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To: OMAP Durable Medical Equipment (DME) Service Providers

From: Joan Kapowich, Manager
OMAP Program and Policy

Re: DME Program, Rulebook Revision 1

Effective: **August 1, 2004**

OMAP updated the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) program Rulebook as follows:

OMAP adopted rule 410-122-0055 to implement modifications to the Oregon Health Plan (OHP) Standard Benefit Package as directed by the 2003 Legislative Assembly in HB 2511. Some benefits are restored while other benefits are removed. Implementation of these amendments is approved by the Centers for Medicare and Medicaid Services (CMS).

OMAP adopted rule 410-122-0085 to establish rules for dispensing supplies and equipment; amended 410-122-0080 to clarify OMAP's reimbursement rate; amended rule 410-122-0202 to extend initial CPAP rental period to three months; and, amended rule 410-122-0530 to add language regarding identifying and labeling client's supplies.

The Table of Contents is updated.

- 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: Each rule is numbered individually for easy replacement.

- If you do not have web access and receive hardcopy of revisions, this letter is attached to the revised rules and Table of Contents.

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

TR 547 8/1/04

DEPARTMENT OF HUMAN SERVICES

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

7-1-04

410-122-0010 Definitions

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

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

(3) Lifetime need – 99 months or more.

(4) Manufacturer Part Number (MPN):

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

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

(5) OMAP’s Maximum Allowable Rate – The maximum amount paid by OMAP for a service.

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

(7) Prescription:

(a) A proper written order supported by documentation in the prescribing practitioner’s records.

(b) A prescription must:

(A) Be signed;

(B) Be dated;

(C) Be legible;

(D) Specify the exact medical item or service required;

(E) List the ICD-9-CM diagnosis codes;

(F) List the number of units, and;

(G) List the length of time needed.

(c) An original, fax, or electronic prescription is acceptable.

(8) Purchase price – Includes:

(a) Delivery;

(b) Assembly;

(c) Adjustments, if needed, and;

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

(9) Rental fees – Include:

(a) Delivery;

(b) Training in the use of the equipment;

(c) Pick-up;

(d) Routine service, maintenance and repair, and;

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

410-122-0020 Prescription Requirements

(1) The durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider must:

(a) Obtain a prescription before providing DMEPOS, and;

(b) Retain a copy of the prescription in his or her records.

(2) A prescription is required to:

(a) Purchase;

(b) Rent, or;

(c) Modify an original DMEPOS.

(3) Prescriptions are not required for:

(a) Repairs;

(b) Parts needed for repairs, or;

(c) Replacement parts (e.g., batteries).

(4) 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 (IPPB) devices;

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

(e) Respiratory assist devices (RAD) and related supplies;

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

(5) A new prescription is required:

(a) Once a year, for:

(A) Incontinent supplies;

(B) Ostomy supplies;

(C) Urological supplies, and;

(D) Some diabetic supplies, per Medicare guidelines.

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

(c) When an item is replaced;

(d) When there is a change of DMEPOS provider.

(6) DMEPOS providers may change a prescription by documenting the change on the prescription with the:

(a) Date;

(b) Time;

(c) Initials, and;

(d) The name of the person who provided the change (e.g., prescribing practitioner).

Stat.Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

410-122-0040 Prior Authorization Requirements

(1) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers must obtain prior authorization (PA) for DMEPOS that indicate PA is required.

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

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

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

(c) For clients enrolled in an OMAP Medical Plan, PA must be requested from the OMAP Medical Plan;

(d) For all other clients, PA must be requested from the Office of Medical Assistance Programs (OMAP).

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

(4) PA requests must be submitted within five working days from the initiation of service for DMEPOS provided after normal working hours.

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

Stat.Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

410-122-0055 Standard Benefit Package Limitations

(1) Durable medical equipment and medical supply codes that are listed in Table 122-0055 are covered for clients on the Standard Benefit Package. DMEPOS providers must use the criteria and limitations shown for each code in Division 122. See OMAP General Rules Division 120 for additional information concerning the OHP Standard Benefit Package.

(2) Durable medical equipment and medical supply codes that are not listed in Table 122-0055 are not covered on the Standard Benefit Package and are billable to the client.

(3) The OHP Standard Benefit Package includes limited home enteral/parenteral services and intravenous services (see 410-148-0090).

Table 122-0055

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-01-04

Table 122-0055

Category	Codes
Diabetic Supplies	A4210, A4211, A4244, A4245, A4250, A4253, A4254, A4255, A4256, A4258, A4259, A4772, E0607, E2100, E2101, S8490
Respiratory:	A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7046, E0470, E0471, E0561, E0562, E0601, S8186
Oxygen	E1390, E1391, E1405, E1406, E0424, E0425, E0430, E0431, E0441, E0443, E0434, E0435, E0439, E0440, E0442, E0444, E0455, E0550, E0555, E0560
Ventilator	A4611, A4612, A4613, A4618, E0450, E0454, E0461, E0457, E0459, E0460, E0472
Suction Pump	A4609, A4610, A4624, A4628, A7000, A7001, A7002, E0600, E2000
Tracheostomy Supplies:	A4481, A4483, A4623, A4625, A4626, A4629, A7501, A7502, A7503, A7504, A7505, A7506, A7507, A7508, A7509, A7520, A7521, A7522, A7524, A7525, A7526, S8189
Urology Supplies:	A4310, A4311, A4312, A4313, A4314, A4315, A4316, A4320, A4322, A4324, A4325, A4326, A4327, A4328, A4331, A4332, A4333, A4334, A4338, A4340, A4344, A4346, A4348, A4351, A4352, A4353, A4354, A4355, A4356, A4357, A4358, A4359, A4927, A5102, A5105, A5112, A5113, A5114, A5131, A5200
Ostomy Supplies:	A4331, A4361, A4362, A4364, A4365, A4366, A4367, A4369, A4371, A4372, A4373, A4375, A4376, A4377, A4378, A4379, A4380, A4381, A4382, A4383, A4384, A4385, A4387, A4388, A4389, A4390, A4391, A4392, A4393, A4394, A4395, A4396, A4397, A4398, A4399, A4402, A4404, A4405, A4406, A4407, A4408, A4409, A4410, A4413, A4414, A4415, A4416, A4417, A4418, A4419, A4420, A4422, A4423, A4424, A4425, A4426, A4427, A4428, A4429, A4430, A4431, A4432, A4433, A4434, A4455, A5051, A5052, A5053, A5054, A5055, A5062, A5063, A5071, A5072, A5073, A5081, A5082, A5093, A5119, A5121, A5122, A5126, A5131

410-122-0080 Coverage and Exclusions

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

(2) The Office of Medical Assistance Programs (OMAP) does not cover equipment and services not medically appropriate (see OAR 410-120-1200).

(3) Reimbursement:

(a) OMAP reimburses for the lowest level of service, which meets medical appropriateness. See OAR 410-120-1280 (Billing) and 410-120-1340 (Payment) for clients with Medicare, third party resource (TPR) or alternate resource, coverage.

(b) Reimbursement is based on OMAP's maximum allowable rate, manufacturer's suggested retail price or usual charge, whichever is the lowest.

(4) Criteria as listed with individual codes is considered the medical appropriateness for that item. Unless stated otherwise, the number of units per month is limited by medical appropriateness. If no criteria is listed or there are questions about the criteria, medical appropriateness is determined by OMAP.

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

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

(7) Inpatient hospital reimbursement – 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.

(8) Equipment that has been paid for by OMAP becomes the property of the client.

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

(10) Any needed repairs or maintenance for client-owned equipment is the responsibility of OMAP (based on client eligibility). If the item is in the Medicare Capped Rental Program for a client with Medicare and Medicaid coverage, then continue to bill Medicare for maintenance, per Medicare's schedule.

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

(12) Before renting, purchase should be considered for long-term requirements.

(13) Equipment not covered for purchase, rent or repair by OMAP, includes, but is not limited to the following (or similar/related equipment): Table 122-0080.

Stat.Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

Table 122-0080 Coverage and 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
410-122-0080 Page 3
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
410-122-0080 Page 4
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
8-1-04

410-122-0085 Dispensing

(1) Providers must not dispense a quantity of supplies exceeding a client's expected utilization.

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

(3) Provider may contact the client to check the quantity on hand and continued need for product. An order cannot be dispensed if the client has more than a 15-day supply.

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

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

8-1-04

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:

(a) Medicare Statistical Analysis DMERC (SADMERC) Palmetto Government Benefits Administrators, or;

(b) AOPA.

(3) Written verification of coding from SADMERC or AOPA will be accepted as true and correct, at OMAP's discretion.

Stat.Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

410-122-0182 Legend

This is an explanation of the codes used throughout the DMEPOS program rules.

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

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

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

(4) MR – Months Rented:

(a) “13” – Indicates that the equipment is considered paid for and owned by the client, after 13 consecutive months of rent by the same provider or when purchase price is reached (whichever is the lesser);

(b) “16” – Indicates that the equipment is considered paid for and owned by the client, after 16 consecutive months of rent by the same provider or when purchase price is reached (whichever is the lesser).

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

410-122-0184 Repairs

(1) 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.

(2) 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.

(3) 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).

(4) If equipment is sent to the manufacturer for repair or non-routine service, the manufacturer must itemize the invoice as to:

(a) Parts;

(b) Labor time – documentation of start and stop time is not required, and;

(c) Shipping and handling – shipping and handling will not be reimbursed.

(5) Procedure Codes:

(a) E1340 – Repair or non-routine service requiring the skill of a technician, labor component, per 15 minutes:

(A) OMAP will repair;

(B) Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned equipment.

(b) K0462 – Temporary replacement for client-owned equipment being repaired, any type:

(A) PA required;

(B) OMAP will rent;

(C) Also covered for payment by OMAP when client is a resident of a nursing facility if supplied for client-owned equipment;

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

(E) 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;

(F) Include the following information about the temporary replacement:

(i) Manufacturer;

(ii) Brand name;

(iii) Model name, and;

(iv) Model number.

(G) Limited to one month;

(6) Prescription not required.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

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410-122-0186 Reimbursement and Prior Authorization Requirements for Codes E1399 and K0108

(1) Reimbursement for codes E1399 and K0108 is capped as follows:

(a) E1399 – $2,500;

(b) K0108 – $1,000.

(2) The amount of OMAP's reimbursement for codes E1399 and K0108 is determined as follows:

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

(b) If an MSRP is not available, reimbursement will be one of the following (whichever is the lowest amount) plus 20%:

(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) If (2)(a) or (b) are not available, reimbursement will be the "estimated price" plus 20%. An "estimated price" is the price the provider expects the manufacturer to charge.

(3) When requesting prior authorization (PA) for items billed at or above $100, the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider:

(a) Must submit a copy of:

(A) The items from (2) (a-c) that will be used to bill;

(B) A copy of the manufacturer's part number, and;

(C) Item description.

(b) May be required to submit the item's picture.

(4) The DMEPOS provider must submit verification for items billed under code E1399 when no specific HCPCS code is available and an item category is not specified in OAR 410 division 122 rules. Verification can come from an organization such as:

(a) Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC), or;

(b) American Orthotic and Prosthetic Association (AOPA).

(5) OMAP can review items that are more than the maximum allowable/cap ($2,500 - E1399, $1,000 - K0108) on a case-by-case basis. In order for OMAP to review an item the provider must submit the following documentation:

(a) The reason that a less expensive alternative is not medically appropriate, and;

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

(c) The expected outcome or change in client’s condition.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

410-122-0190 Equipment and Services Not Otherwise Classified

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

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

(3) Procedure Codes – Table 122-0190.

(4) Criteria for code E1399:

(a) Use modifier TW when using code E1399 for back-up equipment;

(b) Code E1399 includes but is not limited to use for the following:

(A) Walker gliders – Not covered for clients in a nursing facility;

(B) Oxymiser cannula – Not covered for clients in a nursing facility;

(C) Hydraulic bathtub lift – Not covered for clients in a nursing facility;

(D) Heavy-duty or extra-wide rehab shower/commode chair – Not covered for clients in a nursing facility;

(E) 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.

(c) Code E1399 cannot be used for:

(A) Wheelchair base;

(B) Repairs.

(d) Code E1399 can only be used for gait belts when the:

(A) Client is 60 pounds or greater, and;

(B) Care provider is trained in the proper use, and;

(C) Client meets one of the following criteria:

(i) The client may be able to walk independently, but needs a minor correction of ambulation, or;

(ii) The client needs minimal or standby assistance to walk alone, or;

(iii) The client requires assistance with transfer.

(e) Documentation of medical appropriateness from the prescribing practitioner must:

(A) Be kept on file by the DME provider, and;

(B) Include documentation that the care provider is trained in proper use.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0190 Equipment and Services Not Otherwise Classified

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4335	Incontinence supply – miscellaneous ■ Not covered for clients under three years of age ■ Limited to 360 units per month, of any combination of incontinence products, except underpads. This limitation can be waived if documentation is submitted to show why the higher amount is medically appropriate. ■ Includes but is not limited to pad-in-pant systems	PA	PC				
A4421	Ostomy supply – miscellaneous	PA	PC				
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	PC				
A6261	Wound filler, not elsewhere classified, gel/paste ■ 1 unit of service = 1 fluid ounce	PA	PC				
A6262	Wound filler, not elsewhere classified, dry form ■ 1 unit of service = 1 gram	PA	PC				

Code	Description	PA	PC	RT	MR	RP	NF
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code ■ Includes but is not limited to: ◆ Dale™ tracheostomy tube holder ◆ Dale™ tracheostomy tube holder for neonates/infants	PA	PC				
E1399	DME – miscellaneous ■ See section (4) of this rule for specific criteria for this code. * *See exceptions in section (4)*	PA	PC	RT	16	RP	*
L0999	Addition to spinal orthosis, not otherwise specified	PA	PC				NF
L8239	Elastic support, not otherwise specified	PA	PC				NF

410-122-0200 Pulse Oximeter

(1) Indications and Coverage:

(a) A pulse oximeter may be covered if:

(A) The client has evidence of more than three desaturations below 88% per month, and;

(B) At least one of the following conditions exist:

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

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

(iii) 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;

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

(b) 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;

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

(2) Documentation:

(a) Submit the following documentation for review:

(A) A practitioner order that clearly specifies the medical appropriateness for pulse oximetry testing;

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

(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.

