm Hg, each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8170 full length/chap style, 30-40 mm Hg, each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8180 full length/chap style, 40-50 mm Hg, each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8190 waist length, 18-30 mm Hg, each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8195 waist length, 30-40 mm Hg, each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8200 waist length, 40-50 mm Hg, each – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8210 custom made – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8220 lymphedema – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

L8230	garter belt – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility
L8239	not otherwise specified – prior authorization required by OMAP – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility
S8420	Gradient pressure aid (sleeve and glove combination), custom made – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility
S8421	Gradient pressure aid (sleeve and glove combination), ready made – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility
S8422	Gradient pressure aid (sleeve), custom made, medium weight – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility
S8423	Gradient pressure aid (sleeve), custom made, heavy weight – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facilityCompression Burn Garments
A6501	Compression burn garment, body suit (head to foot), custom fabricated -- OMAP will purchase
A6502	Compression burn garment, chin strap, custom fabricated -- OMAP will purchase
A6503	Compression burn garment, facial hood, custom fabricated -- OMAP will purchase
A6504	Compression burn garment, glove to wrist, custom fabricated -- OMAP will purchase

A6505	Compression burn garment, glove to elbow, custom fabricated -- OMAP will purchase
A6506	Compression burn garment, glove to axilla, custom fabricated -- OMAP will purchase
A6507	Compression burn garment, foot to knee length, custom fabricated -- OMAP will purchase
A6508	Compression burn garment, foot to thigh length, custom fabricated -- OMAP will purchase
A6509	Compression burn garment, upper trunk to waist including arm openings (vest) -- OMAP will purchase
A6510	Compression burn garment, trunk, including arms down to leg opening (leotard), custom fabricated -- OMAP will purchase
A6511	Compression burn garment, lower trunk, including leg opening (panty), custom fabricated -- OMAP will purchase
A6512	Compression burn garment, not otherwise classified, custom fabricated -- OMAP will purchase

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) Procedure Codes:

(a) 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 -- OMAP will purchase -- Also covered for payment by the Office of Medical

Assistance Programs (OMAP) when client is a resident of a nursing facility;

(b) 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 -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(c) 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 -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(d) A5504, For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(e) A5505, For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(f) 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 -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(g) A5507, For diabetics only, not otherwise specified modification (include fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(h) A5509, For diabetics only, direct formed, molded to foot with external heat source (i.e, heat gun) multiple-density insert(s), prefabricated, per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(i) A5510, For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple-density insert(s), prefabricated, per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(j) A5511, For diabetics only, custom-molded from model of patient's foot, multiple-density insert(s), custom fabricated, per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02

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 0480.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-94; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02

Table 0480

CODE	DESCRIPTION	PC	RT	RP	NF
E0650	Pneumatic compressor, non-segmental home model	x	x	x	x
E0651	Pneumatic compressor, segmental home model (lymphedema pump) without calibrated gradient pressure	x	x	x	x
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 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	x	x	x	x

E0655	Non-segmental pneumatic appliance for use with pneumatic compressor half arm, includes hand segment	x	x	x	x
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor full leg, includes foot segment	x	x	x	x
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor full arm, includes hand segment	x	x	x	x
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor half leg, includes foot segment	x	x	x	X
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg, includes foot segment	x	x	x	x
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm, includes hand segment	x	x	x	x
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg, includes foot segment	x	x	x	X

E0671	Segmental gradient pressure pneumatic appliance, full leg, includes foot segment	x	x	x	x
E0672	Segmental gradient pressure pneumatic appliance, full arm, includes hand segment	x	x	x	x
E0673	Segmental gradient pressure pneumatic appliance, half leg, includes foot segment	x	x	x	x

410-122-0500 Transcutaneous Electrical Nerve Stimulator (TENS)

(1) Indications and Coverage:

(a) A transcutaneous electrical nerve stimulator (TENS) is covered when it is medically appropriate in the treatment of clients with chronic, intractable pain or acute post-operative pain who meet the criteria;

(b) May be covered for acute post-operative pain for no more than one month following day of surgery. Continued coverage requires further documentation;

(c) Not covered:

(A) To treat motor function disorders;

(B) For acute pain (less than three months duration) other than post-operative pain;

(C) For etiology that is not accepted as responding to TENS (e.g., headache, visceral abdominal pain, pelvic pain, temporomandibular joint (TMJ) pain and others).

(d) Two month trial period of rental:

(A) A two-month trial period of rental is required prior to purchase. Rental price starting with the initial date of service applies to purchase price regardless of payor;

(B) Included in the rental price are: adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, leadwires, electrodes, additional connecting cable for lead wires, carrying pouches or covers, all necessary training and one months worth of TENS supplies for each month rented;

(C) There should be no separate billing and there will be no separate allowance for replacement electrodes (A4556), conductive paste or gel (A4558), replacement batteries (A4630) or a battery charger.

(2) Documentation:

(a) 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;

(b) For initial request for rental:

(A) For post-operative pain include type and date of surgery and diagnosis, other appropriate treatment modalities tried, including names and dosage of medication, length of each treatment time and the results;

(B) For chronic intractable pain include etiology, length of time pain has been present (must have been present for at least three months), location of pain and other treatment tried and failed.

(c) For purchase following rental: Proof of efficacy and compliance from the prescribing practitioner;

(d) To continue supplies: The following documentation must be received every six months:

(A) A new CMN; or

(B) Other documentation of medical appropriateness.

(3) Procedure Codes:

(a) A4557, Lead wires, (e.g., apnea monitor), per pair -- Prior authorization (PA) required by the Office of Medical Assistance Programs (OMAP) -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility:

(A) One unit of service is for lead wires going to two electrodes;

(B) If all the lead wires of a four lead TENS unit needed to be replaced, billing would be for two units of service.

(b) A4595, Electrical stimulator supplies (e.g., TENS, NMES), 2 lead, per month -- PA required by OMAP -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility:

(A) 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);

(B) One unit of service represents supplies needed for one month for a two lead TENS assuming daily use. Two units of service for one month for a client-owned four lead TENS.

(c) E0720, TENS, two lead, localized stimulation -- PA required by OMAP -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a nursing facility -- Item considered purchased after 16 months of rent;

(d) E0730, TENS, four or more leads for, multiple nerve stimulation -- PA required by OMAP -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a nursing facility -- Item considered purchased after 16 months of rent.

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

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

410-122-0510 Electronic Stimluators

(1) Osteogenic Stimulators -- Indications and Coverage:

(a) Nonspinal Electrical Osteogenesis Stimulator:

(A) A nonspinal electrical osteogenesis stimulator is covered only if any of the following criteria are met:

(i) Nonunion 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; or

(ii) Failed fusion of a joint other than in the spine where a minumum of nine months has elapsed since the last surgery; or

(iii) Congenital pseudarthrosis.

(B) Nonunion of a long bone fracture must be documented by a minumum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minumum of 90 days, each including multiple views of the fracture site, and with a written interpretation by a prescribing practitioner stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

(b) Ultrasonic Osteogenic Stimulators:

(A) Use of ultrasonic osteogenic stimulator is only covered 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 osteogenis stimulator, separated by a minimum of 90 days. Each radiograph must include multiple views of the fracture site accompanied with a written interpretation by a prescribing practitioner stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs; and

(ii) Documentation that the client failed at least one surgical intervention for the treatment of the fracture.

(B) Not covered:

(i) Nonunions of the skull, vertebrae, and those that are tumor related;

(ii) When used concurrently with other noninvasive osteogenic devices;

(iii) Fresh fractures and delayed unions.

(c) Spinal Electrical Osteogenesis Stimulator -- Use of the noninvasive spinal electrical osteogenesis stimulator is only covered for the following indications:

(A) Failed spinal fusion where a minimum of nine months has elapsed since the last surgery; or

(B) Following a multilevel spinal fusion surgery; or

(C) Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site.

(d) Documentation:

(A) The following must be submitted for authorization for osteogenesis stimulators:

(i) Documentation of other alternative treatments tried but found ineffective;

(ii) Copies of prescribing practitioner's progress records;

(iii) Copies of X-ray reports;

(iv) Copies of surgical reports for authorization of ultrasonic osteoenic stimulators;

(v) Statement of medical appropriateness or copy of CMN from prescribing practitioner.

(B) Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the Durable Medical Equipment (DME) provider.

(e) Procedure Codes:

(A) E0747, Osteogenis stimulator electrical (non-invasive) other than spinal application. One time payment per condition -- Prior authorization (PA) required by the Office of Medical Assistance Programs (OMAP) -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(B) E0748, Osteogenesis stimulator, electrical, noninvasive, spinal applications -- OMAP will purchase -- one time payment per condition -- PA required by OMAP -- also covered for payment by OMAP when client is a resident of a nursing facility;

(C) E0760, Osteogenesis stimulator, low intensity ultrasound, noninvasive -- OMAP will purchase -- PA required by OMAP -- Also covered for payment by OMAP when client is a resident of a nursing facility.