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

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

(d) Continued approval beyond the initial authorization, is based on ongoing review of above documentation including appropriate and 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:

(A) PA required;

(B) The Office of Medical Assistance Programs (OMAP) will purchase.

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

(A) PA required;

(B) OMAP will rent;

(C) OMAP will repair;

(D) Item considered purchased after 16 months of rent;

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

(F) 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

7-1-04

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

(1) Definitions:

(a) 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:

(A) “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.”;

(B) “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.”

(b) Apnea-Hypopnea Index (AHI) – 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.

(2) Indications and Coverage:

(a) Use of a continuous positive airway pressure (CPAP) system is covered for:

(A) Sleep Disordered Breathing – Obstructive apnea, central apnea, mixed apnea, and sleep hypopnea syndrome when the polysomnogram indicates:

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

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

(B) Upper airway resistance syndrome (UARS) when the following criteria are met:

(i) An arousal index > 15, and;

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

(I) Epworth sleepiness scale > 10, or;

(I) History of moderate or severe sleepiness, or;

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

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

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

(3) Documentation:

(a) The following information must be submitted with the initial prior authorization (PA) request 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) Documentation from the treating practitioner that the client is continuing to effectively use the CPAP device must be submitted with the request for PA for purchase after the three-month rental period is completed.

(4) Procedure Codes – Table 122-0202:

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

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

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0601	Continuous airway pressure device (CPAP)	PA	PC	RT	13	RP	NF
Accessories for CPAP							
A7030	Full face mask used with positive airway pressure device, each ■ One per 12 months	PA	PC				NF
A7031	Face mask interface, replacement for full face mask, each ■ One per 12 months	PA	PC				NF
A7032	Replacement cushion for nasal application device, each ■ Two per month	PA	PC				NF
A7033	Replacement pillows for nasal application device, pair ■ Two per month	PA	PC				NF
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head straps ■ One per three months	PA	PC				NF
A7035	Headgear, used with positive airway pressure device ■ One per six months	PA	PC				NF
A7036	Chin strap, used with positive airway pressure device ■ One per six months	PA	PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
A7037	Tubing, used with positive airway pressure device ■ One per one month	PA	PC				NF
A7038	Filter, disposable, used with positive airway pressure device ■ Two per one month	PA	PC				NF
A7039	Filter, non-disposable, used with positive airway pressure device ■ One per six months	PA	PC				NF
A7044	Oral interface used with positive airway pressure device, each	PA	PC				NF
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each	PA	PC		16		NF
E0561	Humidifier, non-heated, used with positive airway pressure device	PA	PC	RT	16	RP	NF
E0562	Humidifier, heated, used with positive airway pressure device	PA	PC	RT	16	RP	NF
S8186	Swivel adapter		PC				NF

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;

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

(b) Oxygen therapy is not covered 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 PO_2 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) Group I – Initial coverage for clients meeting Group I criteria is limited to 12 months or the length of need specified by the prescribing practitioner, whichever is shorter. Coverage criteria includes any of the following:

(a) An arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88% taken at rest (awake), or;

(b) An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during sleep for a client who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake, or;

(c) A decrease in arterial PO_2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5% 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;

(d) An arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken during exercise for a client who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% 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.

(4) Group II – Initial coverage for clients meeting Group II criteria is limited to three months or the length of need specified by the prescribing practitioner, whichever is shorter. Coverage criteria include the presence of:

(a) An arterial PO_2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89% at rest (awake), during sleep, or during exercise (as described under Group 1 criteria), and;

(b) Any of the following:

(A) Dependent edema suggesting congestive heart failure, or;

(B) 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;

(C) Erythrocythemia with a hematocrit greater than 56%.

(5) Group III – Home use of oxygen is presumed not medically appropriate for clients with arterial PO_2 levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.

(6) Blood Gas Study:

(a) The qualifying blood gas study:

(A) 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;

(B) 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;

(C) May be performed while the client is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria;

(b) 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;

(c) For clients initially meeting Group I criteria:

(A) The most recent blood gas study prior to the thirteenth month of therapy must be reported on the Recertification CMN;

(B) 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.

(d) For clients initially meeting Group II criteria:

(A) 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. 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;

(B) 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.

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

(f) 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 PO_2 on the CMN. If the ABG PO_2 result is not a qualifying value, home oxygen therapy is not covered regardless of the oximetry test result;

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

(7) Portable Oxygen Systems:

(a) 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;

(b) If the only qualifying blood gas study was performed during sleep, portable oxygen is not covered;

(c) If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system.

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

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

(10) 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).

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

(12) 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.

(13) Procedure Codes – Table 122-0203.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0203 Oxygen and Oxygen Equipment

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E1390	Oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate, per month ■ All equipment and supplies needed for the operation of the concentrator are included in the rental fee * *Covered if client uses more than 1,000 liters per day*			RT			*
E1391	Oxygen concentrator, dual delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate, per month ■ All equipment and supplies needed for the operation of the concentrator are included in the rental fee * *Covered if client uses more than 1,000 liters per day*			RT			*
Oxygen Enriching Systems							
E1405	Oxygen and water vapor enriching system with heated delivery			RT			NF
E1406	Oxygen and water vapor enriching system without heated delivery			RT			NF
Compressed Gas							
E0424	Stationary compressed gaseous oxygen system, rental, per month			RT			

Code	Description	PA	PC	RT	MR	RP	NF
	■ Includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing						
E0425	Stationary compressed gaseous system purchase ■ Includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing		PC			RP	
E0430	Portable gaseous oxygen system, purchase ■ Includes regulator, flowmeter, humidifier, cannula or mask, and tubing		PC			RP	
E0431	Portable gaseous oxygen system, rental ■ Includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing, per month			RT			
E0441	Oxygen contents, gaseous, (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned) ■ One month supply = one unit		PC				
E0443	Portable oxygen contents, gaseous, (for use only with portable gaseous systems when no stationary gas or liquid system is used) ■ One month supply = one unit		PC				
Liquid Oxygen							
E0434	Portable liquid oxygen system, rental						

Code	Description	PA	PC	RT	MR	RP	NF
	■ Includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing						
E0435	Portable liquid oxygen system, purchase		PC			RP	
	■ Includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor						
E0439	Stationary liquid oxygen system, rental, per month			RT			
	■ Includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing						
E0440	Stationary liquid system, purchase		PC			RP	
	■ Includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing						
E0442	Oxygen contents, liquid, (for use with owned liquid stationary system or when both a stationary and portable liquid system are owned)		PC				
	■ One month supply = one unit						
E0444	Portable oxygen contents, liquid		PC				
	■ For use only with portable liquid systems when no stationary gas or liquid system is used						
	■ One month supply = one unit						

Code	Description	PA	PC	RT	MR	RP	NF
Oxygen Supplies							
E0455	Oxygen tent, excluding croup or pediatric tents, per month			RT			
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		PC	RT	13	RP	
E0555	Humidifier, durable, glass or autoclavable plastic, bottle type ■ For use with regulator or flowmeter ■ Not to be billed in addition to E0424, E0431, E0434, E0439, E0450, E0455, E0460, E1400, E1401, E1402, E1403, E1404, E1405, or E1406		PC				
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery ■ Not to be billed in addition to E0424, E0431, E0434, E0439, E0450, E0455, E0460, E1400, E1401, E1402, E1403, E1404, E1405, or E1406		PC	RT	16	RP	
E0605	Vaporizer, room type		PC				
E1353	Regulator (yoke or other)		PC			RP	
E1355	Stand/rack for oxygen tank		PC				

410-122-0204 Nebulizer

Table 122-0204

Stat.Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0204 Nebulizer

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4619	Face Tent		PC				
A7003	Administration set, with small volume non-filtered pneumatic nebulizer, disposable ■ Includes lid, jar and baffles, tubing, T-piece and mouth piece		PC				
A7004	Small volume non-filtered pneumatic nebulizer, disposable ■ Includes lid, jar and baffles		PC				
A7005	Administration set, with small volume non-filtered pneumatic nebulizer, non-disposable ■ Includes lid, jar and baffles, tubing, T-piece and mouth piece		PC				
A7006	Administration set, with small volume filtered pneumatic nebulizer ■ Includes lid, jar and baffles, tubing, T-piece, mouth piece, and filter		PC				
A7010	Corrugated tubing, disposable, used with large volume nebulizer (1 unit of service = 100 feet)		PC				
A7011	Corrugated tubing, non-disposable, used with large volume nebulizer (1 unit of service = 10 feet)		PC				
A7012	Water collection device, used with large volume nebulizer		PC				
A7013	Filter, disposable, used with aerosol compressor		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A7014	Filter, non-disposable, used with aerosol compressor or ultrasonic generator		PC				
A7015	Aerosol mask, used with DME nebulizer		PC				
A7016	Dome and mouthpiece, used with small volume ultrasonic nebulizer		PC				
A7017	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen		PC				
A7018	Water, distilled, used with large volume nebulizer (1 unit of service = 1,000 ml) ■ Not separately payable or billable with rented oxygen		PC				
A7020	Sterile water or sterile saline, 1,000 ml, used with large volume nebulizer ■ Not separately payable or billable with rented oxygen		PC				
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		PC	RT	13	RP	
E0570	Nebulizer, with compressor		PC	RT	13	RP	
E0571	Aerosol compressor, battery powered, for use with small volume nebulizer		PC		13		

Code	Description	PA	PC	RT	MR	RP	NF
	■ 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.						
E0572	Aerosol compressor, adjustable pressure, light duty for intermittent use		PC		13		
	■ 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.						
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter		PC				
E0585	Nebulizer, with compressor and heater		PC	RT	13	RP	
E1372	Immersion external heater for nebulizer		PC	RT	16	RP	
	■ Not covered with E0585						

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

(4) Documentation:

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

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

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

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

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

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

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

(b) A copy of the Evaluation of Respiratory Assist Device (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;

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0205-1 Respiratory Assist Devices

Coverage criteria for E0470 and E0471 devices – First three months

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

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

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

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

- There is documentation in the client's medical record of a progressive neuromuscular disease (for example, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB), and
- An arterial blood gas $PaCO_2$, done while awake and breathing the client's usual FIO_2, is >= 45 mm Hg, or
- Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the client's usual FIO_2
- For progressive neuromuscular disease (only), maximal inspiratory pressures less than 60 cm/H_2O or forced vital capacity is less than 50% predicted, and
- Chronic obstructive pulmonary disease does not contribute significantly to the client's pulmonary limitation
- If all above criteria are met, either 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.

Severe Chronic Obstructive Pulmonary Disease (COPD)

- An arterial blood gas $PaCO_2$, done while awake and breathing the client's usual FIO_2, is >= 52 mm Hg, and
- Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the client's usual FIO_2 (whichever is higher), and
- Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out
- If all of the above criteria for clients with COPD are met, 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
- If the above criteria are not met, then E0470 and E0471 are not covered

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

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

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

Obstructive Sleep Apnea (OSA) – E0470 only

- A complete facility-based, attended polysomnogram, has established the diagnosis of obstructive sleep apnea, and
- A single level device (E0601, Continuous Positive Airway Pressure Device (CPAP)) has been tried and proven ineffective
- 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
- A E0471 device is not medically appropriate if the primary diagnosis is OSA

Continued coverage beyond the first three months of therapy

Clients covered for the first 3 months of 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.

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

- A signed and dated statement completed by the treating prescribing practitioner no sooner than 61 days after initiating use of the device, declaring that the client is compliantly using the device (an average of 4 hours per 24 hour period) and that the client is benefiting from its use, and
- An Evaluation of Respiratory Assist Device (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.

- 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.
- 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:
  - An arterial blood gas $PaCO_2$, repeated no sooner than 61 days after initiation of compliant use of the E0470, done while awake and breathing the client's usual FIO_2, still remains >= 52 mm Hg, and
  - A sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of 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 FIO_2 (whichever is higher), and
  - A signed and dated statement from the treating prescribing practitioner, completed no sooner than 61 days after initiation of the E0470 device, declaring that the client has been compliantly using the E0470 device (an average of four hours per 24 hour period) but that the client is NOT benefiting from its use, and
  - An Evaluation of Respiratory Assist Device (OMAP 2461) completed by the client, no sooner than 61 days after initiation of the E0470 device.

Coding Guidelines

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.

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.

Table 122-0205-2 Respiratory Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A7030	Full face mask used with positive airway pressure device, each ■ One per 12 months	PA	PC				NF
A7031	Face mask interface, replacement for full face mask, each ■ One per 12 months	PA	PC				NF
A7032	Replacement cushion for nasal application device, each ■ Two per month	PA	PC				NF
A7033	Replacement cushion for nasal application device, pair ■ Not separately covered with E0471	PA	PC				NF
A7034	Nasal application device, used with positive airway pressure devise ■ One per 3 months	PA	PC				NF
A7035	Headgear, used with positive airway pressure device ■ One per 6 months	PA	PC				NF
A7036	Chin strap, used with positive airway pressure device ■ One per 6 months	PA	PC				NF
A7037	Tubing, used with positive airway pressure device ■ One per 1 month	PA	PC				NF
A7038	Filter, disposable, used with positive airway pressure device	PA	PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
	■ 2 per 1 month						
A7039	Filter, non-disposable, used with positive airway pressure device ■ 1 per 6 months	PA	PC				NF
A7044	Oral, interface used with positive airway pressure device, each ■ 1 per 6 months	PA	PC				NF
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each ■ 1 per 6 months	PA	PC				NF
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with non-invasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) ■ All respiratory therapy services needed are included in the fee	PA	PC	RT	13	RP	NF
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with non-invasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) ■ The rental fee includes all equipment, supplies, services (including respiratory therapy services) and training necessary for the effective use of the RAD	PA		RT			NF
E0561	Humidifier, non-heated, used with positive airway pressure device	PA	PC	RT	16	RP	NF

Code	Description	PA	PC	RT	MR	RP	NF
E0562	Humidifier, heated, used with positive airway pressure device	PA	PC	RT	16	RP	NF
S8186	Swivel adapter		PC				NF

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

E0500, IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source the 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 (COPD) who fail to respond to standard therapy.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

410-122-0207 Respiratory Supplies

Table 122-0207

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0207 Respiratory Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4608	Transtracheal oxygen catheter, each		PC				
A4614	Peak expiratory flow meter, hand-held		PC				
A4615	Cannula, nasal		PC				
A4616	Tubing (oxygen), per foot		PC				
A4617	Mouthpiece		PC				
A4620	Variable concentration mask		PC				
A4627	Spacer, bag or reservoir, with/without mask, for use with metered dose inhaler		PC				
A4712	Water, sterile, for injection, per 10 ml		PC				
E0480	Percussor, electric or pneumatic, home model ■ Covered for mobilizing respiratory tract secretions when the client or the operator of the powered percussor has received appropriate training by a prescribing practitioner or therapist and no one competent to administer manual therapy is available		PC	RT	13	RP	
E0606	Postural drainage board		PC	RT	13	RP	
J7051	Sterile saline or water, up to 5 ml each		PC				
S8185	Flutter device		PC				

410-122-0208 Suction Pumps

(1) 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) Table 122-0208.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0208 Suction Pumps

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
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		PC				
A4609	Tracheal suction catheter, closed system, for less than 72 hours of use, each		PC				
A4610	Tracheal suction catheter, closed suction, for 72 or more hours of use, each		PC				
A4624	Tracheal suction catheter, any type, other than closed system, each		PC				
A4628	Oropharyngeal suction catheter, each		PC				
A7000	Canister, disposable, used with suction pump, each		PC				
A7001	Canister, non-disposable, used with suction pump, each		PC				
A7002	Tubing, used with suction pump, each		PC				
E0600	Respiratory suction pump, home model, portable or stationary, electric * Covered when the client is permanently on one of the following: ◆ A volume ventilator		PC	RT	13	RP	*

Code	Description	PA	PC	RT	MR	RP	NF
	◆ Chest shell ◆ Chest wrap, or ◆ Negative pressure ventilator						
E2000	Gastric suction pump, home model, portable or stationary, electric		PC	RT	16		

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 – Table 122-0209.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0209 Tracheostomy Care Supplies

For the code legend see OAR 410-122-cccc

Code	Description	PA	PC	RT	MR	RP	NF
A4481	Tracheostomy filter, any type, any size, each		PC				NF
A4483	Moisture exchanger, disposable		PC				NF
A4623	Tracheostomy, inner cannula		PC				NF
A4625	Tracheostomy care kit for new tracheostomy ■ Contains one plastic tray, one basin, one pair of sterile gloves, tube brush, three pipe cleaners, one pre-cut tracheostomy dressing, one roll of gauze, four 4x4 sponges, two cotton tip applicators, 30” twill tape ■ One tracheostomy care kit per day is covered for two weeks following an open surgical tracheostomy		PC				NF
A4626	Tracheostomy cleaning brush, each		PC				NF
A4629	Tracheostomy care kit for established tracheostomy ■ Contains one tube brush, two pipe cleaners, two cotton tip applicators, 30” twill tape, two 4x4 sponges ■ One tracheostomy care kit per day is considered necessary for routine care of a tracheostomy, starting with post-operative day 15		PC				NF
A7501	Tracheostoma valve, including diaphragm, each		PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
A7502	Replacement diaphragm/faceplate for tracheostoma valve, each		PC				NF
A7503	Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each		PC				NF
A7504	Filter for use in a tracheostoma heat and moisture exchange system, each		PC				NF
A7505	Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each		PC				NF
A7506	Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type, each		PC				NF
A7507	Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each		PC				NF
A7508	Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each		PC				NF
A7509	Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each		PC				NF
A7520	Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each		PC				NF
A7521	Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each		PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
A7522	Trachestomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each		PC				NF
A7524	Tracheostoma stent/stud/button, each		PC				NF
A7525	Tracheostomy mask, each		PC				NF
A7526	Tracheostomy tube/collar, each		PC				NF
S8189	Tracheostomy supply, not otherwise classified	PA	PC				NF

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

7-1-04

Table 122-0210 Ventilators

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4611	Battery, heavy duty; replacement for client-owned ventilator		PC				NF
A4612	Battery, cables; replacement for client-owned ventilator		PC				NF
A4613	Battery charger; replacement for client-owned ventilator		PC			RP	NF
A4618	Breathing circuits, for client-owned ventilator		PC				NF
E0450	Volume ventilator; stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube)	PA		RT			NF
E0454	Pressure ventilator with pressure control, pressure support and flow triggering features	PA		RT			NF
E0461	Volume ventilator, stationary or portable, with back-up rate feature used with non-invasive interface	PA		RT			NF
E0457	Chest shell (cuirass)	PA	PC	RT	16	RP	NF
E0459	Chest wrap	PA	PC	RT	13	RP	NF
E0460	Negative pressure ventilator; portable or stationary	PA		RT			NF
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous position airway pressure device)	PA		RT			NF

Code	Description	PA	PC	RT	MR	RP	NF
S8999	Resuscitation bag		PC				NF

410-122-0220 Pacemaker Monitor

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

(a) The Office of Medical Assistance Programs (OMAP) will purchase;

(b) 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:

(a) OMAP will purchase;

(b) 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

7-1-04

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 122-0240.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0240 APNEA Monitor

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4556	Electrodes (e.g., apnea monitor) per pair	PA	PC				
A4557	Lead wires (e.g., apnea monitor) per pair	PA	PC				
A4558	Conductive paste or gel	PA	PC				
E0619	Apnea Monitor with recording feature	PA		RT			
E0618	Apnea monitor without recording feature ■ Includes client cable	PA		RT			

410-122-0250 Breast Pumps

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

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

(b) Medical appropriateness for infant:

(A) Pre-term; or

(B) Term and hospitalized beyond five days; or

(C) Cleft palate or cleft lip; or

(D) Cranial-facial abnormalities; or

(E) Unable to suck adequately; or

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

(G) Failure to thrive.

(c) Medical appropriateness for mother:

(A) Has breast abscess; or

(B) Mastitis; or

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

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

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

(2) Other information:

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

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

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

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

(e) Rental will not exceed 60 days;

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

(3) Procedure Codes:

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

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

(A) OMAP will rent;

(B) Prior authorization required by OMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

410-122-0255 External Breast Prostheses

(1) Indications and Coverage:

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

(b) Useful lifetime expectancy:

(A) For silicon breast prosthesis two years;

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

(2) Procedure Codes: Table 122-0255.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0255 External Breast Prostheses

For the code legend see OAR 410-122-0182

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

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

410-122-0260 Home Uterine Monitoring

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

(a) Pre-term labor – this pregnancy:

(A) Incompetent cervix;

(B) Cervical cerclage;

(C) Polyhydramnios;

(D) Anomalies of the uterus;

(E) Cone biopsy;

(F) Cervical dilation or effacement;

(G) Unknown etiology.

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

(c) Multiple gestation.

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

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

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

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

(a) Prior Authorization (PA) required;

(b) OMAP will rent.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

410-122-0280 Heating/Cooling Accessories

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0280 Heating/Cooling Accessories

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4265	Paraffin, per pound		PC				
E0200	Heat lamp without stand (table model) includes bulb or infrared element		PC	RT	16		
E0205	with stand		PC	RT	16		
E0210	Electric heat pad – standard		PC				
E0215	moist		PC				
E0217	Water circulating heat pad with pump		PC	RT	16	RP	
E0220	Hot water bottle		PC				
E0230	Ice cap or collar		PC				
E0235	Paraffin bath unit portable (without paraffin)		PC	RT	16	RP	
E0236	Pump for water circulating pad		PC	RT	16	RP	
E0238	non-electric		PC				
E0249	Pad for water circulating heat unit		PC				

410-122-0300 Light Therapy

Table 122-0300

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0300 Light Therapy

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4633	Replacement bulb/lamp for ultraviolet light therapy system, each		PC				
E0691	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less	PA	PC	RT	16	RP	
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel	PA	PC	RT	16	RP	
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel	PA	PC	RT	16	RP	
E0694	Ultraviolet multi-directional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection	PA	PC	RT	16	RP	
S9098	Home visit, phototherapy services (e.g., bili-lite), including equipment rental, nursing services blood draw, supplies, and other services, per diem, per day			RT			

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) The client's living quarters must be able to accommodate the requested wheelchair. OMAP will not be responsible for adapting living quarters;

(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:

(A) All labor charges involved in the assembly and delivery, and;

(B) All adjustments for three months after the date delivered, and;

(C) Emergency services, education and on-going assistance with use of the wheelchair for three months after date delivered.

(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, armrests, legrests and/or headrests, 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.

(D) 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: Table 122-0320.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0320 Manual Wheelchair Base

For the code legend see OAR 410-122-0182

* *Covered when nursing facility criteria found in section (1) of this rule is met*

Code	Description	PA	PC	RT	MR	RP	NF
E1161	Manual adult size wheelchair, includes tilt-in-space Clients must meet the criteria for a wheelchair (manual or powered), plus the following: ■ Dependent for transfers, and ■ Spends a minimum of four hours a day continuously in a wheelchair, and ■ 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 ■ One of the following: ◆ High risk of skin breakdown ◆ Poor postural control, especially of the head and trunk ◆ Hyper/hypotonia ◆ Requires frequent change of position with poor upright sitting Documentation must support the criteria required for this code.	PA	PC	RT	16	RP	*

** Covered when nursing facility criteria found in section (1) of this rule is met*

Code	Description	PA	PC	RT	MR	RP	NF
K0001	Standard wheelchair ■ 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 swing-away detachable	PA	PC	RT	13	RP	*
K0002	Standard hemi (low seat) wheelchair ■ 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 swing-away detachable ■ 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	PA	PC	RT	13	RP	*
K0003	Light-weight wheelchair ■ 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 swing-away detachable	PA	PC	RT	13	RP	*

Code	Description	PA	PC	RT	MR	RP	NF
	■ 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 light-weight wheelchair						
K0004	High strength, light-weight wheelchair	PA	PC	RT	13	RP	*
	■ 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 swing-away detachable						
	■ Covered when a client:						
	◆ Self-propels the wheelchair while engaging in frequent activities that cannot functionally be performed in a standard or light-weight wheelchair, or						
	◆ The activities may cause permanent damage to a standard or light-weight chair, or						
	◆ When a client requires a seat width, depth or height that cannot be accommodated in a standard, light-weight or hemi-wheelchair, and spends at least two hours per day in the wheelchair						

** Covered when nursing facility criteria found in section (1) of this rule is met*

Code	Description	PA	PC	RT	MR	RP	NF
K0005	Ultra-light-weight wheelchair ■ 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 swing-away detachable	PA	PC	RT	16	RP	*
K0006	Heavy-duty wheelchair ■ 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 swing-away detachable ■ Reinforced back and seat upholstery ■ Can support client weighing >250 pounds or the client has severe spasticity ■ 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)	PA	PC	RT	13	RP	*
K0007	Extra heavy-duty wheelchair	PA	PC	RT	13	RP	*

** Covered when nursing facility criteria found in section (1) of this rule is met*

Code	Description	PA	PC	RT	MR	RP	NF
	■ 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 swing-away detachable ■ Reinforced back and seat upholstery ■ Can support client weighing >300 pounds ■ 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)						
K0009	Other manual wheelchair/base	PA	PC	RT	16	RP	

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) Table 122-0325.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0325 Motorized/Power Wheelchair Base

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
K0010	Standard-weight frame motorized/power wheelchair ■ 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 swing-away detachable	PA	PC	RT	13	RP	
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking ■ 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 swing-away detachable	PA	PC	RT	13	RP	
K0012	Light-weight portable motorized/power wheelchair ■ 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 swing-away detachable ■ Weight < 80 lbs without battery	PA	PC	RT	13	RP	

Code	Description	PA	PC	RT	MR	RP	NF
	■ Folding back or collapsible frame						
K0014	Other motorized/power wheelchair base	PA	PC	RT	16	RP	
	■ Use in addition to K0108 for power recline or tilt-in space						
	■ Use for pediatric motorized/power wheelchair base						

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. If 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:

(i) Would be bed confined or confined to a non-mobile chair without the use of a POV;

(ii) Is unable to operate a manual wheelchair;

(iii) Is capable of safely operating the controls for the POV;

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

(v) Must be able to accommodate the requested POV inside their living quarters. The Office of Medical Assistance Programs (OMAP) will not be responsible for adapting living quarters.

(C) The cost of the POV includes all options and accessories that are provided at the time of initial purchase, including but not limited to batteries, battery chargers, seating systems, etc.

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

(c) 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;

(d) Only one wheelchair or POV will be rented or purchased to meet the medical need. OMAP will not pay for backup chairs.

(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 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider;

(b) Submit list of all DMEPOS 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;

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

(E) Physical limitations should be objective and quantitative;

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

(3) E1230 – Power operated vehicle (3 or 4 wheel non-highway):

(a) PA required;

(b) OMAP will purchase, rent and repair;

(c) Item considered purchased after 16 months of rent;

(d) Initial batteries and battery charger are included in the cost.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

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 – Adjustable height armrests are covered if the client:

(a) Requires an arm height that is different than what is available using non-adjustable arms, and;

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

(4) 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.