(2) Neuromuscular Stimulator:

(a) Indications and Coverage:

(A) Treatment of disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse are causing atrophy. Examples include but are not limited to:

(i) Casting or splinting of a limb;

(ii) Contracture due to scarring of soft tissue as in burn lesions;

(iii) Hip replacement surgery (until orthotic training begins).

(B) Relation of muscle spasm;

(C) Prevention or retardation of disuse atrophy;

(D) Re-education of muscle;

(E) Increasing local blood circulation;

(F) Maintaining or increasing range of motion.

(b) Documentation. The following must be submitted for authorization:

(A) Copies of prescribing practitioner's progress records;

(B) Statement of medical appropriateness from prescribing practitioner;

(C) Copy of practitioner's prescription;

(D) Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider.

(c) Procedure Codes:

(A) A4595, Electrical stimulator supplies, two lead, per month (e.g., TENS, NMES). 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);

(B) E0745, Neuromuscular stimulator, electronic shock unit. PA required by OMAP -- OMAP will rent, purchase and repair -- Item

considered purchased after 16 months of rent -- Also covered for payment by OMAP when client is a resident of a nursing facility.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

410-122-0520 Diabetic Supplies

(1) Indications and Coverage:

(a) Home blood glucose monitors are indicated for clients who are diabetics and who can better control their blood glucose levels by frequently checking and appropriately contacting their treating practitioner for advice and treatment;

(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) Purchase fee includes normal, low and high-calibrator solution/chips (A4256), battery (A4254), and spring-powered lancet device (A4258).

(2) Documentation:

(a) Documentation of medical appropriateness which has been reviewed and signed by the treating practitioner must be kept on file by the DME provider;

(b) When billing for quantities of supplies greater than those described in the policy (e.g., more than 100 blood glucose test strips per month for insulin dependent diabetes mellitus) documentation supporting the medical appropriateness for the higher utilization must be on file in the DME provider's records;

(c) The DME provider is required to have a new written order from the treating practitioner every 12 months.

(3) Procedure Codes:

(a) A4210, Needle-free injection device, each -- OMAP will purchase;

(b) A4211, Supplies for self administered injections -- OMAP will purchase:

(A) Used for transparent syringe without a needle for insulin delivery; or

(B) Used for adapter for transferring insulin from vial to transparent syringe without a needle, only.

(c) A4244, Alcohol or peroxide, per pint -- OMAP will purchase;

(d) A4245, Alcohol wipes, per box -- OMAP will purchase;

(e) A4250, Urine test or reagent strips or tablets, per 100 tablets or strips, OMAP will purchase;

(f) A4253, Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips -- OMAP will purchase:

(A) Limits for noninsulin dependent diabetes mellitus (NIDDM) -- 100 every three months;

(B) Limits for insulin dependent diabetes mellitus (IDDM) -- 100 per month.

(g) A4254, Replacement battery, any type, for use with medically appropriate home blood glucose monitor owned by client, each -- OMAP will purchase;

(h) A4255, Platforms for home blood glucose monitor, 50 per box -- OMAP will purchase;

(i) A4256, Normal, low and high calibrator solution/chips -- Replacement only, not billable with new blood glucose monitor -- OMAP will purchase;

(j) A4258, Spring-powered device for lancet, each -- OMAP will purchase;

(k) A4259, Lancets, per box (of 100) -- OMAP will purchase:

(A) Limits for noninsulin dependent diabetes mellitus (NIDDM) -- 100 every three months;

(B) Limits for insulin dependent diabetes mellitus (IDDM) -- 100 per month.

(l) A4772, Dextrostick or glucose test strips, per box -- OMAP will purchase;

(m) E0607, Home blood glucose monitor -- OMAP will purchase -- OMAP will repair;

(n) E2100, Blood glucose monitor with integrated voice synthesizers OMAP will purchase -- OMAP will repair. Covered when the following conditions are met:

(A) The client and device meet one of the conditions listed above for coverage of standard home blood glucose monitors; and

(B) The client's treating practitioner certifies a severe visual impairment (>20/200 or worse corrected).

(o) E2101, Blood glucose monitor with integrated lancing/blood sample collection -- OMAP will purchase and repair. Covered when all of the the following conditions are met:

(A) The client and device meet one of the conditions listed above for coverage of standard home blood glucose monitors; and

(B) The client's treating practitioner certifies a severe visual impairment (>20/200 or worse corrected); and

(C) The client's treating practitioner certifies that the client has an impairment of manual dexterity severe enough to require the use of this special monitoring system.

(p) S8490, Insulin syringes (100 syringes, any size) -- OMAP will purchase.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02

410-122-0525 External Insulin Infusion Pump

(1) Indications and Coverage:

(a) Administration of continuous subcutaneous insulin for the treatment of diabetes mellitus which has been documented by a fasting serum C-peptide level that is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method, (As an example, if the normal range for C-peptide in a laboratory is 0.9-4 ng/ml, a C-peptide level of 0.99 or less (i.e., 0.9 x 1.1) would qualify for consideration of coverage.), must meet criteria (A) or (B):

(A) -- The client has completed a comprehensive diabetes education program, has 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 has 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 criteria (i) while on the multiple injection regimen:

(i) -- Glycosylated hemoglobin level (HbA1C) greater than 7%;

(ii) -- Plus one or more of the following:

(I) -- History of recurring hypoglycemia;

(II) -- Wide fluctuations in blood glucose before mealtime;

(III) -- Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL;

(IV) -- History of severe glycemic excursions.

(B) -- The client has been on an external insulin infusion pump prior to enrollment in the Medical Assistance Program and has documented frequency of glucose self-testing an average of at least four times per day during the month prior to Medical Assistance Program enrollment.

(C) Continued coverage of an external insulin pump and supplies requires that the client be seen and evaluated by the treating practitioner at least every three months;

(D) In addition, the external insulin infusion pump must be ordered and follow-up care rendered by a practitioner 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.

(2) Documentation:

Medical justification which supports the above criteria must be submitted with the request for prior authorization (PA) and kept on file by the DME provider.

(3) Procedure Codes:

(a) A4221, Supplies for maintenance of drug infusion catheter, per week. Includes cannulas, needles, dressings and infusion supplies—PA required-- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(b) A4232, Syringe with needle for external insulin pump, sterile, 3 cc.—PA required--OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(A) Does not include the insulin;

(B) Describes the insulin reservoir for use with E0784.

(c) E0784, External ambulatory infusion pump, insulin. Includes instruction in use of pump—PA required--OMAP will purchase, rent and repair--Item considered purchased after 16 months of rent -- Also covered for payment by OMAP when client is a resident of a nursing facility;

(d) K0601, Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each—OMAP will purchase--Also covered for payment by OMAP when client is a resident of a nursing facility;

(e) K0602, Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each—OMAP will purchase--Also covered for payment by OMAP when client is a resident of a nursing facility;

(f) K0603, Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each—OMAP will purchase-Also covered for payment by OMAP when client is a resident of a nursing facility;

(g) K0604, Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each –OMAP will purchase--Also covered for payment by OMAP when client is a resident of a nursing facility;

(h) K0605, Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each—OMAP will purchase--Also covered for payment by OMAP when client is a resident of a nursing facility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-122-0530 Proof of Delivery

(1) Suppliers are required to maintain proof of delivery documentation in their files.

(2) The proof of delivery requirements are outlined below according to the method of delivery:

(a) Method 1 -- Supplier delivering items directly to the client or authorized representative:

(A) A delivery slip which has been signed and dated by the client or authorized representative is required in order to verify that the item was received. The date of signature on the delivery slip must be the date that the item was received by the client or authorized representative. An acceptable delivery slip must include the client's name, the quantity and a detailed description of the items being delivered, brand name, serial number;

(B) The date of service on the claim must be the date that the item was received by the client or authorized representative.

(b) Method 2 -- Supplier utilizing a delivery/shipping service to deliver items:

(A) If the supplier utilizes a delivery shipping service, acceptable proof of delivery would include the delivery service's tracking slip and a supplier's shipping invoice. The supplier's shipping invoice must include:

(i) The client's name;

(ii) The quantity and detailed description of the item(s) being delivered;

(iii) Brand name;

(iv) Serial number; and

(v) Delivery service's package identification number associated with the client's package(s). The delivery service's tracking slip must reference each client's package(s), the delivery address and the corresponding package identification number given by the delivery service.

(B) For mail order items, the date of service on the claim must be the shipping date.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01

410-122-0540 Ostomy Supplies: Colostomy, Illeostomy, Ureterostomy

(1) Indications and Coverage: Ostomy supplies are covered for use for clients with a surgically created opening (stoma) to divert urine, feces, or ilial contents to outside of the body.

(2) Documentation: Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider. An order for the ostomy supplies which has been signed and dated 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

4-1-04

Table 0540 Procedure Codes

A4331	Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each, – OMAP will purchase
A4361	Ostomy face plate, each – May not bill for A4375, A4376, A4379, or A4380 at the same time – Office of Medical Assistance Programs (OMAP) will purchase
A4362	Skin barrier; solid, 4 x 4 or equivalent, standard wear; each – OMAP will purchase
A4364	Adhesive, liquid or equal, any type; per oz. – OMAP will purchase
A4365	Adhesive remover wipes, any type, 50 per box – OMAP will purchase
A4366	Ostomy vent, any type, each – OMAP will purchase
A4367	Ostomy Belt, each – OMAP will purchase
A4369	Ostomy skin barrier, liquid (spray, brush, etc.); per oz – OMAP will purchase
A4371	Ostomy skin barrier, powder, per oz. – OMAP will purchase
A4372	Ostomy skin barrier, solid 4x4 or equivalent, with built-in convexity, each – OMAP will purchase
A4373	Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each – OMAP will purchase
A4375	Ostomy pouch, drainable, with faceplate attached, plastic, each – OMAP will purchase

A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each – OMAP will purchase
A4377	Ostomy pouch, drainable, for use on faceplate, plastic, each – OMAP will purchase
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each – OMAP will purchase
A4379	Ostomy pouch, urinary, with faceplate attached, plastic, each – OMAP will purchase
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each – OMAP will purchase
A4381	Ostomy pouch, urinary, for use on faceplate, plastic, each – OMAP will purchase
A4382	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each – OMAP will purchase
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each – OMAP will purchase
A4384	Ostomy faceplate equivalent, silicone ring, each – OMAP will purchase
A4385	Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, without built-in convexity, each – OMAP will purchase
A4387	Ostomy pouch, closed, with barrier attached, with built-in convexity (one piece), each – OMAP will purchase
A4388	Ostomy pouch, drainable, with extended wear barrier attached (one piece), each – OMAP will purchase

A4389	Ostomy pouch, drainable, with barrier attached, with built-in convexity (one piece), each – OMAP will purchase
A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built- in convexity (one piece), each – OMAP will purchase
A4391	Ostomy pouch, urinary, with extended wear barrier attached, without built-in convexity (one-piece), each – OMAP will purchase
A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (one piece), each – OMAP will purchase
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (one piece), each – OMAP will purchase
A4394	Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce – OMAP will purchase
A4395	Ostomy deodorant for use in ostomy pouch, solid, per tablet – OMAP will purchase
A4396	Ostomy belt with peristomal hernia support – OMAP will purchase
A4397	Irrigation supply, sleeve, each – OMAP will purchase
A4398	Ostomy irrigation supply bag, each – may bill for A4399 at the same time – OMAP will purchase
A4399	Ostomy irrigation supplies, cone/catheter, including brush – may bill for A4398 at the same time – OMAP will purchase

A4402	Lubricant, per ounce, (1 unit of service = 1 ounce) – OMAP will purchase
A4404	Ostomy Ring, each – OMAP will purchase
A4405	Ostomy skin barrier, non-pectin based, paste, per ounce – OMAP will purchase
A4406	Ostomy skin barrier, pectin based, paste, per ounce – OMAP will purchase
A4407	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each – OMAP will purchase
A4408	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each – OMAP will purchase
A4409	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each – OMAP will purchase
A4410	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each – OMAP will purchase
A4413	Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system) with filter, each – OMAP will purchase
A4414	Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, 4 x 4 inches or smaller, each – OMAP will purchase
A4415	Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4 x 4 inches, each – OMAP will purchase

A4416	Ostomy pouch, closed, with barrier attached, with filter, each – OMAP will purchase.
A4417	Ostomy pouch, closed, with barrier attached, with filter, with built-in convexity, each – OMAP will purchase.
A4418	Ostomy pouch, closed; without barrier attached, with filter, each – OMAP will purchase.
A4419	Ostomy pouch, closed; for use on barrier with non-locking flange, with filter, (2-piece), each – OMAP will purchase.
A4420	Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each – OMAP will purchase.
A4422	Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each – OMAP will purchase
A4423	Ostomy pouch, closed; for use on barrier with locking flange (2 piece), with filter, each – OMAP will purchase.
A4424	Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each – OMAP will purchase.
A4425	Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each, OMAP will purchase
A4426	Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each, OMAP will purchase
A4427	Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each, OMAP will purchase

A4428	Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each, OMAP will purchase
A4429	Ostomy pouch, urinary, with barrier, attached, with built-in convexity, with faucet-type tap with valve (1 piece), each, OMAP will purchase
A4430	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each, OMAP will purchase
A4431	Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each, OMAP will purchase
A4432	Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each, OMAP will purchase
A4433	Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each , OMAP will purchase
A4434	Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type, OMAP will purchase
A4455	Adhesive remover or solvent (for tape, cement or other adhesive) (1 unit of service = 1 oz. of liquid or spray) – OMAP will purchase
A5051	Ostomy pouch, closed; with barrier attached (1 piece), standard wear, each – OMAP will purchase
A5052	Ostomy pouch, closed; without barrier attached (1 piece), each – OMAP will purchase
A5053	Ostomy pouch, closed; for use on faceplate, each – OMAP will purchase

A5054	Ostomy pouch, closed for use on barrier with flange (2 piece), each – OMAP will purchase
A5055	Stoma cap, each – OMAP will purchase
A5062	Ostomy pouch, drainable, without barrier attached (1 piece), each – OMAP will purchase
A5063	Ostomy pouch, drainable, for use on barrier with flange (2 piece system), each – OMAP will purchase
A5071	Ostomy pouch, urinary, with barrier attached (1 piece), each – OMAP will purchase
A5072	Ostomy pouch, urinary, without barrier attached (1 piece), each – OMAP will purchase
A5073	Ostomy pouch, urinary, for use on barrier with flange (2 piece), each – OMAP will purchase
A5081	Continent device; plug for continent stoma, each – OMAP will purchase
A5082	Catheter for continent stoma, each – OMAP will purchase
A5093	Ostomy accessory; convex insert, each – OMAP will purchase
A5119	Skin barrier, wipes, box per 50 – OMAP will purchase
A5121	Skin barrier, solid, 6 x 6 or equivalent, each – OMAP will purchase
A5122	Skin barrier, solid, 8 x 8 or equivalent, each – OMAP will purchase
A5126	Adhesive or non-adhesive; disc or foam pad – OMAP will purchase

A5131 Appliance cleaner, incontinence and ostomy appliances, per 16 oz. – OMAP will purchase

4-1-04

410-122-0560 Urological Services

(1) Urinary catheters and external urinary collection devices are covered to drain or collect urine for a client who has permanent urinary incontinence or permanent urinary retention.

(2) Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in that client within three months.

(3) This does not require a determination that there is no possibility that the client's condition may improve sometime in the future.

(4) If the medical record, including the judgement of the attending prescribing practitioner, indicates the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is considered met.

(5) Follow Medicare's guidelines for usage exceeding the stated limits per DMERC Region D Supplier Manual.

(6) Documentation:

(a) Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider;

(b) When billing for quantities of supplies greater than those described in the policy (e.g., more than one indwelling catheter per month, more than two bedside drainage bags per month, more than 35 male external catheters per month, etc.) documentation supporting the medical appropriateness for the higher utilization must be on file in the DME provider's records.

(7) Procedure Codes: Table 122- 0560.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 0560

A4310 Insertion tray without drainage bag and without catheter (accessories only) – Office of Medical Assistance Programs (OMAP) will purchase

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

A4311 Insertion tray without drainage bag, with indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.) – OMAP will purchase

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

A4312 Insertion tray without drainage bag with indwelling catheter, foley type, two-way, all silicone – OMAP will purchase

Limited to one per month for routine catheter maintenance

Not covered for intermittent catheterization

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, foley type, three-way for continuous irrigation – OMAP will purchase

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.) – OMAP will purchase

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

A4315 Insertion tray with drainage bag with indwelling catheter, foley type, two-way, all silicone – OMAP will purchase intermittent catheterization

Not covered at the same time as A4310, A4312, A4332, A4344, A4354, A4357

A4316 Insertion tray with drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation – OMAP will purchase

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

A4320 Irrigation tray with bulb or piston syringe, any purpose – OMAP will purchase

A4322 Irrigation syringe, bulb or piston, each – OMAP will purchase

A4324 Male external catheter, with adhesive coating, each – OMAP will purchase

Limited to 35 per month

Adhesive strips or tape are included in the allowable

Not covered at the same time as K0572, K0573

A4325 Male external catheter, with adhesive strap, each – OMAP will purchase

Limited to 35 per month

Adhesive strips or tape are included in the allowable

Not covered at the same time as K0572, K0573

A4326 Male external catheter specialty type with integral collection chamber, each – OMAP will purchase