(5) Batteries/chargers for motorized/power wheelchairs are separately payable from the purchased wheelchair base.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0340 Wheelchair Options/Accessories

For the code legend see OAR 410-122-0182

* *Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
Arm of Chair							
E0973	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each		PC	RT	16	RP	*
K0015	Detachable, non-adjustable height armrest, each		PC	RT	16	RP	*
K0017	Detachable, adjustable height armrest, base, each		PC	RT	16	RP	*
K0018	Detachable, adjustable height armrest, upper portion, each		PC	RT	16	RP	*
K0019	Arm pad, each		PC	RT	16	RP	*
K0020	Fixed, adjustable height armrest, pair		PC	RT	16	RP	*
K0106	Arm trough, each		PC	RT	16	RP	*
Back of Chair							
E0966	Manual wheelchair accessory, headrest extension, each	PA	PC	RT	16	RP	*
E0971	Anti-tipping device, wheelchair		PC	RT	16	RP	*
E0974	Manual wheelchair accessory, anti-rollback device, each		PC	RT	16	RP	*
E0982	Wheelchair accessory, back upholstery, replacement only, each ■ Included in the allowance for a heavy-duty or extra-heavy-duty wheelchair		PC	RT	16	RP	*

Code	Description	PA	PC	RT	MR	RP	NF
	■ Not medically appropriate if used in conjunction with other manual wheelchair bases ■ Covered if used with a power wheelchair base and the client weighs more than 200 pounds						
E1226	Manual wheelchair accessory, fully reclining back, each ■ Covered if the client spends at least two hours per day in the wheelchair and has one or more of the following conditions/needs: ◆ Quadriplegia ◆ Fixed hip angle ◆ Trunk or lower extremity casts/braces that require the reclining back feature for positioning ◆ Excess extensor tone of the trunk muscles ◆ Client needs to rest in a recumbent position two or more times during the day and transfer between wheelchair and bed is very difficult ■ Use for fully reclining back which is manually operated		PC	RT	16	RP	NF
K0023	Solid back insert, planar back, single density foam, attached with straps ■ A prefabricated back seating module which is incorporated into a wheelchair base		PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
K0024	Solid back insert, planar back, single density foam, with adjustable hook-on hardware ■ A prefabricated back seating module which is incorporated into a wheelchair base		PC	RT	16	RP	*
Seating Systems							
K0115	Seating systems, back module, posterior-lateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base		PC				NF
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		PC				NF
Seat							
E0962	1” cushion, for wheelchair, any type		PC				
E0963	2” cushion, for wheelchair, any type		PC				
E0964	3” cushion, for wheelchair, any type		PC				
E0965	4” cushion, for wheelchair, any type		PC				
E0981	Wheelchair accessory, seat upholstery, replacement only, each		PC	RT	16	RP	*
E0985	Wheelchair accessory, seat lift mechanism	PA	PC	RT	16	RP	*
E0992	Manual wheelchair accessory, solid seat insert ■ Includes hardware		PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
	■ Covered when the client spends at least two hours per day in the wheelchair						
E2201	Manual wheelchair accessory, non-standard seat frame, width greater than or equal to 20 inches and less than 24 inches		PC	RT	16	RP	*
E2202	Manual wheelchair accessory, non-standard seat frame width, 24-27 inches		PC	RT	16	RP	*
E2203	Manual wheelchair accessory, non-standard seat frame depth, 20 to less than 22 inches		PC	RT	16	RP	*
E2204	Manual wheelchair accessory, non-standard seat frame depth, 22 to 25 inches		PC	RT	16	RP	*
E2340	Power wheelchair accessory, non-standard seat frame width, 20-23 inches		PC	RT	16	RP	*
E2341	Power wheelchair accessory, non-standard seat frame width, 24-27 inches		PC	RT	16	RP	*
E2342	Power wheelchair accessory, non-standard seat frame depth, 20 or 21 inches		PC	RT	16	RP	*
E2343	Power wheelchair accessory, non-standard seat frame depth, 22-25 inches		PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
K0056	Seat height < 17” or > 21” for a high strength, lightweight or ultra-lightweight wheelchair ■ 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		PC	RT	16	RP	*
Footrest/Legrest							
E0951	Heel loop/holder, with or without ankle strap, each		PC	RT	16	RP	*
E0952	Toe loop/holder, each		PC	RT	16	RP	*
E0990	Wheelchair accessory, elevating legrest, complete assembly, each ■ 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, and ◆ Significant edema of the lower extremities that requires having an elevating leg rest or criteria for a reclining back option are met, and ◆ A wheelchair with a reclining back.		PC	RT	16	RP	*
E0995	Wheelchair accessory, calf rest/pad, each		PC	RT	16	RP	*
E1020	Residual limb support system for wheelchair		PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
K0037	High mount flip-up footrest, each		PC	RT	16	RP	*
K0038	Leg strap, each		PC	RT	16	RP	*
K0039	Leg strap, H style, each		PC	RT	16	RP	*
K0040	Adjustable angle foot-plate, each		PC	RT	16	RP	*
K0041	Large size foot-plate, each		PC	RT	16	RP	*
K0042	Standard size foot-plate, each		PC	RT	16	RP	*
K0043	Footrest, lower extension tube, each		PC	RT	16	RP	*
K0044	Footrest, upper hanger bracket, each		PC	RT	16	RP	*
K0045	Footrest, complete assembly		PC	RT	16	RP	*
K0046	Elevating leg rest, lower extension tube, each ■ Covered if the client has: ◆ A musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee ◆ Significant edema of the lower extremities that requires having an elevating leg rest, or criteria for a reclining back option are met, and ◆ A wheelchair with a reclining back		PC	RT	16	RP	*
K0047	Elevating leg rest, upper hanger bracket, each ■ Covered if the client has: ◆ A musculoskeletal condition or the presence of a cast or brace		PC	RT	16	RP	*

Code	Description	PA	PC	RT	MR	RP	NF
	which prevents 90 degree flexion at the knee ◆ Significant edema of the lower extremities that requires having an elevating leg rest, or criteria for a reclining back option are met, and ◆ A wheelchair with a reclining back						
K0050	Ratchet assembly		PC	RT	16	RP	*
K0051	Cam release assembly, footrest or leg rest, each		PC	RT	16	RP	*
K0052	Swing-away, detachable footrests, each, replacement ■ Included in allowance for the wheelchair base		PC	RT	16	RP	*
K0053	Elevating footrests, articulating (telescoping), each ■ Covered if the client has: ◆ A musculoskeletal condition, or the presence of a cast or brace which prevents 90 degree flexion at the knee, and ◆ Significant edema of the lower extremities that requires having an elevating leg rest, or criteria for a reclining back option are met.		PC	RT	16	RP	*
K0195	Elevating leg rests, pair (for use with capped rental wheelchair base) ■ Covered if the client has:			RT			*

Code	Description	PA	PC	RT	MR	RP	NF
	◆ A musculoskeletal condition, or the presence of a cast or brace, which prevents 90 degree flexion at the knee						
	◆ Significant edema of the lower extremities that requires having an elevating leg rest, or criteria for a reclining back option are met						
Hand Rims Without Projections							
K0059	Plastic coated hand rim, each		PC	RT	16	RP	*
K0060	Steel hand rim, each		PC	RT	16	RP	*
K0061	Aluminum hand rim, each		PC	RT	16	RP	*
Hand Rims With Projections							
E0967	Manual wheelchair accessory, hand rim with projections, each		PC	RT	16	RP	*
Rear Wheels							
K0064	Zero pressure tube (flat free inserts), any size, each		PC	RT	16	RP	*
K0065	Spoke protectors, each		PC	RT	16	RP	*
K0066	Solid tire, any size, each		PC	RT	16	RP	*
K0067	Pneumatic tire, any size, each		PC	RT	16	RP	*
	■ If both a pneumatic tire and pneumatic tire tube are provided on the same date, bill both K0067 and K0068						
K0068	Pneumatic tire tube, each		PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
	■ If both a pneumatic tire and pneumatic tire tube are provided on the same date, bill both K0067 and K0068						
K0069	Rear wheel assembly, complete, with solid tire, spokes or molded, each		PC	RT	16	RP	*
K0070	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each		PC	RT	16	RP	*
Front Casters							
K0071	Front caster assembly, complete, with pneumatic tire, each		PC	RT	16	RP	*
K0072	Front caster assembly, complete, with semi-pneumatic tire, each		PC	RT	16	RP	*
K0073	Caster pin lock, each		PC	RT	16	RP	*
K0074	Pneumatic caster tire, any size, each		PC	RT	16	RP	*
K0075	Semi-pneumatic caster tire, any size, each		PC	RT	16	RP	*
K0076	Solid caster tire, any size, each		PC	RT	16	RP	*
K0077	Front caster assembly, complete, with solid tire, each		PC	RT	16	RP	*
K0078	Pneumatic caster tire tube, each		PC	RT	16	RP	*
Wheel Lock							
E0961	Manual wheelchair accessory, wheel lock brake extension (handle), each		PC	RT	16	RP	*
E0974	Manual wheelchair accessory, anti-rollback device, each		PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
	■ Covered if the client is able to propel self and needs the device because of ramps						
K0081	Wheel lock assembly, complete, each		PC	RT	16	RP	*
Batteries/Chargers for Motorized/Power Wheelchair							
E2360	Power wheelchair accessory, 22 NF non-sealed lead acid battery, each		PC				*
E2361	Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)		PC				*
E2362	Power wheelchair accessory, Group 24 non-sealed lead acid battery, each		PC				*
E2363	Power wheelchair accessory, Group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)		PC				*
E2364	Power wheelchair accessory, U-1 non-sealed lead acid battery, each		PC				*
E2365	Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)		PC				*
E2366	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each		PC	RT	16	RP	*
	■ Covered if criteria for a power wheelchair are met						
	■ There will be no additional allowance if a dual mode charger is used						

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
	■ A battery charger is included in the allowance for a power wheelchair base (K0010-K0014) ■ A battery charger should be billed separately only when it is a replacement						
Motorized/Power Wheelchair Parts							
E1002	Wheelchair accessory, power seating system, tilt only	PA	PC	RT	16	RP	*
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction	PA	PC	RT	16	RP	*
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	PA	PC	RT	16	RP	*
E1005	Wheelchair accessory, power seating system, recline only, with power shear reduction	PA	PC	RT	16	RP	*
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	PA	PC	RT	16	RP	*
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	PA	PC	RT	16	RP	*
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	PA	PC	RT	16	RP	*
E1010	Wheelchair accessory, addition to power seating system, power leg elevation system, each ■ Including leg rest	PA	PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
E2320	Power wheelchair accessory, hand or chin control interface, remote joystick or touchpad, proportional ■ Including all related electronics, and fixed mounting hardware	PA	PC	RT	16	RP	*
E2321	Power wheelchair accessory, hand control interface, remote joystick, non-proportional ■ Including all related electronics, mechanical stop switch, and fixed mounting hardware	PA	PC	RT	16	RP	*
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, non-proportional ■ Including all related electronics, mechanical stop switch, and fixed mounting hardware	PA	PC	RT	16	RP	*
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, pre-fabricated		PC	RT	16	RP	*
E2324	Power wheelchair accessory, chin cup for chin control interface		PC	RT	16	RP	*
E2325	Power wheelchair accessory, sip and puff interface, non-proportional ■ Including all related electronics, mechanical stop switch, and manual swing-away mounting hardware	PA	PC	RT	16	RP	*
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	PA	PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
E2327	Power wheelchair accessory, head control interface, mechanical, proportional ■ Including all related electronics, mechanical direction change switch, and fixed mounting hardware	PA	PC	RT	16	RP	*
E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional ■ Including all related electronics and fixed mounting hardware	PA	PC	RT	16	RP	*
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, non-proportional ■ Including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	PA	PC	RT	16	RP	*
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, non-proportional ■ Including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	PA	PC	RT	16	RP	*
K0090	Rear wheel tire for power wheelchair, any size, each		PC	RT	16	RP	*
K0091	Rear wheel tire tube other than zero pressure for power wheelchair, any size, each		PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
K0092	Rear wheel assembly for power wheelchair, complete, each		PC	RT	16	RP	*
K0093	Rear wheel zero pressure tire tube (flat free insert) for power wheelchair, any size, each		PC	RT	16	RP	*
K0094	Wheel tire for power base, any size, each		PC	RT	16	RP	*
K0095	Wheel tire tube other than zero pressure for each base, any size, each		PC	RT	16	RP	*
K0096	Wheel assembly for power base, complete, each		PC	RT	16	RP	*
K0097	Wheel zero pressure tire tube (flat free insert) for power base, any size, each		PC	RT	16	RP	*
K0098	Drive belt for power wheelchair		PC	RT	16	RP	*
K0099	Front caster for power wheelchair, each		PC	RT	16	RP	*
Shock Absorbers							
E1015	Shock absorber for manual wheelchair, each	PA	PC	RT	16	RP	*
E1016	Shock absorber for power wheelchair, each	PA	PC	RT	16	RP	*
E1017	Heavy-duty shock absorber for heavy-duty or extra heavy-duty manual wheelchair, each	PA	PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
E1018	Heavy-duty shock absorber for heavy-duty or extra heavy-duty power wheelchair	PA	PC	RT	16	RP	*
Miscellaneous Accessories							
E0950	Wheelchair accessory, tray, each		PC	RT		RP	*
E0955	Wheelchair accessory, headrest, cushioned, prefabricated, including fixed mounting hardware, each		PC	RT		RP	*
E0956	Wheelchair accessory, lateral trunk or hip support, prefabricated, including fixed mounting hardware, each		PC	RT		RP	*
E0957	Wheelchair accessory, medial thigh support, prefabricated, including fixed mounting hardware, each		PC	RT		RP	*
E0958	Manual wheelchair accessory, one-arm drive attachment, each ■ Covered if the client propels the chair himself/herself with only one hand and the need is expected to last at least six months		PC	RT	16	RP	*
E0959	Manual wheelchair accessory, each, adapter for amputee, each		PC	RT	16	RP	*
E0960	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware		PC	RT	16	RP	*
E0972	Wheelchair accessory, transfer board or device, each		PC	RT	16	RP	*
E0978	Wheelchair accessory, safety belt/pelvic strap, each		PC	RT	16	RP	*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
E0983	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control		PC	RT	13	RP	*
E0984	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control		PC	RT	16	RP	*
E0986	Manual wheelchair accessory, push-rim activated power assist	PA	PC	RT	16	RP	*
E1028	Wheelchair accessory, manual swing-away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory		PC	RT	16	RP	*
E1029	Wheelchair accessory, ventilator tray, fixed		PC	RT	16	RP	*
E1030	Wheelchair accessory, ventilator tray, gimbaled	PA	PC	RT	16	RP	*
K0104	Cylinder tank carrier, each		PC	RT	16	RP	*
K0105	IV hanger, each		PC	RT	16	RP	*
K0108	Wheelchair component or accessory, not otherwise specified ■ Each item requested must be itemized with a clear description of item, manufacturer, model name number, Manufacturer's Suggested Retail Price (MSRP) and price	PA	PC	RT	16	RP	*