A4327 Female external urinary collection device, meatal cup, each – OMAP will purchase

Limited to one per week

A4328 Female external urinary collection device; pouch, each – OMAP will purchase

Limited to one per day

A4331 Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each – OMAP will purchase

A4332 Lubricant, individual sterile packet, for insertion of urinary catheter, each – OMAP will purchase

Not covered for intermittent catheterization

Not covered at the same time as A4310, A4311, A4312, A4313, A4314, A4315, A4316, A4353, A4354

A4333 Urinary catheter anchoring device, adhesive skin attachment, each – OMAP will purchase

Limited to three per week

A4334 Urinary catheter anchoring device, leg strap, each – OMAP will purchase

Limited to one per month

A4338 Indwelling catheter; foley type, two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each – OMAP will purchase

Limited to one per month for routine catheter maintenance

Not covered at the same time as A4311

A4340 Indwelling catheter; specialty type, e.g., coude, mushroom, wing, etc., each – OMAP will purchase

Limited to one per month for routine catheter maintenance

A4344 Indwelling catheter Foley type, two-way, all silicone, each – OMAP will purchase

Limited to one per month for routine catheter maintenance

Not covered at the same time as A4312, A4315

A4346 Indwelling catheter, Foley type, three-way for continuous irrigation, each – OMAP will purchase

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

A4348 Male external catheter with integral collection compartment, extended wear, each – OMAP will purchase

A4351 Intermittent urinary catheter; straight tip, each – OMAP will purchase

Limited to one per week

Not covered at the same time as A4352 or A4353

A4352 Intermittent urinary catheter; coude (curved) tip, each – OMAP will purchase

Limited to one per week

Not covered at the same time as A4332, A4351 or A4353

A4353 Intermittent urinary catheter with insertion supplies – OMAP will purchase

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

A4354 Catheter insertion tray with drainage bag but without catheter – OMAP will purchase

Not covered at the same time as A4310, A4314, A4315, A4316, A4332, A4357

A4355 Irrigation tubing set for continuous bladder irrigation through a three-way indwelling foley catheter, each – OMAP will purchase

A4356 External urethral clamp or compression device (not to be used for a catheter clamp), each – OMAP will purchase

Limited to one per three months

A4357 Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each – OMAP will purchase

Limited to two per month Not covered at the same time as A4314, A4315, A4316, A4354, A5102

A4358 Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each – OMAP will purchase

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

A4359 Urinary suspensory without leg bag, each – OMAP will purchase

Not covered at the same time as A5105

A4402 Lubricant, per ounce – OMAP will purchase

A4450 Tape, non-waterproof, per 18 square inches – OMAP will purchaseNot covered at the same time as A4325

A4452 Tape, waterproof, per 18 square inches – OMAP will purchase.Not covered at the same time as A4325A4927 Gloves, non-sterile, per 100– OMAP will purchase

Limited to 200 pair per month

A4930 Gloves, sterile, per pair --- OMAP will purchase

A5102 Bedside drainage bottle, with or without tubing, rigid or expandable, each – OMAP will purchase

Limited to two per six months

Not covered at the same time as A4357

A5105 Urinary suspensory; with leg bag, with or without tube – OMAP will purchase

Not covered at the same time as A4358, A4359, A5112, A5113, A5114

A5112 Urinary leg bag; latex – OMAP will purchase

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

A5113 Leg strap; latex, replacement only, per set – OMAP will purchase

Not covered at the same time as A4112, A4358, A5105

A5114 Leg strap; foam or fabric, replacement only, per set – OMAP will purchase

Not covered at the same time as A4358, A5105, A5112

A5131 Appliance cleaner, incontinence and ostomy appliances, per 16 oz. – OMAP will purchase

A5200 Percutaneous catheter/tube anchoring device, adhesive skin attachment – OMAP will purchase

4-1-04

410-122-0580 Bath Supplies

(1) Indications and Limitations of Coverage. A rehab shower/commode chair is covered if a client meets the following criteria:

(a) Client is unable to use a standard shower chair/bench due to a musculoskeletal condition and;

(b) Client has positioning, trunk stability or neck support needs that a standard shower chair/bench cannot provide and;

(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.

For a rehab/shower chair, submit documentation to support criteria in 410-122-0580 (1) (a-d), including a list of equipment available for client’s use.

(3) Procedure Codes: Table 122-0580

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 0580

E0160 Sitz type bath or equipment, portable, used with or without commode—the Office of Medical Assistance Programs will purchase

E0161 Sitz type bath or equipment, portable, used with or without commode with faucet attachments—OMAP will purchase

E0162 Sitz bath chair—OMAP will purchase

E0241 Bathtub wall rail, each — OMAP will purchase

E0242 Bathtub rail floor base—OMAP will purchase

E0243 Toilet rail, each—OMAP will purchase

E0245 Tub stool or bench—OMAP will purchase

E0246 Transfer tub rail attachment --OMAP will purchase

E0247 Transfer bench for tub or toilet with or without commode opening –OMAP will purchase

E0248 Transfer bench, heavy duty, for tub or toilet with or without commode opening--OMAP will purchase

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

Prior authorization required—OMAP will purchase, rent and repair

4-1-04

410-122-0590 Patient Lifts

(1) Indications and Coverage -- A lift is covered if transfer between bed an 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) 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 -- Not covered at the same time as E0630 or E0635;

(b) E0630, Client lift, hydraulic with seat or sling -- OMAP will purchase, rent, and repair -- PA required -- Item considered purchased after 16 months of rent;

(c) E0635, Client lift, electric, with seat or sling -- OMAP will purchase, rent, and repair -- PA required -- Item considered purchased after 16 months of rent.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02

410-122-0600 Toilet Supplies

(1) Procedure Codes -- Table 0600-1.

(2) Commodes:

(a) Indications and Coverage: For use when the client is physically incapable of utilizing regular toilet facilities. This would occur when:

(A) The client is confined to a single room; or

(B) The client is confined to one level of the home environment and there is no toilet on that level; or

(C) The client is confined to the home and there are no toilet facilities in the home.

(b) Documentation: An order for the commode which is signed by the prescribing practitioner must be kept on file by the DME supplier. The practitioner's records must contain information which supports the medical appropriateness of the item ordered;

(c) Procedure Code -- Table 0600-2.

(3) Extra-Wide/Heavy Duty Commodes:

(a) Indications and Coverage:

(A) A client who weighs 300 pounds or more;

(B) For use when the client is physically incapable of utilizing regular toilet facilities. This would occur when:

(i) The client is confined to a single room; or

(ii) The client is confined to one level of the home environment and there is no toilet on that level; or

(iii) The client is confined to the home and there are no toilet facilities in the home.

(b) Documentation: Documentation of medical appropriateness must be submitted for prior authorization and kept on file by the DME provider, and must include height and weight;

(c) Procedure Code -- 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 required -- OMAP will purchase, rent, repair -- Item considered purchased after 16 months of rent.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

Table 0600-1

E0244	Raised toilet seat – OMAP will purchase
E0275	Bedpan, standard metal or plastic – OMAP will purchase
E0276	Bedpan, fracture metal or plastic – OMAP will purchase
E0325	Urinal, male, jug-type, any material – OMAP will purchase
E0326	Urinal, female, jug-type, any material – OMAP will purchase

Table 0600-2

E0163 Commode chair – stationary with fixed arms – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

E0164 Commode chair, mobile with fixed arms – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

E0165 Commode chair, stationary, with detachable arms – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

Covered if necessary to facilitate transferring the client

Covered if the client has a body configuration that requires extra width

E0166 Commode chair, mobile, with detachable arms – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent

Covered if necessary to facilitate transferring the client

Covered if the client has a body configuration that requires extra width

E0167 Pail or pan for use with commode chair – OMAP will purchase

Replacement only

Not covered at same time as E0163, E0164, E0165, E0166

410-122-0620 Miscellaneous Supplies

Table 122-0620

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 0620

A4206	Syringe with needle, sterile 1cc, each – also used for.3cc or.5cc sterile syringe with needle – the Office of Medical Assistance Programs (OMAP) will purchase
A4207	Syringe with needle, sterile, 2cc, each – OMAP will purchase
A4208	Syringe with needle, sterile, 3cc, each – OMAP will purchase
A4209	Syringe with needle, sterile, 5cc or greater, each – OMAP will purchase
A4213	Syringe, sterile, 20cc or greater, each – OMAP will purchase
A4215	Needle only, sterile, any size, each – OMAP will purchase
A4244	Alcohol or peroxide, per pint – OMAP will purchase
A4245	Alcohol wipes, per box – OMAP will purchase
A4246	Betadine or phisohex solution, per pint – OMAP will purchase
A4247	Betadine or iodine swabs/wipes, per box – OMAP will purchase
A4250	Urine test or reagent strips or tablets (100 tablets or strips) – OMAP will purchase
A4320	Irrigation tray with bulb or piston syringe, any purpose – OMAP will purchase
A4322	Irrigation syringe, bulb or piston, each – OMAP will purchase

A4330	Perianal fecal collection pouch with adhesive, each – OMAP will purchase
A4455	Adhesive remover or solvent (for tape, cement or other adhesive) (1 unit of service equals 1 oz. of liquid or spray) – OMAP will purchase
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope – OMAP will purchase
A4663	Blood pressure cuff only – OMAP will purchase
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 – OMAP will purchase – prior authorization required
A4773	Hemostix, per bottle – OMAP will purchase
E0191	Heel or elbow protector, each – OMAP will purchase
E0370	Air pressure elevator for heel – OMAP will purchase
E0701	Helmet with face guard and soft interface materials, prefabricated -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a nursing facility
E0776	IV pole – OMAP will purchase – OMAP will rent – OMAP will repair – Item considered purchased after 16 months of rent
L8501	Tracheostomy speaking valve – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility (see Speech/Hearing Services rules for billing instructions)

S8265	Haberman feeder for cleft lip/palate – OMAP will purchase
V5266	Battery for use in hearing device – limited to 60 batteries per calendar year – OMAP will purchase – Also covered for payment by OMAP when client is a resident of a nursing facility

4-1-04

410-122-0625 Surgical Dressing Procedure Codes

Table 122-0625.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 0625

A4450	Tape, non-waterproof, per 18 square inches -- OMAP will purchase
A4452	Tape, waterproof, per 18 square inches -- OMAP will purchase
A4462	Abdominal dressing holder, each – OMAP will purchase
A4927	Gloves, nonsterile, per 100 -- OMAP will purchase -- Limited to 200 pair per month
A4930	Gloves, sterile, per pair, limited to sterile procedure only -- OMAP will purchase
A6010	Collagen based wound filler, dry form, per gram of collagen – OMAP will purchase
A6011	Collagen based wound filler, gel/paste, per gram of collagen -- OMAP will purchase
A6021	Collagen dressing, pad size 16 sq. in. or less, each – OMAP will purchase
A6022	Collagen dressing, pad size more than 16 sq. in., but less than or equal to 48 sq. in., each – OMAP will purchase
A6023	Collagen dressing, pad size more than 48 sq. in., each – OMAP will purchase
A6024	Collagen dressing, wound filler, per 6 in. – OMAP will purchase
A6025	Gel sheet for dermal or epidermal application, (e.g., silicone, hydrogel, other), each – OMAP will purchase
A6154	Wound pouch, each – OMAP will purchase

A6196	Alginate dressing, wound cover, pad size 16 sq. inches or less, each dressing – OMAP will purchase
A6197	Alginate dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing – OMAP will purchase
A6198	Alginate dressing, wound cover, pad size more than 48 sq. inches, each dressing – OMAP will purchase
A6199	Alginate dressing, wound filler (1 unit of service = 6 inches) – OMAP will purchase
A6200	Composite dressing, pad size 16 sq. inches or greater, but less than or equal to 48 sq. inches, without adhesive border, each dressing – OMAP will purchase
A6201	Composite dressing, pad size more than 16 sq. inches, but less than or equal to 48 sq. inches, without adhesive border, each dressing – OMAP will purchase
A6202	Composite dressing, pad size more than 48 sq. inches, without adhesive border, each dressing – OMAP will purchase
A6203	Composite dressing, pad size 16 sq. inches or less, with any size adhesive border, each dressing – OMAP will purchase
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 – OMAP will purchase
A6205	Composite dressing, pad size more than 48 sq. inches, with any size adhesive border, each dressing – OMAP will purchase
A6206	Contact layer, 16 sq. inches, or less, each dressing – OMAP will purchase

A6207	Contact layer, more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing – OMAP will purchase
A6208	Contact layer, more than 48 sq. inches, each dressing – OMAP will purchase
A6209	Foam dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing – OMAP will purchase
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 – OMAP will purchase
A6211	Foam dressing, wound cover, pad size more than 48 sq. inches, without adhesive border, each dressing – OMAP will purchase
A6212	Foam dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing – OMAP will purchase
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 – OMAP will purchase
A6214	Foam dressing, wound cover, pad size more than 48 sq. inches, with any size adhesive border, each dressing – OMAP will purchase
A6215	Foam dressing, wound filler (1 unit of service = 1 gram) – OMAP will purchase
A6216	Gauze, non-impregnated, nonsterile, pad size 16 sq. inches or less, without adhesive border, each dressing – OMAP will purchase

A6217 Gauze, non-impregnated, nonsterile, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing – OMAP will purchase

A6218 Gauze, non-impregnated, nonsterile, pad size more than 48 sq. inches, without adhesive border, each dressing – OMAP will purchase

A6219 Gauze, non-impregnated, nonsterile, pad size 16 sq. inches, or less, with any size adhesive border, each dressing – OMAP will purchase

A6220 Gauze, non-impregnated, nonsterile, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing – OMAP will purchase

A6221 Gauze, non-impregnated, nonsterile, pad size more than 48 sq. inches, with any size adhesive border, each dressing – OMAP will purchase

A6222 Gauze, impregnated with other than water, normal saline, or hydrogel, pad size 16 sq. inches or less, without adhesive border, each dressing – OMAP will purchase

A6223 Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing – OMAP will purchase

A6224 Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 48 sq. inches, without adhesive border, each dressing – OMAP will purcha

A6231 Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. inches or less, each dressing – OMAP will purchase

A6232 Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing – OMAP will purchase

A6233 Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 48 sq. inches, each dressing – OMAP will purchase

A6234 Hydrocolloid dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing – OMAP will purchase

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 – OMAP will purchase

A6236 Hydrocolloid dressing, wound cover, pad size more than 48 sq. inches, without adhesive border, each dressing – OMAP will purchase

A6237 Hydrocolloid dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing – OMAP will purchase

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 – OMAP will purchase

A6239 Hydrocolloid dressing, wound cover, pad size more than 48 sq. inches, with any size adhesive border, each dressing – OMAP will purchase

A6240 Hydrocolloid dressing, wound filler, paste (1 unit of service = 1 ounce) – OMAP will purchase

A6241 Hydrocolloid dressing, wound filler, dry form (1 unit of service = 1 gram) – OMAP will purchase

A6242 Hydrogel dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing – OMAP will purchase

A6243 Hydrogel dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing – OMAP will purchase

A6244 Hydrogel dressing, wound cover, pad size more than 48 sq. inches, without adhesive border, each dressing – OMAP will purchase

A6245 Hydrogel dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing – OMAP will purchase

A6246 Hydrogel 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 – OMAP will purchase

A6247 Hydrogel dressing, wound cover, pad size more than 48 sq. inches, with any size adhesive border, each dressing – OMAP will purchase

A6248 Hydrogel dressing, wound filler, gel (1 unit of service = 1 fluid ounce) – OMAP will purchase

A6251 Specialty absorptive dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing – OMAP will purchase

A6252 Specialty absorptive dressing, wound cover, pad size morethan 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing – OMAP will purchase

A6253 Specialty absorptive dressing, wound cover, pad size more than 48 sq. inches without adhesive border, each dressing – OMAP will purchase

A6254 Specialty absorptive dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing – OMAP will purchase

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 – OMAP will purchase

A6256 Specialty absorptive dressing, wound cover, pad size more than 48 sq. inches with any size adhesive border, each dressing – OMAP will purchase

A6257 Transparent film, 16 sq. inches or less, each dressing – OMAP will purchase

A6258 Transparent film, more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing – OMAP will purchase

A6259 Transparent film, more than 48 sq. inches, each dressing – OMAP will purchase

A6261 Wound filler, not elsewhere classified, gel/paste (1 unit of service = 1 fluid ounce) – PA required by OMAP – OMAP will purchase

A6262 Wound filler, not elsewhere classified, dry form (1 unit of service = 1 gram) – PA required by OMAP – OMAP will purchase

A6266 Gauze, impregnated, other than water or normal saline, or zinc paste, any width (1 unit of service = 1 linear yard) – OMAP will purchase

A6402 Gauze, non-impregnated, sterile, pad size 16 sq. inches or less, without adhesive border, each dressing – OMAP will purchase

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 – OMAP will purchase

A6404 Gauze, non-impregnated, sterile, pad size more than 48 sq. inches, without adhesive border, each dressing – OMAP will purchase

A6410 Eye pad, sterile, each -- OMAP will purchase

A6411 Eye pad, non-sterile, each -- OMAP will purchase

A6512 Eye patch, occlusive, each-- OMAP will purchase

OMAP will purchase the following;

A6441 Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard

A6442 Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard

A6443 Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard

A6444 Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per yard

A6445 Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard

A6446 Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard

A6447 Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard

A6448 Light compression bandage, elastic, knitted/woven, width less than three inches, per yard

A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard
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
A6453	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard
A6454	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard
A6455	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard
A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven width greater than or equal to three inches and less than five inches, per yard

4-1-04

410-122-0630 Incontinent Supplies

(1) For this rule, as determined by Center for Medicare/Medicaid Services (CMS), “adult diapers” stands for adult briefs, and “child and adult briefs” stands for protective underwear.