Code	Description	PA	PC	RT	MR	RP	NF
	■ 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 ■ Used for but not limited to: ◆ Non-standard seat dimensions that do not fall under specific codes ◆ Accessories or options for a new wheelchair and replacement parts for a wheelchair being repaired ◆ Thigh abduction pommels ◆ Seat backs or cushions that do not fall under specific codes ◆ Non-joystick control devices ◆ Upgraded electronics ◆ Custom fabricated seat component when billing for a two-piece seating system (use K0115 for the custom fabricated back component) ◆ Non-standard seat height that does not fall under specific codes, (e.g., 16" height) ◆ Roho mini max for wheelchair back						
K0452	Wheelchair bearings, any type		PC				*

** Covered when supplied for client-owned wheelchair*

Code	Description	PA	PC	RT	MR	RP	NF
Pressure Pads							
E0176	Air pressure pad or cushion, non-positioning	PA	PC				NF
E0178	Gel or gel-like pressure pad or cushion, non-positioning	PA	PC				NF
E0179	Dry pressure pad or cushion, non-positioning		PC				
E0192	Low pressure and positioning equalization pad for wheelchair	PA	PC			RP	NF

410-122-0360 Canes and Crutches

(1) Indications and Coverage: When prescribed by a practitioner for a client with a condition causing impaired ambulation and there is a potential for ambulation.

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

(3) Table 122-0360.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0360 Canes and Crutches

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
Canes							
A4636	Replacement, handgrip, cane, crutch or walker, each		PC				
A4637	Replacement, tip, cane, crutch, walker, each		PC				
E0100	Cane, includes canes of all materials, adjustable or fixed, with tips		PC				
E0105	Quad or three prong, includes canes of all materials, adjustable or fixed, with tips		PC	RT	16		
Crutches							
A4635	Underarm pad, crutch, replacement, each		PC				
A4636	Replacement, handgrip, cane, crutch or walker, each		PC				
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips		PC	RT	16	RP	
E0111	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips		PC	RT	16	RP	
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips		PC	RT	16		
E0113	Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip		PC	RT	16		

Code	Description	PA	PC	RT	MR	RP	NF
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips		PC	RT	16	RP	
E0116	Crutch, underarm, other than wood, adjustable or fixed, each, with pad, tip and handgrip		PC	RT	16	RP	
E0117	Crutch, underarm, articulating, spring assisted, each		PC	RT	16	RP	
E0153	Platform attachment, forearm, crutch, each		PC	RT	16	RP	

410-122-0365 Standing and Positioning Aids

(1) Indications and coverage: If a client has one aid that meets his/her medical needs, regardless of who obtained it, the 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) The prescription;

(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;

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

(3) Gait Belts:

(a) Covered when:

(A) The client weighs 60 lbs. or more, and;

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

(C) The client can walk independently, but needs:

(i) A minor correction of ambulation, or;

(ii) Needs minimal or standby assistance to walk alone, or;

(iii) Requires assistance with transfer.

(b) Use code E1399.

(4) Coverage criteria for standing frame systems, prone standers, supine standers or boards and accessories for standing frames:

(a) The client must be sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit;

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

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

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

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

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

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

(h) The client does not have access to equipment from another source.

(5) The following must be met in addition to the criteria listed for sidelyers and custom positioners:

(a) The client must be sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit;

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

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

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

(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.

(7) Procedure Codes – Table 122-0365:

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0365 Standing and Positioning Aids

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0638	Standing frame system, any size, with or without wheels ■ Must meet the criteria listed in section (4) of this rule ■ Not covered for electric mobility option	PA	PC	RT		RP	
E1399	DME, miscellaneous – Prone stander, supine stander or board ■ Must meet the criteria listed in section (4) of this rule	PA	PC	RT	16	RP	
E1399	DME, miscellaneous – Accessories for standing frame ■ Covered if the client: ◆ Must meet the criteria listed in section (4) of this rule, and ◆ Cannot be successfully positioned in equipment without specified accessories	PA	PC			RP	
E1399	DME, miscellaneous – Sidelyer includes accessories ■ Covered if the criteria in section (5) of this rule is met and one of the following: ◆ The client has contractures that are capable of being reduced or fixed contractures, or ◆ The client has positioning and support needs that cannot be met with other positioning devices, or	PA	PC			RP	

Code	Description	PA	PC	RT	MR	RP	NF
	◆ Positioning is needed to prevent reflux during feeding.						
E1399	DME, miscellaneous – Custom positioner ■ Labor is included in the purchase price ■ Not used for positioners that are ready-made and subsequently modified to fit an individual client ■ Positioners are considered customized when it is virtually impossible to meet another person's positioning needs in the equipment ■ Covered if: ◆ The configuration of the client's body cannot be supported by commercially available positioners due to size, orthopedic deformities, physical deformities or pressure ulcers, and ◆ The criteria in section (5) of this rule is met.	PA	PC			RP	

410-122-0375 Walkers

(1) Indications and 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

7-1-04

Table 122-0375 Walkers

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4636	Replacement, handgrip, cane, crutch or walker, each		PC				
A4637	Replacement, tip, cane, crutch, walker, each		PC				
E0130	Walker, rigid (pick-up), adjustable or fixed height		PC	RT	16	RP	
E0135	Walker, folding (pick-up), adjustable or fixed height		PC	RT	16	RP	
E0140	Walker, with trunk support, adjustable or fixed height, any type		PC	RT	16	RP	
E0141	Walker, rigid, wheeled, adjustable or fixed height		PC	RT	16	RP	
E0143	Walker, folding, wheeled, adjustable or fixed height		PC	RT	16	RP	
E0144	Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat		PC	RT	16	RP	
E0147	Walker, heavy duty, multiple braking system, variable wheel resistance ■ 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.		PC	RT	16	RP	

Code	Description	PA	PC	RT	MR	RP	NF
E0148	Walker, heavy duty, without wheels, rigid or folding, any type, each ■ Meets the criteria for a standard walker. ■ For clients who weigh more than 300 pounds. ■ May be fixed height or adjustable height.		PC	RT	16	RP	
E0149	Walker, heavy duty, wheeled, rigid or folding, any type, each ■ Meets the criteria for a standard walker. ■ For clients who weigh more than 300 pounds. ■ May be fixed height or adjustable height.		PC	RT	16	RP	
E0154	Platform attachment, walker, each		PC	RT	16	RP	
E0155	Wheel attachment, rigid pick-up walker, per pair		PC			RP	
E0156	Seat attachment, walker		PC			RP	
E0157	Crutch attachment, walker, each		PC	RT	16	RP	
E0158	Leg extensions for a walker, per set of four – for clients 6’ tall or more		PC	RT	16	RP	
E0159	Brake attachment for wheeled walker replacement, each		PC	RT	16	RP	
E1399	Walker, child sized	PA	PC	RT	16	RP	NF

Code	Description	PA	PC	RT	MR	RP	NF
	■ 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.						

410-122-0380 Hospital Beds

(1) Definitions:

(a) Fixed Height Hospital Bed – A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment;

(b) Variable Height Hospital Bed – A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments;

(c) Semi-Electric Hospital Bed – A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments.

(2) Hospital Bed Criterion:

(a) 1 – Client requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month;

(b) 2 – Client requires, for alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;

(c) 3 – Client requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed;

(d) 4 – Client requires traction equipment which can only be attached to a hospital bed;

(e) 5 – Client’s level of functioning can only be met with a hospital bed.

(f) 6 – Client is capable of operating the controls;

(g) 7 – Client requires frequent changes in body position and/or has an immediate need for a change in body position;

(h) 8 – Client requires a bed height different from that provided by a fixed height hospital bed in order to permit transfers to chair, wheelchair or standing position;

(i) 9 – Client weighs more than 350 pounds.

(3) Indications and coverage:

(a) Fixed Height Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5.

(b) Variable Height Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5 and 8.

(c) Semi-Electric Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5, 6, and 7.

(d) Heavy-Duty and Extra Heavy-Duty Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5, 6, 7, and 9.

(4) 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;

(d) In addition to the above documentation requirements, you must document:

(A) The reasons why a variable height bed does not meet the needs of the client when requesting PA for semi-electric hospital beds, and;

(B) The client's height and weight when requesting PA for Heavy-Duty and Extra Heavy-Duty hospital beds.

(5) Procedure Codes – Table 122-0380.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0380 Hospital Beds

For the code legend see OAR 410-122-0182

* *PA required beginning the third month*

Code	Description	PA	PC	RT	MR	RP	NF
Fixed Height							
E0250	Hospital Bed, fixed height, with any type side rails, with mattress	*	PC	RT	13	RP	
E0251	Hospital Bed, fixed height, with any type side rails, without mattress	*	PC	RT	13	RP	
E0290	Hospital Bed, fixed height, without side rails, with mattress	*	PC	RT	13	RP	
E0291	Hospital Bed, fixed height, without side rails, without mattress	*	PC	RT	13	RP	
Variable Height							
E0255	Hospital bed, variable height (Hi-Lo), with any type side rails, with mattress	*	PC	RT	13	RP	
E0256	Hospital bed, variable height (Hi-Lo), with any type side rails, without mattress	*	PC	RT	13	RP	
E0292	Hospital bed, variable height (Hi-Lo), without side rails, with mattress	*	PC	RT	13	RP	
E0293	Hospital bed, variable height (Hi-Lo), without side rails, without mattress	*	PC	RT	13	RP	
Semi-Electric							
E0260	Hospital Bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	*	PC	RT	13	RP	
E0261	Hospital Bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	*	PC	RT	13	RP	

** PA required beginning the third month*

Code	Description	PA	PC	RT	MR	RP	NF
E0294	Hospital Bed, semi-electric (head and foot adjustment) without side rails, with mattress	*	PC	RT	13	RP	
E0295	Hospital Bed, semi-electric (head and foot adjustment) without side rails, without mattress	*	PC	RT	13	RP	
Heavy-Duty and Extra Heavy-Duty							
E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	*	PC	RT	13	RP	
E0302	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	*	PC	RT	13	RP	
E0303	Hospital bed, heavy duty, extra-wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	*	PC	RT	13	RP	
E0304	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	*	PC	RT	13	RP	

410-122-0400 Pressure Reducing Support Surfaces

(1) Definitions:

(a) Comprehensive Ulcer Treatment Program – generally includes:

(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, including instruction and frequency intervals;

(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.

(b) Mattress Overlay – Device designed to be placed on top of a standard hospital or home mattress;

(c) Mattress Replacement – Device that takes the place of the standard hospital or home mattress;

(d) 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;

(e) The staging of pressure ulcers used in this policy is as follows:

(A) Stage 1 – Non-blanchable 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.

(f) Home – Adult foster care, assisted living facility, residential care facilities, and private residence.

(2) Group 1

(a) Indications and Coverage – Covered if the client:

(A) Does not bottom out, and;

(B) Has a care plan established by the prescribing practitioner or other licensed health care practitioner directly involved in the client's care, which must include a comprehensive ulcer treatment program (see section (1)), and;

(C) Meets Group 1:

(i) Criterion (1), or;

(ii) Criterion (2) or (3) and at least one of criteria (4) through (7).

(b) Criterion:

(A) 1 – Completely immobile (e.g., client cannot make changes in body position without assistance);

(B) 2 – Limited mobility (e.g., client cannot independently make changes in body position significant enough to alleviate pressure);

(C) 3 – Any stage pressure ulcer on the trunk or pelvis;

(D) 4 – Impaired nutritional status;

(E) 5 – Fecal or urinary incontinence;

(F) 6 – Altered sensory perception;

(G) 7 – Compromised circulatory status.

(c) 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;

(d) Procedure Codes – Table 122-0400-1:

(A) The following additional criteria applies to codes A4640, E0180, and E0181 – An air pump or blower which provides:

(i) Either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and;

(ii) Inflated cell height of the air cells through which air is being circulated is 2.5” or greater, and;

(iii) 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.

(B) The following additional criteria applies to codes E0186, E0187, and E0196:

(i) Total height of 5” or greater, durable waterproof cover and can be placed directly on a hospital bed frame, and;

(ii) Non-powered pressure reducing mattress.

(3) Group 2:

(a) Indication and Coverage – Covered if all of the following are met:

(A) The client is in a home setting or nursing facility;

(B) The client is confined to a bed or chair as a result of severely limited mobility;

(C) In the home setting, a willing and trained adult caregiver is available to assist the client with:

(i) Activities of daily living;

(ii) Fluid balance;

(iii) Skin care;

(iv) Repositioning;

(v) Recognition and management of altered mental status;

(vi) Dietary needs;

(vii) Prescribed treatments, and;

(viii) Management of the pressure reducing support surface.

(D) 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:

(E) The client meets:

(i) Criterion (1) and (2) and (3); or

(ii) Criterion (4); or

(iii) Criterion (5) or (6):

(b) Criterion definitions:

(A) 1 – Multiple stage II pressure ulcers located on the trunk or pelvis;

(B) 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;

(C) 3 – The ulcers have worsened or remained the same over the last 30 days;

(D) 4 – Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis;

(E) 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;

(F) 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).

(c) The allowable rental fee includes all equipment, supplies, and service appropriate for the effective use of the support surface;

(d) Not covered for the prevention of pressure ulcers or pain control;

(e) Documentation:

(A) The following documentation must be submitted with the initial request for clients in the home setting or nursing facility:

(i) A prescribing practitioner prescription;

(ii) An evaluation done by the resident care manager (for clients in a nursing facility) or licensed health professional, which includes:

(I) A description of the underlying condition – diagnosis, prognosis, rehabilitation potential and nutritional status;

(II) A comprehensive assessment and evaluation of the individual after conservative treatment with other pressure reducing products or methods has been tried without success;

(III) A statement of goals for stepping down the intensity of support therapy.

(iii) A summary of a nutritional assessment by a registered dietician (for clients in a nursing facility) or licensed health professional, within the last 90 days

(iv) Client's height and weight, may approximate if unable to obtain;

(v) Pre-albumin and total lymphocyte count values within the last 60 days;

(vi) Written description of pressure ulcers, which includes:

(I) Numbers;

(II) Locations;

(III) Sizes, and;

(IV) Stages.

(vii) Dated photographs of pressure ulcers;

(viii) 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) For clients who are not in a nursing facility, the following documentation must be submitted in addition to the previous documentation for the initial request:

(i) The client is receiving skilled wound care nursing services either through a home health agency or through the private duty nurse program;

(ii) A copy of the comprehensive ulcer treatment program (see section (1) of this rule for definition), which is client specific and includes but is not limited to the following:

(I) The number of hours per 24-hour period that the pressure reducing support surface will be utilized;

(II) Any contributing factors, such as mobility status, impaired sensory perception, circulatory status, etc.;

(III) Treatment must include healing;

(IV) 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.

(V) If the client has had a recent myocutaneous flap or skin graft, include a copy of the operative report, and care plan.

(C) For subsequent requests, submit the following documentation:

(i) Dated photographs of pressure ulcers;

(ii) Copies of skin flow sheets;

(iii) Copies of any pertinent notes in the progress records;

(iv) Copies of records supporting changes in laboratory values or nutritional status;

(v) Written description of pressure ulcers by nurse, prescribing practitioner, or other licensed health care practitioner, including:

(I) Numbers;

(II) Locations;

(III) Sizes, and;

(IV) Stages.

(vi) Copy of current care plan.

(D) 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.

(f) Procedure Codes – Table 122-0400-2:

(A) The following additional criteria applies to codes for powered pressure reducing mattresses/overlays (E0193, E0277, and E0372):

(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/overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is:

(I) 5” or greater for mattresses;

(II) 3” or greater for overlays.

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses/overlays), and air pressure provide adequate client lift, reduce pressure and prevent bottoming out;

(iv) A surface designed to reduce friction and shear.

(B) The following additional criteria applies to codes for non-powered pressure reducing mattresses/overlays (E0371 and E0373):

(i) Height and design of individual cells which provide significantly more pressure reduction than a Group 1 mattress/overlay and prevent bottoming out;

(ii) Total height of:

(I) 5” or greater for mattresses;

(II) 3” or greater for overlays.

(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.

(4) Group 3 – Air-fluidized beds are not covered.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0400-1 Pressure Reducing Support Surfaces

For the code legend see OAR 410-122-0182

* *See additional criteria shown in sections (2)(d)(A) and (B) for codes A4640, E0180, E0181, E0186, E0187, and E0196.*

Code	Description	PA	PC	RT	MR	RP	NF
*A4640	Replacement pad for use with medically appropriate alternating pressure pad owned by client		PC			RP	NF
*E0180	Pressure pad, alternating with pump		PC	RT	16	RP	
*E0181	Pressure pad, alternating with pump, heavy-duty		PC	RT	16	RP	
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.		PC	RT	16	RP	
E0184	Dry pressure mattress ■ Non-powered pressure reducing mattress ■ 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.	PA	PC	RT	16		
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width ■ Gel or gel-like layer with a height of 2” or greater ■ Non-powered pressure reducing mattress overlay	PA	PC	RT	16	RP	

* *See additional criteria shown in sections (2)(d)(A) and (B) for codes A4640, E0180, E0181, E0186, E0187, and E0196.*

Code	Description	PA	PC	RT	MR	RP	NF
*E0186	Air pressure mattress	PA	PC	RT	16	RP	
*E0187	Water pressure mattress	PA	PC	RT	16	RP	
E0188	Synthetic sheepskin pad		PC				
E0189	Lambs wool sheepskin pad		PC				
*E0196	Gel pressure mattress	PA	PC	RT	16		
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	PC	RT	16	NF	
E0198	Water pressure pad for mattress, standard mattress length and width ■ Filled height of 3” or greater ■ Non-powered pressure reducing mattress overlay	PA	PC	RT	16	RP	
E0199	Dry pressure pad for mattress, standard mattress length and width ■ 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 non-convoluted overlay and foam with a density and other qualities that provide adequate pressure reduction and durable waterproof cover ■ Non-powered pressure reducing mattress overlay		PC	RT			

Table 122-0400-2 Pressure Reducing Support Surfaces

For the code legend see OAR 410-122-0182

* *See additional criteria shown in sections (3)(f)(A) and (B) for codes E0193, E0277, E0371, E0372, and E0373.*

Code	Description	PA	PC	RT	MR	RP	NF
E0193	Powered air flotation bed (low air loss therapy), per month ■ A semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which is characterized by the previously listed additional criteria for powered pressure reducing mattresses/overlays. ■ Can be placed directly on a hospital bed frame ■ Use also for powered pressure reducing mattress overlay* – low air loss powered flotation without low air loss or alternating pressure	PA		RT	16	RP	NF
E0277	Powered pressure reducing mattress, air, per month ■ A powered pressure reducing mattress* – alternating pressure, low air loss, or powered flotation without low air loss ■ Can be placed directly on a hospital bed frame ■ Use also for powered pressure reducing mattress overlay* – low air loss powered flotation without low air loss, or alternating pressure	PA		RT	16	RP	NF

* *See additional criteria shown in sections (3)(f)(A) and (B) for codes E0193, E0277, E0371, E0372, and E0373.*

Code	Description	PA	PC	RT	MR	RP	NF
E0371	Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width, per month ■ An advanced non-powered pressure reducing mattress overlay*	PA		RT	16	RP	NF
E0372	Powered air overlay for mattress, standard mattress length and width, per month ■ A powered pressure reducing mattress overlay* – low air loss, powered flotation without low air loss, or alternating pressure	PA		RT			NF
E0373	Non-powered, advanced pressure reducing mattress ■ An advanced non-powered pressure-reducing mattress* ■ Can be placed directly on a hospital bed frame	PA	PC	RT	16	RP	NF

410-122-0420 Hospital Bed Accessories

(1) Table 122-0420.

(2) 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) See Table 122-0420 for procedure codes.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0420 Hospital Bed Accessories

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
Frames, Traction Devices, etc.							
E0840	Traction frame, attached to headboard, cervical traction		PC	RT	16	RP	
E0850	Traction stand, free-standing, cervical traction		PC	RT	16	RP	
E0855	Cervical traction equipment not requiring additional stand or frame		PC	RT	16	RP	
E0860	Traction equipment, overdoor, cervical		PC				
E0870	Traction frame, attached to footboard, extremity traction (e.g., Buck's)		PC	RT	16	RP	
E0880	Traction stand, free-standing, extremity traction, (e.g., Buck's)		PC	RT	16	RP	
E0890	Traction frame, attached to footboard, pelvic traction		PC	RT	16	RP	
E0900	Traction stand, free-standing, pelvic traction (e.g., Buck's)		PC	RT	16	RP	
E0920	Fracture frame, attached to bed, includes weights		PC	RT	16	RP	
E0930	Fracture frame, free-standing, includes weights		PC	RT	16	RP	
E0941	Gravity assisted traction device, any type		PC	RT	16	RP	
E0942	Cervical head harness/halter		PC				
E0943	Cervical pillow		PC				

Code	Description	PA	PC	RT	MR	RP	NF
E0944	Pelvic belt/harness/boot		PC				
E0945	Extremity belt/harness		PC				
E0946	Fracture frame, dual with cross bars, attached to bed (e.g., Balken, 4-poster)		PC	RT	16	RP	
E0947	Fracture frame, attachments for complex pelvic traction		PC	RT	16	RP	
E0948	Fracture frame, attachments for complex cervical traction		PC	RT	16	RP	
Mattresses							
E0271	Mattress, inner-spring (replacement for client owned hospital bed)		PC				
E0272	Mattress, foam rubber (replacement for client owned hospital bed)		PC				
Rails							
E0305	Bedside rails, half-length, for use with hospital or non-hospital bed		PC	RT	16		
E0310	Bedside rails, full-length, for use with hospital or non-hospital bed		PC	RT	16		
Trapeze Bars							
E0910	Trapeze bars, a.k.a. client helper, attached to bed, complete with grab bar ■ Not covered when used on a non-hospital bed ■ Covered when it is either an integral part of or used on a hospital bed and both the hospital bed and the trapeze bar are medically appropriate		PC	RT	16	RP	

Code	Description	PA	PC	RT	MR	RP	NF
E0940	Trapeze bar, free-standing, complete with grab bar ■ When prescribed, it must meet the same criteria as the attached equipment and the client must not be renting or own a hospital bed		PC	RT	16	RP	

410-122-0470 Supports and Stockings

(1) Cosmetic support panty hose (i.e., Leggs®, No Nonsense®, etc.) are not covered.

(2) Procedure Codes - Table 122-0470.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0470 Supports and Stockings

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4565	Slings		PC				
L0120	Cervical, flexible non-adjustable (foam collar)		PC				
L0210	Thoracic rib belt		PC				NF
L8300	Truss, single with standard pad		PC				NF
L8310	Truss, double		PC				NF
Elastic Supports							
L8100	Gradient compression stocking, below knee, 18-30 mm Hg, each		PC				NF
L8110	below knee, 30-40 mm Hg, each		PC				NF
L8120	below knee, 40-50 mm Hg, each		PC				NF
L8130	thigh length, 18-30 mm Hg, each		PC				NF
L8140	thigh length, 30-40 mm Hg, each		PC				NF
L8150	thigh length, 40-50 mm Hg, each		PC				NF
L8160	full length/chap style, 18-30 mm Hg, each		PC				NF
L8170	full length/chap style, 30-40 mm Hg, each		PC				NF
L8180	full length/chap style, 40-50 mm Hg, each		PC				NF
L8190	waist length, 18-30 mm Hg, each		PC				NF
L8195	waist length, 30-40 mm Hg, each		PC				NF
L8200	waist length, 40-50 mm Hg, each		PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
L8210	custom made		PC				NF
L8220	lymphedema		PC				NF
L8230	garter belt		PC				NF
L8239	not otherwise specified	PA	PC				NF
S8420	Gradient pressure aid (sleeve and glove combination), custom made		PC				NF
S8421	Gradient pressure aid (sleeve and glove combination), ready made		PC				NF
S8422	Gradient pressure aid (sleeve), custom made, medium weight		PC				NF
S8423	Gradient pressure aid (sleeve), custom made, heavy weight		PC				NF
Compression Burn Garments							
A6501	Compression burn garment, body suit (head-to-foot), custom fabricated		PC				
A6502	Compression burn garment, chin strap, custom fabricated		PC				
A6503	Compression burn garment, facial hood, custom fabricated		PC				
A6504	Compression burn garment, glove-to-wrist, custom fabricated		PC				
A6505	Compression burn garment, glove-to-elbow, custom fabricated		PC				
A6506	Compression burn garment, glove-to-axilla, custom fabricated		PC				
A6507	Compression burn garment, foot-to-knee length, custom fabricated		PC				
A6508	Compression burn garment, foot-to-thigh length, custom fabricated		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6509	Compression burn garment, upper trunk-to-waist including arm openings (vest)		PC				
A6510	Compression burn garment, trunk, including arms down-to-leg opening (leotard), custom fabricated		PC				
A6511	Compression burn garment, lower trunk, including leg opening (panty), custom fabricated		PC				
A6512	Compression burn garment, not otherwise classified, custom fabricated	PA	PC				

410-122-0475 Therapeutic Shoes for Diabetics

(1) Indications and Coverage:

(a) For each client, coverage of the footwear and inserts is limited to one of the following within one calendar year:

(A) One pair of custom molded shoes (including inserts provided with such shoes) and two additional pair of inserts; or

(B) One pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of inserts.

(b) An individual may substitute modification(s) of custom molded or extra-depth shoes instead of obtaining one pair of inserts, other than the initial pair of inserts. The most common shoe modifications are:

(A) Rigid rocker bottoms;

(B) Roller bottoms;

(C) Metatarsal bars;

(D) Wedges;

(E) Offset heels.

(c) Payment for any expenses for the fitting of such footwear is included in the fee;

(d) Payment for the certification of the need for therapeutic shoes and for the prescription of the shoes (by a different practitioner from the one who certifies the need for the shoes) is considered to be included in the visit or consultation in which these services are provided;

(e) Following certification by the physician managing the client’s systemic diabetic condition, a podiatrist or other qualified practitioner, knowledgeable in the fitting of the therapeutic shoes and inserts, may prescribe the particular type of footwear necessary.