(2) Miscellaneous:

(a) A4335, Incontinent supply; miscellaneous -- Prior authorization (PA) required -- OMAP will purchase -- Limited to 360 units per month, based on medical appropriateness, of any combination of products (including miscellaneous incontinent supply, adult-sized, child-sized or youth-sized disposable diaper, disposable liner or shield and disposable and washable brief but excluding underpads) unless documentation supporting increased medically appropriate usage is sent to OMAP for review and PA. Includes, but not limited to:

(A) Disposable belted undergarments;

(B) Disposable slip-on (TM) undergarments.

(b) A4554**,** Disposable underpads, all sizes (e.g., Chuxs) each -- PA required -- OMAP will purchase:

(A) Limited to 150 units per month unless documentation supporting increased medically appropriate usage is sent to OMAP Medical Unit for review and prior authorization;

(B) Limited to use for fecal incontinence, urinary incontinence and draining wounds;

(C) Not covered for client under 3 years of age for incontinence (fecal or urinary).

(c) A4927**,** Gloves, non-sterile, per100 (50 pairs) -- OMAP will purchase:

(A) Limited to 400 units (Total 400 count or 200 pairs) per month;

(B) Not covered for feeding, washing or doing laundry.

(d) A4535, Disposable liner / shield for incontinence, each – PA required -- OMAP will purchase:

(A) Incontinence supplies not covered for clients under three years of age;

(B) Includes but not limited to, pant liner, insert, insert pad, shield, pad, guard, booster pad or beltless undergarment;

(C) Limited to 360 units per month, based on medical appropriateness, of any combination of products (i.e., adult briefs and liners) unless documentation supporting increased medically appropriate usage is sent to OMAP for review and PA.

(3) Disposable Child-sized Supplies

(a) A4529**,** Child-sized incontinence product, diaper, small / medium size, each -- PA required -- OMAP will purchase.

(A) Not covered for child under three years of age;

(B) Limited to 360 units per month, based on medical appropriateness, of any combination of products (including miscellaneous incontinent supply, adult-sized, child-sized or youth-sized disposable diaper, disposable liner or shield and disposable and washable brief but excluding underpads)

(b) A4530, Child-sized incontinence product, diaper, large size, each -- PA required -- OMAP will purchase;

(A) Not covered for child under three years of age;

(B) Limited to 360 units per month, based on medical appropriateness, of any combination of products (including miscellaneous incontinent supply, adult - sized, child-sized or youth-

sized disposable diaper, disposable liner or shield and disposable and washable brief but excluding underpads)

(c) A4531, Child-sized incontinence product, brief, small/medium size, each -- PA required -- OMAP will purchase:

(A) Not covered for child under three years of age;

(B) Not covered for nocturnal enuresis;

(C) Limited to 100 units per month, based on medical appropriateness.

(d) A4532, Child-sized incontinence product, brief, large size, each -- PA required -- OMAP will purchase:

(A) Not covered for child under three years of age;

(B) Not covered for nocturnal enuresis;

(C) Limited to 100 units per month, based on medical appropriateness.

(4) Disposable Adult-sized Supplies:

(a) A4533, Youth-sized incontinent product, diaper, each -- PA required -- OMAP will purchase:

(A) Not covered for child under three years of age;

(B) Limited to 360 units per month, based on medical appropriateness, of any combination of products (including miscellaneous incontinent supply, adult - sized, child-sized or youth-sized disposable diaper, disposable liner or shield and disposable and washable brief but excluding underpads) unless documentation supporting increased medically appropriate usage is sent to OMAP for review and PA.

(b) A4521, Adult-sized incontinence product, diaper, small size, each -- PA required -- OMAP will purchase:

(A) Not covered for child under three years of age;

(B) Limited to 360 units per month, based on medical appropriateness, of any combination of products (including miscellaneous incontinent supply, adult - sized, child-sized or youth-sized disposable diaper, disposable liner or shield and disposable and washable brief but excluding underpads) unless documentation supporting increased medically appropriate usage is sent to OMAP for review and PA.

(c) A4522, Adult-sized incontinence product, diaper, medium size, each -- PA required -- OMAP will purchase:

(A) Not covered for child under three years of age;

(B) Limited to 360 units per month, based on medical appropriateness, of any combination of products (including miscellaneous incontinent supply, adult-sized, child-sized or youth-sized disposable diaper, disposable liner or shield and disposable and washable brief but excluding underpads) unless documentation supporting increased medically appropriate usage is sent to OMAP for review and PA.

(d) A4523, Adult-sized incontinence product, diaper, large size, each -- PA required -- OMAP will purchase:

(A) Not covered for child under three years of age;

(B) Limited to 360 units per month, based on medical appropriateness, of any combination of products (including miscellaneous incontinent supply, adult- sized, child-sized or youth-sized disposable diaper, disposable liner or shield and disposable and washable brief but excluding underpads) unless documentation supporting increased medically appropriate usage is sent to OMAP for review and PA.

(e) A4524, Adult-sized incontinence product, diaper, extra large size, each -- PA required -- OMAP will purchase:

(A) Not covered for child under three years of age;

(B) Limited to 360 units per month, based on medical appropriateness, of any combination of products (including miscellaneous incontinent supply, adult - sized, child-sized or youth-sized disposable diaper, disposable liner or shield and disposable and washable brief but excluding underpads) unless documentation supporting increased medically appropriate usage is sent to OMAP for review and PA.

(5) Disposable Protective Underwear:

(a) Coverage Criteria :

(b) Item covered if it meets the following criteria:

(A) Fecal or urinary incontinence; and

(B) Documented bowel and bladder retraining program; and

(C) Partial ability to be continent; and

(D) Documented treatment failure with other, less-expensive products; and either:

(i) Autism with tactile aversion; or

(ii) Other medically appropriate reasons.

(b) Documentation -- Documentation to be submitted with request for PA:

(A) Bowel and bladder retraining program (this can be in the form of a care plan);

(B) Medical reason for incontinence;

(C) Medical proof that other products have been tried and failed;

(D) Documented progress of achieving or maintaining goals of bowel and bladder retraining program.

(c) Procedure Codes:

(A) A4534**,** Youth-sized incontinence product, briefs, each -- PA required -- OMAP will purchase:

(i) Limited to 100 units per month;

(ii) Not covered for child under three years of age;

(iii) Not covered for nocturnal enuresis.

(B) A4525, Adult-sized incontinence product, brief, small size, each -- PA required -- OMAP will purchase:

(i) Limited to 100 units per month;

(ii) Not covered for child under three years of age;

(iii) Not covered for nocturnal enuresis.

(C) A4526, Adult-sized incontinence product, brief, medium size, each -- PA required -- OMAP will purchase:

(i) Limited to 100 units per month;

(ii) Not covered for child under three years of age;

(iii) Not covered for nocturnal enuresis.

(D) A4527, Adult-sized incontinence product, brief, large size, each -- PA required -- OMAP will purchase:

(i) Limited to 100 units per month;

(ii) Not covered for child under three years of age;

(iii) Not covered for nocturnal enuresis.

(E) A4528**,** Adult-sized incontinence product, brief, extra large size, each -- PA required -- OMAP will purchase:

(i) Limited to 100 units per month;

(ii) Not covered for child under three years of age;

(iii) Not covered for nocturnal enuresis.

(6) Washable Incontinent Supplies:

(a) A4536, Protective underwear, washable, any size, each -- PA required -- OMAP will purchase;;

(A) Not covered for child under three years of age,

(B) Limited to 12 units per 12 months.

(b) A4537, Underpad, reusable, washable, any size, each -- PA required -- OMAP will purchase:

(A) Not covered for child under three years of age;

(B) Limited to 8 units per 12 months,

(c) Washable underpad (A4537) and disposable underpad (A4554) should not be covered at the same time.

(d) Washable brief/protective underwear (A4536) and disposable brief (A4525, A4526, A4527, A4528, A4531, A4532 and A4534) may be covered at the same time when the disposable briefs are used for

trips like visit to doctor or visit to physical therapist etc. The number of units must not exceed the limit.

(7) Diaper Service:

(a) A4538, Diaper service, reusable diaper, each diaper -- PA required -- OMAP will rent;

(b) Coverage limitations:

(A) Not covered at the same time as disposable products;

(B) Not covered for children under three years of age;

(C) Limited to 360 units per month, based on medical appropriateness, of any combination of products (including miscellaneous incontinent supply, adult-sized, child-sized or youth-sized disposable diaper, disposable liner or shield and disposable and washable brief but excluding underpads) unless documentation supporting increased medically appropriate usage is sent to OMAP for review and PA.