(2) Documentation:

(a) The practitioner who is managing the individual's systemic diabetic condition documents that the client has diabetes and one or more of the following conditions:

(A) Previous amputation of the other foot, or part of either foot;

(B) History of previous foot ulceration of either foot;

(C) History of pre-ulcerative calluses of either foot;

(D) Peripheral neuropathy with evidence of callus formation of either foot;

(E) Foot deformity of either foot; or

(F) Poor circulation in either foot; and

(G) Certifies that the client is being treated under a comprehensive plan of care for his or her diabetes and that he or she needs therapeutic shoes.

(b) Documentation of the above criteria, may be completed by the prescribing practitioner or supplier but must be reviewed for accuracy of the information and signed and dated by the certifying physician to indicate agreement and must be kept on file by the DME supplier.

(3) Procedure Codes – Table 122-0475.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0475 Therapeutic Shoes for Diabetics

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A5500	For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe		PC				NF
A5501	For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of client's foot (custom molded shoe), per shoe		PC				NF
A5503	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe		PC				NF
A5504	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe		PC				NF
A5505	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe		PC				NF
A5506	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe		PC				NF
A5507	For diabetics only, not otherwise specified modification (include fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe		PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
A5509	For diabetics only, direct formed, molded to foot with external heat source (i.e., heat gun) multiple-density insert(s), prefabricated, per shoe		PC				NF
A5510	For diabetics only, direct formed, compression molded to client's foot without external heat source, multiple-density insert(s), prefabricated, per shoe		PC				NF
A5511	For diabetics only, custom-molded from model of client's foot, multiple-density insert(s), custom fabricated, per shoe		PC				NF

410-122-0480 Pneumatic Compression Devices (Used for Lymphedema)

(1) A pneumatic compression device (lymphedema pump) is medically appropriate only for the treatment of refractory lymphedema involving one or more limbs.

(2) Causes of lymphedema include but are not limited to the following conditions with a diagnosis on the currently funded lines of the Prioritized List of Health Services:

(a) Spread of malignant tumors to regional lymph nodes with lymphatic obstruction;

(b) Radical surgical procedures with removal of regional groups of lymph nodes;

(c) Post-radiation fibrosis;

(d) Scarring of lymphatic channels (e.g., those with generalized refractory edema from venous insufficiency which is complicated by recurrent cellulitis); when all of the following criteria have been met:

(A) There is significant ulceration of the lower extremity(ies);

(B) The client has received repeated, standard treatment from a practitioner using such methods as a compression bandage system or its equivalent;

(C) The ulcer(s) have failed to heal after six months of continuous treatment.

(e) Congenital anomalies.

(3) Pneumatic compression devices may be covered only when prescribed by a practitioner and when they are used with appropriate practitioner oversight, i.e., practitioner evaluation for the client's condition to determine medical appropriateness of the device, suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment. Used as treatment of last resort.

(4) All pressure devices require a one-month trial period prior to purchase. The rental period is applied toward purchase.

(5) All necessary training to utilize a pressure device is included in rental or purchase fee.

(6) Documentation:

(a) The practitioner must document the client's condition, medical appropriateness and instruction as to the pressure to be used, the frequency and duration of use and that the device is achieving the purpose of reduction and control of lymphedema;

(b) The determination by the practitioner of the medical appropriateness of pneumatic compression device must include:

(A) The client's diagnosis and prognosis;

(B) Symptoms and objective findings, including measurements which establish the severity of the condition;

(C) The reason the device is required, including the treatments which have been tried and failed; and

(D) The clinical response to an initial treatment with the device. The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment session and parameters, and ability of the client (or caregiver) to apply the device for continued use in the home.

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

(d) If the client has venous stasis ulcers, documentation supporting the medical appropriateness for the device should include a signed and dated statement from the prescribing practitioner indicating:

(A) The location and size of venous stasis ulcer(s);

(B) How long each ulcer has been continuously present;

(C) Whether the client has been treated with regular compression bandaging for the past six months;

(D) Whether the client has been treated with custom fabricated gradient pressure stockings/sleeves, approximately when, and the results of the treatment;

(E) Other treatment for the venous stasis ulcer(s) during the past six months;

(F) Whether the client has been seen regularly by a practitioner for treatment of venous stasis ulcer(s) during the past six months.

(7) Procedure Codes -- Table 122-0480.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0480 Pneumatic Compression Devices (Used for Lymphedema)

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0650	Pneumatic compressor, non-segmental home model		PC	RT		RP	NF
E0651	Pneumatic compressor, segmental home model (lymphedema pump) without calibrated gradient pressure		PC	RT		RP	NF
E0652	Pneumatic compressor, segmental home model (lymphedema pump) with calibrated gradient pressure ■ Documentation on file must show that E0650 or E0651, or other less costly alternatives, failed to manage the client's condition ■ Must include measurements of pump pressure, dates and times applied, and serial multiple level measurements of the involved extremity ■ If used for a painful focal lesion, documentation must support what prevented the use of E0650 or E0651 ■ Chamber pressure must be listed for all pumps used		PC	RT		RP	NF

Code	Description	PA	PC	RT	MR	RP	NF
	■ Must show the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a non-segmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber						
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor half arm, includes hand segment		PC	RT		RP	NF
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor full leg, includes foot segment		PC	RT		RP	NF
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor full arm, includes hand segment		PC	RT		RP	NF
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor half leg, includes foot segment		PC	RT		RP	NF
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg, includes foot segment		PC	RT		RP	NF
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm, includes hand segment		PC	RT		RP	NF
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg, includes foot segment		PC	RT		RP	NF
E0671	Segmental gradient pressure pneumatic appliance, full leg, includes foot segment		PC	RT		RP	NF

Code	Description	PA	PC	RT	MR	RP	NF
E0672	Segmental gradient pressure pneumatic appliance, full arm, includes hand segment		PC	RT		RP	NF
E0673	Segmental gradient pressure pneumatic appliance, half leg, includes foot segment		PC	RT		RP	NF

410-122-0500 Transcutaneous Electrical Nerve Stimulator (TENS)

(1) Indications and 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 – Table 122-0500.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0500 Transcutaneous Electrical Nerve Stimulator (TENS)

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4557	Lead wires, (e.g., apnea monitor), per pair ■ One unit of service is for lead wires going to two electrodes ■ If all the lead wires of a four lead TENS unit needed to be replaced, billing would be for two units of service	PA	PC				NF
A4595	Electrical stimulator supplies (e.g., TENS, NMES), 2 lead, per month ■ 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 ■ 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	PA	PC				NF
E0720	TENS, two lead, localized stimulation	PA	PC	RT	16	RP	NF

Code	Description	PA	PC	RT	MR	RP	NF
E0730	TENS, four or more leads for, multiple nerve stimulation	PA	PC	RT	16	RP	NF

410-122-0510 Electronic Stimulators

(1) Osteogenic Stimulators - Indications and Coverage:

(a) Non-spinal Electrical Osteogenesis Stimulator:

(A) A non-spinal 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 minimum of nine months has elapsed since the last surgery; or

(iii) Congenital pseudarthrosis.

(B) Non-union of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by 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) Non-unions 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 – Table 122-0510.

(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 – Table 122-0510.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0510 Electronic Stimulators

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0747	Osteogenis stimulator electrical (non-invasive) other than spinal application ■ One time payment per condition	PA	PC				NF
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal applications, one time payment per condition	PA	PC				NF
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	PA	PC				NF
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 ■ Battery charger – if rechargeable batteries are used						
E0745	Neuromuscular stimulator, electronic shock unit	PA	PC	RT	16	RP	NF

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 – Table 122-0520.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0520 Diabetic Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4210	Needle-free injection device, each		PC				
A4211	Supplies for self-administered injections ■ Used for transparent syringe without a needle for insulin delivery, or ■ Used for adapter for transferring insulin from vial to transparent syringe without a needle, only		PC				
A4244	Alcohol or peroxide, per pint		PC				
A4245	Alcohol wipes, per box		PC				
A4250	Urine test or reagent strips or tablets, per 100 tablets or strips		PC				
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips ■ Limits for non-insulin dependent diabetes mellitus (NIDDM) – 100 every three months ■ Limits for insulin dependent diabetes mellitus (IDDM) – 100 per month		PC				
A4254	Replacement battery, any type, for use with medically appropriate home blood glucose monitor owned by client, each		PC				
A4255	Platforms for home blood glucose monitor, 50 per box		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4256	Normal, low and high calibrator solution/chips ■ Replacement only, not billable with new blood glucose monitor		PC				
A4258	Spring-powered device for lancet, each		PC				
A4259	Lancets, per box of 100 ■ Limits for NIDDM – 100 every three months ■ Limits for IDDM – 100 per month		PC				
A4772	Dextrostick or glucose test strips, per box		PC				
E0607	Home blood glucose monitor		PC			RP	
E2100	Blood glucose monitor with integrated voice synthesizers Covered when the following conditions are met: ■ The client and device meet one of the conditions listed for coverage of standard home blood glucose monitors (section (1) of this rule), and ■ The client's treating practitioner certifies a severe visual impairment (>20/200 or worse corrected)		PC			RP	
E2101	Blood glucose monitor with integrated lancing/blood sample collection Covered when all of the following conditions are met:		PC			RP	

Code	Description	PA	PC	RT	MR	RP	NF
	■ The client and device meet one of the conditions listed for coverage of standard home blood glucose monitors (section (1) of this rule), and ■ The client's treating practitioner certifies a severe visual impairment (>20/200 or worse corrected), and ■ 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						
S8490	Insulin syringes, any size		PC				
	■ 100 syringes						

410-122-0530 Proof of Delivery

(1) Suppliers are required to maintain proof of delivery documentation in their files. Proof of delivery must be available upon request.

(2) Proof of delivery requirements are based on the method of delivery.

(3) A delivery slip is required for items delivered directly by the supplier to the client or authorized representative. The delivery slip must include the following:

(a) The client or authorized representative's signature with the date the items were received (when billing, use this date as the date of service), and;

(b) The client's name, and;

(c) The quantity, brand name, serial number and a detailed description of the items being delivered.

(4) A tracking slip and a supplier's shipping invoice is required for items delivered by a delivery/shipping service to the client or authorized representative:

(a) The supplier's shipping invoice must include the:

(A) Client's name, and;

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

(C) Delivery service's package identification number associated with the client's packages, and;

(D) Shipping date (when billing, use this date as the date of service).

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

(A) Each client's packages, and;

(B) The delivery address and corresponding package identification number given by the delivery service.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

410-122-0525 External Insulin Infusion Pump

(1) Coverage for an external insulin infusion pump for the 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, must meet criteria (a) or (b):

(a) The client has:

(A) Completed a comprehensive diabetes education program;

(B) 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;

(C) 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;

(D) A Glycosylated hemoglobin level (HbA1C) greater than 7%, and ~~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:

(A) Been on an external insulin infusion pump prior to enrollment in the Medical Assistance Program, and;

(B) Documented frequency of glucose self-testing an average of at least four times per day during the month prior to Medical Assistance Program enrollment.

(2) 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.

(3) 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.

(4) 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.

(5) Procedure Codes – Table 122-0525.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0525 External Insulin Infusion Pump

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4221	Supplies for maintenance of drug infusion catheter, per week ■ Includes cannulas, needles, dressings and infusion supplies	PA	PC				NF
A4232	Syringe with needle for external insulin pump, sterile, 3 cc. ■ Does not include the insulin ■ Describes the insulin reservoir for use with E0784	PA	PC				NF
E0784	External ambulatory infusion pump, insulin ■ Includes instruction in use of pump	PA	PC	RT	16	RP	NF
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each		PC				NF
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each		PC				NF
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each		PC				NF
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each		PC				NF
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each		PC				NF

410-122-0530 Proof of Delivery

(1) Suppliers are required to maintain proof of delivery documentation in their files. Proof of delivery must be available upon request.

(2) Proof of delivery requirements are based on the method of delivery.

(3) A delivery slip is required for items delivered directly by the supplier to the client or authorized representative. The delivery slip must include the following:

(a) The client or authorized representative's signature with the date the items were received (when billing, use this date as the date of service), and;

(b) The client's name, and;

(c) The quantity, brand name, serial number and a detailed description of the items being delivered.

(4) A tracking slip and a supplier's shipping invoice is required for items delivered by a delivery/shipping service to the client or authorized representative:

(a) The supplier's shipping invoice must include the:

(A) Client's name, and;

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

(C) Delivery service's package identification number associated with the client's packages, and;

(D) Shipping date (when billing, use this date as the date of service).

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

(A) Each client's packages, and;

(B) The delivery address and corresponding package identification number given by the delivery service.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

410-122-0540 Ostomy Supplies: Colostomy, Illeostomy, Ureterostomy

(1) Indications and Coverage: The use of ostomy supplies are covered for clients with a surgically created opening (stoma) to divert urine, feces, or ilial contents to outside of the body.

(2) Documentation: The prescription, and documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider.