(c) Quantity delivered by provider must match prior authorized units.

(d) Service provider must document proof of delivery to the client. Delivery receipt must show signature as well as name of signer.

(8) Quantity specification:

(a) For prior authorization (PA) and reimbursement purpose, a unit count 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 or case or carton, total number of individual pieces of that item contained within that respective measurement (box or case or carton) must be specified in the unit column on PA request form. See table 0630-1;

(9) Incontinence product categories: See Table 0630-2;

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-01-03

Table 0630-1

Example	Container	Individual pieces (count)	Units considered for PA
1.	1 box of diapers	10	10
2.	1 box of gloves	100 pieces (50 pairs)	100

10-01-03

Table 0630-2

Type	Definition	Size		HCPCS Code	Max Unit Limit	Fee schedule. $ per unit
Disposable	Diaper (taped)	Adult	Small	A4521	360/Month	0.50
			Medium	A4522	360/Month	0.68
			Large	A4523	360/Month	0.75
			Extra Large	A4524	360/Month	0.80
		Child	Small / Med	A4529	360/Month	0.50
			Large	A4530	360/Month	0.50
		Youth		A4533	360/Month	0.50
	Brief (pull ups or Protective underwear)	Adult	Small	A4525	100/Month	1.30
			Medium	A4526	100/Month	1.35
			Large	A4527	100/Month	1.21
			Extra Large	A4528	100/Month	1.28
		Child	Small/ Med	A4531	100/Month	0.50
			Large	A4532	100/Month	0.50
		Youth		A4534	100/Month	1.20
	Liner / Shield	Wearable		A4535	360/month. Any combination.	0.45
	Misc. Belted / Slip-on	Wearable		A4335	360/month. Any combination	1.00
	Underpads	Any		A4554	150/month	0.25
Washable, Re-usable	Protective Underwear	Any		A4536	12 per year	12.00
	Underpad	Any		A4537	8 per year	16.00

10-01-03

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 0640.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01

Table 0640 Procedure Codes

Code	Description	PC	RT	16R	RP	NF
V2623	Prosthetic Eye, plastic, custom	X				X
V2624	Polishing/Resurfacing of ocular prosthesis	X				X
V2625	Enlargement of ocular prosthesis	X				X
V2626	Reduction of ocular prosthesis	X				X
V2627	Scleral cover shell	X				X
V2628	Fabrication and fitting of ocular conformer	X				X
V2629	Prosthetic eye, other type	X				X

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 rule 410-122-0470 Supports and Stockings, 410-122-0255 External Breast Prosthesis, and 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 L1500, L1510, and L1520.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 122-0660 Codes Not Covered

L1844	L5780	L6310	L6935	L7030	L7266
L2750	L5781	L6360	L6940	L7035	L7272
L2780	L5782	L6638	L6945	L7040	L7274
L3031	L5822	L6646	L6950	L7045	L7360
L3251	L5824	L6648	L6955	L7170	L7362
L5610	L5828	L6825	L6960	L7180	L7364
L5613	L5830	L6875	L6965	L7185	L7366
L5614	L5847	L6881	L6970	L7186	L7367
L5722	L5848	L6882	L6975	L7190	L7368
L5724	L5980	L6920	L7015	L7191	L7500
L5726	L5989	L6925	L7020	L7260	L7520
L5728	L6025	L6930	L7025	L7261	L7900
L8010					
L8500					
L8501					
L8505					
L8507					

L8510

L8511

L8512

L8513

L8514

L8614

L8619

4-1-04

410-122-0678 Dynamic Adjustable Extension/Flexion Device Procedure Codes

Table122-0678.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 0678

E1800	Dynamic adjustable elbow extension/flexion device, includes soft interface material – the Office of Medical Assistance Programs (OMAP) will purchase and rent. Item considered purchased after 16 months of rent – Also covered for payment by OMAP when client is a resident in a nursing facility
E1802	Dynamic adjustable forearm pronation/supernator device, includes soft interface material – OMAP will purchase and rent. Item considered purchased after 16 months of rent – Also covered for payment by OMAP when client is a resident in a nursing facility
E1805	Dynamic adjustable wrist extension/flexion device, includes soft interface material – OMAP will purchase and rent. Item considered purchased after 16 months of rent – Also covered for payment by OMAP when client is a resident in a nursing facility
E1810	Dynamic adjustable knee extension/flexion device, includes soft interface material – OMAP will purchase and rent. Item considered purchased after 16 months of rent – Also covered for payment by OMAP when client is a resident in a nursing care facility
E1815	Dynamic adjustable ankle extension/flexion device, includes soft interface material – OMAP will purchase and rent. Item considered purchased after 16 months of rent – Also covered for payment by OMAP when client is a resident in a nursing care facility
E1820	Replacement soft interface material, dynamic adjustable extension/flexion device – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

E1825	Dynamic adjustable finger extension/flexion device, includes soft interface material – OMAP will purchase and rent. Item considered purchased after 16 months of rent – Also covered for payment by OMAP when client is a resident in a nursing facility
E1830	Dynamic adjustable toe extension/flexion device, includes soft interface material – OMAP will purchase and rent. Item considered purchased after 16 months of rent – Also covered for payment by OMAP when client is a resident in a nursing facility
E1840	Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material – OMAP will purchase and rent. Item considered purchased after 16 months of rent – Also covered for payment by OMAP when client is a resident in a nursing facility

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 0680.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

Table 0680

A4364	Adhesive liquid, or equal, any type, per ounce 0 -- OMAP will purchase – Also covered for payment for client who is a resident in a nursing facility
A4365	Adhesive remover wipes, any type, per box of 50. OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility
L8040	Nasal prosthesis provided by a non-physician – PA required by OMAP – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility A removable superficial prosthesis which restores all or part of the nose It may include the nasal septum
L8041	Midfacial prosthesis provided by a non-physician – PA required by OMAP – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility 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 intraoral maxillary component Adjacent facial tissue/structures include one or more of the following: soft tissue of the cheek, upper lip, or forehead
L8042	Orbital prosthesis provided by a non-physician – PA required by OMAP – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

A removable superficial prosthesis which restores the eyelids and the hard and soft tissue of the orbit

It may also include the eyebrow

This code does not include the ocular prosthesis component

L8043 Upper facial prosthesis provided by a non-physician – PA required by OMAP – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

A removable superficial prosthesis which restores the orbit plus significant adjacent facial tissue/structures, but does not include the nose or any intraoral 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

L8044 Hemi-facial prosthesis provided by a non-physician – PA required by OMAP – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

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 intraoral maxillary component

This code does not include the ocular prosthesis component

L8045 Auricular prosthesis provided by a non-physician – PA required by OMAP – OMAP will purchase – Also covered

for payment by OMAP when client is a resident in a nursing facility

A removable superficial prosthesis which restores all or part of the ear

L8046 Partial facial prosthesis provided by a non-physician – PA required by OMAP – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

A removable superficial prosthesis which restores a portion of the face but which does not specifically involve the nose, orbit or ear

L8047 Nasal septal prosthesis provided by a non-physician – PA required by OMAP – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

A removable superficial prosthesis which occludes a hole in the nasal septum but which does not include superficial nasal tissue

L8048 Unspecified maxillofacial prosthesis, provided by a non physician – PA required by OMAP – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility

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

L8049 Repair or modification of maxillofacial prosthesis, labor component, 15-minute increments provided by a non physician – PA required by OMAP – OMAP will repair – Also covered for payment by OMAP when client is a resident in a nursing facility

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

410-122-0700 Negative Pressure Wound Therapy

(1) Prior authorization (PA) will be given for six weeks of negative pressure wound therapy at a time.

(2) Definitions:

(a) Negative pressure wound therapy (NPWT) is the controlled application of subatmospheric pressure to a wound using an electrical pump to intermittently or continuously convey subatmospheric pressure through connecting tubing to a specialized wound dressing which 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;

(b) A licensed health care professional, for the purposes of this policy, may be a physician, physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or physical therapist (PT). The licensed health care professional should be licensed to assess wounds and/or administer wound care within the state where the client is receiving NPWT;

(c) Lack of improvement of a wound, as used within this policy, is defined as a lack of progress in quantitative measurements of wound characteristics including wound length and width (surface area), or depth measured serially and documented, over a specified time interval. Wound healing is defined as improvement occurring in either surface area or depth of the wound;

(d) The staging of pressure ulcers used in this policy is as follows:

(A) Stage I -- Nonblanchable erythema of intact light toned skin or darker or violet hue in darkly pigment skin;

(B) Stage II -- Partial thickness skin loss involving epidermis and/or dermis;

(C) Stage III -- Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia;

(D) Stage IV -- Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.

(3) Indications and Coverage -- Equipment:

(a) Initial Coverage -- A NPWT pump and supplies are covered for:

(A) Ulcers and wounds in the home or nursing facility -- 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. A complete wound therapy program described by criterion 1 and criteria 2, 3, or 4, as applicable depending on the type of wound, should have been tried or considered and ruled out prior to application of NPWT:

(i) 1 -- For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT:

(I) a -- Documentation in the client's medical record of evaluation, care, and wound measurements by a licensed medical professional; and

(II) b -- Application of dressings to maintain a moist wound environment; and

(III) c -- Debridement of necrotic tissue if present; and

(IV) d -- Evaluation of and provision for adequate nutritional status.

(ii) 2 -- For Stage III or IV pressure ulcers:

(I) a -- The client has been appropriately turned and positioned; and

(II) b -- The client has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis, (a group 2 or 3 support surface is not required if the ulcer is not on the trunk or pelvis) and;

(III) c -- The client's moisture and incontinence have been appropriately managed.

(iii) 3 -- For neuropathic (for example, diabetic) ulcers:

(I) a -- the client has been on a comprehensive diabetic management program; and

(II) b -- Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.

(iv) 4 -- For venous insufficiency ulcers:

(I) a -- Compression bandages and/or garments have been consistently applied; and

(II) b -- Leg elevation and ambulation have been encouraged.

(v) 5 -- Preoperative myocutaneous flap or graft:

(i) a -- Accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments;

(ii) b -- Other conditions of the client that will not allow for healing times achievable with other topical wound treatments.

(B) Exclusions from coverage -- An NPWT pump and supplies are not covered when one or more of the following are present:

(i) The presence in the wound of necrotic tissue with eschar, if debridement is not attempted;

(ii) Untreated osteomyelitis within the vicinity of the wound;

(iii) Cancer present in the wound;

(iv) The presence of a fistula to an organ or body cavity within the vicinity of the wound.

(b) Continued Coverage:

(A) For consideration of continued coverage for negative pressure wound therapy (NPWT), a licensed medical professional must, on a regular basis:

(i) Directly assess the wound(s) being treated with the NPWT pump; and

(ii) Supervise or directly perform the NPWT dressing changes.

(iii) On at least a monthly basis, document changes in the ulcer's dimensions and characteristics.

(B) If criteria (3)(b)(A)(i)-(iii) are not met, continued coverage of the NPWT pump and supplies will be denied as not medically appropriate.

(c) When Coverage Ends -- For covered wounds and ulcers, and NPWT pump and supplies will be denied as not medically appropriate with any of the following, whichever occurs earliest:

(A) Criteria in section (3)(b)(A)(i)-(iii) of this rule cease to occur; or

(B) In the judgement of the treating practitioner, adequate wound healing has occurred to the degree that NPWT may be discontinued; or

(C) Any measurable degree of wound healing has failed to occur over the prior month. There must be documented in the client's medical records quantitative measurements of wound characteristics including wound length and width (surface area), or depth, serially observed and documented, over a specified time interval. The recorded wound

measurements must be consistently and regularly updated and must have demonstrated progressive wound healing form month to month; or

(D) Four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home or nursing facility) have elapsed using an NPWT pump in the treatment of any wound. Coverage beyond four months will be given individual consideration based upon required additional documentation; or

(E) Once equipment or supplies are no longer being used for the client, whether or not by the prescribing practitioner's order.

(4) Documentation:

(a) The following information must be submitted with the initial written request:

(A) A completed OMAP 3123;

(B) An evaluation by the licensed health care professional supervising the care, describing the underlying condition (diagnosis, prognosis, rehabilitation potential and nutritional status) as well as a comprehensive assessment and evaluation of the client after conservative treatment has been tried without success;

(C) Documentation of other pressure reducing products or methods used but not proven adequate;

(D) Serum total lymphocyte count and prealbumin values within the last 30 days;

(E) Dated photographs of wound or ulcer with client's name.

(b) At review, submit:

(A) Dated photographs of pressure sores;

(B) Copies of skin flow sheets;

(C) Copies of any pertinent notes in the progress records;

(D) A completed OMAP 3124.

(5) Procedure Codes: Table 122-0700.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 0700

A6550	Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each – PA required – OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility
A6551	Canister set for negative pressure wound therapy electrical pump, stationary or portable, each – PA required–OMAP will purchase – Also covered for payment by OMAP when client is a resident in a nursing facility
E2402	Negative pressure wound therapy electrical pump, stationary or portable—PA required—OMAP will rent—Also covered for payment by OMAP when client is a resident in a nursing facility

4-1-04

410-122-0720 Pediatric Wheelchairs

(1) Indications and Coverage:

(a) The purchase, rental, or modification of a pediatric wheelchair is covered when all of the following criteria are met:

(A) The client's condition is such that without the use of a wheelchair the client would be bed-confined or confined to a non-mobile chair; and

(B) The client is not functionally ambulatory and the wheelchair is necessary to function within the home.

(b) The Office of Medical Assistance Programs (OMAP) will not pay for backup chairs. Only one wheelchair will be maintained, rented, repaired, purchased or modified for each client to meet the medical appropriateness; however, if a client's current wheelchair no longer meets the medical appropriateness or repair to the wheelchair exceeds replacement cost, a new wheelchair may be authorized. If a client has a wheelchair that meets his/her medical needs regardless of who has obtained it, OMAP will not provide another chair;

(c) One month's rental of a wheelchair is covered if a client-owned wheelchair is being repaired;

(d) Living quarters must be able to accommodate requested wheelchair. OMAP will not be responsible for adapting the living quarters to accommodate the wheelchair;

(e) Backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, wheelchair gloves, and upgrades to allow performance of leisure or recreational activities are not covered;(f) Do not use E1399 for manual wheelchair base;

(g) Reimbursement for wheelchair codes includes all labor charges involved in the assembly and delivery of the wheelchair and all adjustments for three months after date the client takes delivery.

Reimbursement also includes emergency services, education and on-going assistance with use of the wheelchair for three months after the client takes delivery.

(2) Documentation:

(a) Documentation of medical appropriateness which has been reviewed and signed by the treating prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(b) Submit list of all DME available or being used to meet the client's needs when requesting prior authorization (PA);(c) Submit Wheelchair and Seating Prescription and Justification form (OMAP 3125) or reasonable facsimile, with recommendations for most appropriate equipment. This must be submitted by physical therapist, occupational therapist, prescribing practitioner, or registered nurse, when requesting a PA. The evaluation must include client's functional ambulation status in their customary environment.

(3) Procedure Codes:

(a) E1011, Modification to pediatric wheelchair, width adjustment package (not to be dispensed with initial chair) -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(b) E1012, Integrated seating system, planar, for pediatric wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(c) E1013, Integrated seating system, contoured, for pediatric wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(d) E1014, Reclining back, addition to pediatric wheelchair -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(e) E1025, Lateral thoracic support, non-contoured, for pediatric wheelchair, each (includes hardware) -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(f) E1026, Lateral thoracic support, contoured, for pediatric wheelchair, each (includes hardware) -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(g) E1027, Lateral/anterior support, for pediatric wheelchair, each includes hardware) -- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair.

(4) Pediatric Tilt-in Space:

(a) Indications and coverage for tilt-in space: clients must meet the criteria for a wheelchair (manual or powered), plus the following:

(A) Dependent for transfers; and

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

(C) Plan of care must address the need to change position at frequent intervals and not be left in the tilt position most of the time; and

(D) One of the following:

(i) High risk of skin breakdown;

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

(iii) Hyper/hypotonia;

(iv) Requires frequent change of position with poor upright sitting.

(b) Documentation -- must support the above criteria.

(c) Procedure Codes:

(A) E1231, Wheelchair pediatric size, tilt-in space, rigid, adjustable, with seating system --- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(B) E1232, Wheelchair pediatric size, tilt-in space, folding, adjustable, with seating system --- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(C) E1233, Wheelchair pediatric size, tilt-in space, rigid, adjustable, without seating system --- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(D) E1234 Wheelchair pediatric size, tilt-in space, folding, adjustable, without seating system --- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(E) E1235, Wheelchair pediatric size, rigid, adjustable, with seating system --- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent. Also covered for

payment when client is a resident of a nursing facility if supplied for client-owned chair;

(F) E1236, Wheelchair pediatric size, folding, adjustable, with seating system --- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(G) E1237, Wheelchair pediatric size, rigid, adjustable, without seating system --- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair;

(H) E1238, Wheelchair pediatric size, folding, adjustable, without seating system --- PA required -- OMAP will purchase, rent and repair -- Item considered purchased after16 months of rent. Also covered for payment when client is a resident of a nursing facility if supplied for client-owned chair.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03