(3) Procedure Codes: Table 122-0540.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0540 Ostomy Supplies: Colostomy, Illeostomy, Ureterostomy

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4331	Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each		PC				
A4361	Ostomy face plate, each ■ May not bill for A4375, A4376, A4379, or A4380 at the same time		PC				
A4362	Skin barrier; solid, 4 x 4 or equivalent, standard wear, each		PC				
A4364	Adhesive, liquid or equal, any type, per oz.		PC				
A4365	Adhesive remover wipes, any type, 50 per box		PC				
A4366	Ostomy vent, any type, each		PC				
A4367	Ostomy Belt, each		PC				
A4369	Ostomy skin barrier, liquid (spray, brush, etc.), per oz		PC				
A4371	Ostomy skin barrier, powder, per oz.		PC				
A4372	Ostomy skin barrier, solid 4x4 or equivalent, with built-in convexity, each		PC				
A4373	Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each		PC				
A4375	Ostomy pouch, drainable, with faceplate attached, plastic, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each		PC				
A4377	Ostomy pouch, drainable, for use on faceplate, plastic, each		PC				
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each		PC				
A4379	Ostomy pouch, urinary, with faceplate attached, plastic, each		PC				
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each		PC				
A4381	Ostomy pouch, urinary, for use on faceplate, plastic, each		PC				
A4382	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each		PC				
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each		PC				
A4384	Ostomy faceplate equivalent, silicone ring, each		PC				
A4385	Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, without built-in convexity, each		PC				
A4387	Ostomy pouch, closed, with barrier attached, with built-in convexity (one piece), each		PC				
A4388	Ostomy pouch, drainable, with extended wear barrier attached (one piece), each		PC				
A4389	Ostomy pouch, drainable, with barrier attached, with built-in convexity (one piece), each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built- in convexity (one piece), each		PC				
A4391	Ostomy pouch, urinary, with extended wear barrier attached, without built-in convexity (one-piece), each		PC				
A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (one piece), each		PC				
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (one piece), each		PC				
A4394	Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce		PC				
A4395	Ostomy deodorant for use in ostomy pouch, solid, per tablet		PC				
A4396	Ostomy belt with peristomal hernia support		PC				
A4397	Irrigation supply, sleeve, each		PC				
A4398	Ostomy irrigation supply bag, each ■ May bill for A4399 at the same time		PC				
A4399	Ostomy irrigation supplies, cone/catheter, including brush ■ May bill for A4398 at the same time		PC				
A4402	Lubricant, per ounce ■ One unit of service = one oz		PC				
A4404	Ostomy ring, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4405	Ostomy skin barrier, non-pectin based, paste, per ounce		PC				
A4406	Ostomy skin barrier, pectin based, paste, per ounce		PC				
A4407	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each		PC				
A4408	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each		PC				
A4409	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each		PC				
A4410	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each		PC				
A4413	Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system) with filter, each		PC				
A4414	Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, 4 x 4 inches or smaller, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4415	Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4 x 4 inches, each		PC				
A4416	Ostomy pouch, closed, with barrier attached, with filter, each		PC				
A4417	Ostomy pouch, closed, with barrier attached, with filter, with built-in convexity, each		PC				
A4418	Ostomy pouch, closed; without barrier attached, with filter, each		PC				
A4419	Ostomy pouch, closed; for use on barrier with non-locking flange, with filter, (2-piece), each		PC				
A4420	Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each		PC				
A4422	Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each		PC				
A4423	Ostomy pouch, closed; for use on barrier with locking flange (2 piece), with filter, each		PC				
A4424	Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each		PC				
A4425	Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each		PC				
A4426	Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4427	Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each		PC				
A4428	Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each		PC				
A4429	Ostomy pouch, urinary, with barrier, attached, with built-in convexity, with faucet-type tap with valve (1 piece), each		PC				
A4430	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each		PC				
A4431	Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each		PC				
A4432	Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each						
A4433	Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each		PC				
A4434	Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type		PC				
A4455	Adhesive remover or solvent (for tape, cement or other adhesive ■ One unit of service = one oz. of liquid or spray)		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A5051	Ostomy pouch, closed; with barrier attached (1 piece), standard wear, each		PC				
A5052	Ostomy pouch, closed; without barrier attached (1 piece), each		PC				
A5053	Ostomy pouch, closed; for use on faceplate, each		PC				
A5054	Ostomy pouch, closed for use on barrier with flange (2 piece), each		PC				
A5055	Stoma cap, each		PC				
A5062	Ostomy pouch, drainable, without barrier attached (1 piece), each		PC				
A5063	Ostomy pouch, drainable, for use on barrier with flange (2 piece system), each		PC				
A5071	Ostomy pouch, urinary, with barrier attached (1 piece), each		PC				
A5072	Ostomy pouch, urinary, without barrier attached (1 piece), each		PC				
A5073	Ostomy pouch, urinary, for use on barrier with flange (2 piece), each		PC				
A5081	Continent device; plug for continent stoma, each		PC				
A5082	Catheter for continent stoma, each		PC				
A5093	Ostomy accessory; convex insert, each		PC				
A5119	Skin barrier, wipes, box per 50		PC				
A5121	Skin barrier, solid, 6 x 6 or equivalent, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A5122	Skin barrier, solid, 8 x 8 or equivalent, each		PC				
A5126	Adhesive or non-adhesive; disc or foam pad		PC				
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.		PC				

410-122-0560 Urological 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 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, 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

7-1-04

Table 122-0560 Urological Services

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4310	Insertion tray without drainage bag and without catheter (accessories only) ■ Limited to one per month ■ Not covered for intermittent catheterization ■ Not covered at the same time as A4311, A4312, A4313, A4314, A4315, A4316, A4332, A4353, A4354		PC				
A4311	Insertion tray without drainage bag, with indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.) ■ Limited to one per month ■ Not covered for intermittent catheterization ■ Not covered at the same time as, A4310, A4312, A4313, A4314, A4315, A4316, A4332, A4338, A4340, A4344, A4346, A4351, A4352, A4353, A4354		PC				
A4312	Insertion tray without drainage bag with indwelling catheter, foley type, two-way, all silicone ■ Limited to one per month for routine catheter maintenance ■ Not covered for intermittent catheterization		PC				

Code	Description	PA	PC	RT	MR	RP	NF
	■ Not covered at the same time as A4310, A4311, A4313, A4314, A4315, A4316, A4332, A4338, A4340, A4344, A4346, A4351, A4352, A4353, A4354, A5105						
A4313	Insertion tray without drainage bag with indwelling catheter, foley type, three-way for continuous irrigation ■ Limited to one per month for routine catheter maintenance ■ Not covered for intermittent catheterization ■ Not covered at the same time as A4310, A4311, A4312, A4314, A4315, A4316, A4332, A4338, A4340, A4344, A4346, A4351, A4352, A4353, A4354		PC				
A4314	Insertion tray with drainage bag with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.) ■ 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		PC				
A4315	Insertion tray with drainage bag with indwelling catheter, foley type, two-way, all silicone ■ Not covered for intermittent catheterization		PC				

Code	Description	PA	PC	RT	MR	RP	NF
	■ 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 ■ Limited to one per month for routine catheter maintenance ■ Not covered for intermittent catheterization ■ Not covered at the same time as A4310, A4313, A4332, A4344, A4346, A4354, A4357		PC				
A4320	Irrigation tray with bulb or piston syringe, any purpose		PC				
A4322	Irrigation syringe, bulb or piston, each		PC				
A4324	Male external catheter, with adhesive coating, each ■ Limited to 35 per month ■ Adhesive strips or tape are included in the allowable ■ Not covered at the same time as K0572, K0573		PC				
A4325	Male external catheter, with adhesive strap, each ■ Limited to 35 per month ■ Adhesive strips or tape are included in the allowable ■ Not covered at the same time as K0572, K0573		PC				
A4326	Male external catheter specialty type with integral collection chamber, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4327	Female external urinary collection4 device, meatal cup, each ■ Limited to one per week		PC				
A4328	Female external urinary collection device; pouch, each ■ Limited to one per day		PC				
A4331	Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each		PC				
A4332	Lubricant, individual sterile packet, for insertion of urinary catheter, each ■ Not covered for intermittent catheterization ■ Not covered at the same time as A4310, A4311, A4312, A4313, A4314, A4315, A4316, A4353, A4354		PC				
A4333	Urinary catheter anchoring device, adhesive skin attachment, each – OMAP will purchase ■ Limited to three per week		PC				
A4334	Urinary catheter anchoring device, leg strap, each ■ Limited to one per month		PC				
A4338	Indwelling catheter; foley type, two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each ■ Limited to one per month for routine catheter maintenance ■ Not covered at the same time as A4311		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4340	Indwelling catheter; specialty type, e.g., coude, mushroom, wing, etc., each ■ Limited to one per month for routine catheter maintenance		PC				
A4344	Indwelling catheter Foley type, two-way, all silicone, each ■ Limited to one per month for routine catheter maintenance ■ Not covered at the same time as A4312, A4315		PC				
A4346	Indwelling catheter, Foley type, three-way for continuous irrigation, each ■ Limited to one per month for routine catheter maintenance ■ Not covered at the same time as A4313, A4316 ■ Limited to use for continuous irrigation of indwelling catheter		PC				
A4348	Male external catheter with integral collection compartment, extended wear, each		PC				
A4351	Intermittent urinary catheter; straight tip, each ■ Limited to one per week ■ Not covered at the same time as A4352 or A4353		PC				
A4352	Intermittent urinary catheter; coude (curved) tip, each ■ Limited to one per week ■ Not covered at the same time as A4332, A4351 or A4353		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4353	Intermittent urinary catheter with insertion supplies ■ Includes a catheter, lubricant, gloves, antiseptic solution, applicators, drape, and a tray or bag in a sterile package intended for single use ■ Limited to one per week ■ Not covered at the same time as A4310, A4332, A4344, A4351, A4352		PC				
A4354	Catheter insertion tray with drainage bag but without catheter ■ Not covered at the same time as A4310, A4314, A4315, A4316, A4332, A4357		PC				
A4355	Irrigation tubing set for continuous bladder irrigation through a three-way indwelling foley catheter, each		PC				
A4356	External urethral clamp or compression device (not to be used for a catheter clamp), each ■ Limited to one per three months		PC				
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each ■ Limited to two per month Not covered at the same time as A4314, A4315, A4316, A4354, A5102		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4358	Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each ■ For clients who are ambulatory, up in a chair or wheelchair bound ■ Limited to two per month ■ Not covered at the same time as A5105, A5112, A5113, A5114		PC				
A4359	Urinary suspensory without leg bag, each ■ Not covered at the same time as A5105		PC				
A4402	Lubricant, per ounce		PC				
A4450	Tape, non-waterproof, per 18 square inches ■ Not covered at the same time as A4325		PC				
A4452	Tape, waterproof, per 18 square inches ■ Not covered at the same time as A4325		PC				
A4927	Gloves, non-sterile, per 100 ■ Limited to 200 pair per month		PC				
A4930	Gloves, sterile, per pair		PC				
A5102	Bedside drainage bottle, with or without tubing, rigid or expandable, each ■ Limited to two per six months ■ Not covered at the same time as A4357		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A51054	Urinary suspensory; with leg bag, with or without tube ■ Not covered at the same time as A4358, A4359, A5112, A5113, A5114		PC				
A5112	Urinary leg bag; latex ■ Limited to one per month ■ For clients who are ambulatory, up in a chair or wheelchair bound ■ Not covered at the same time as A4358, A5113, A5114		PC				
A5113	Leg strap; latex, replacement only, per set ■ Not covered at the same time as A4112, A4358, A5105		PC				
A5114	Leg strap; foam or fabric, replacement only, per set ■ Not covered at the same time as A4358, A5105, A5112		PC				
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.		PC				
A5200	Percutaneous catheter/tube anchoring device, adhesive skin attachment		PC				

410-122-0580 Bath Supplies

(1) Indications and Coverage – A rehab shower/commode chair is covered when all of the following criteria are met:

(a) Client is unable to use a standard shower chair/bench due to a musculoskeletal condition;

(b) Client has positioning, trunk stability or neck support needs that a standard shower chair/bench cannot provide;

(c) The home (shower) can accommodate a rehab/shower chair;

(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 the above criteria, 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

7-1-04

Table 122-0580 Bath Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0160	Sitz type bath or equipment, portable, used with or without commode		PC				
E0161	Sitz type bath or equipment, portable, used with or without commode with faucet attachments		PC				
E0162	Sitz bath chair		PC				
E0241	Bathtub wall rail, each		PC				
E0242	Bathtub rail floor base		PC				
E0243	Toilet rail, each		PC				
E0245	Tub stool or bench		PC				
E0246	Transfer tub rail attachment		PC				
E0247	Transfer bench for tub or toilet with or without commode opening		PC				
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening		PC				
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	PA	PC	RT		RP	

Code	Description	PA	PC	RT	MR	RP	NF
	◆ Non-corrosive construction						
	◆ Padded seat						
	◆ Wheeled Adjustable head immobilized						
	◆ Reclining back						
	◆ Braking system						
	◆ Leg and/or restraint belt						

410-122-0590 Patient Lifts

(1) Indications and Coverage – A lift is covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the client would be bed confined.

(2) Procedure Codes:

(a) E0621 – Sling or seat, client lift, canvas or nylon:

(A)The Office of Medical Assistance Programs (OMAP) will purchase;

(B) Prior authorization (PA) required;

(C) Not covered at the same time as E0630 or E0635.

(b) E0630 – Client lift, hydraulic with seat or sling:

(A) OMAP will purchase;

(B) OMAP will rent;

(C) OMAP will repair;

(D) PA required;

(E) Item considered purchased after 16 months of rent.

(c) E0635 – Client lift, electric, with seat or sling:

(A) OMAP will purchase;

(B) OMAP will rent;

(C) OMAP will repair;

(D) PA required;

(E) Item considered purchased after 16 months of rent.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

410-122-0600 Toilet Supplies

(1) Commodes:

(a) Covered when the client is physically incapable of utilizing regular toilet facilities. This would occur when the client is confined to:

(A) A single room; or

(B) One level of the home environment and there is no toilet on that level; or

(C) The home and there are no toilet facilities in the home.

(b) Documentation: The practitioner's records must contain information which supports the medical appropriateness of the item ordered;

(2) Extra-wide/heavy-duty commodes:

(a) Are covered when the client weighs 300 pounds or more and meets the criteria for commodes;

(b) Documentation: Documentation must include the prescription and the client's height and weight. Submit this information when requesting prior authorization;

(3) Procedure Codes – Table 122-0600.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0600 Toilet Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0163	Commode chair – stationary with fixed arms		PC	RT	16	RP	
E0164	Commode chair, mobile with fixed arms		PC	RT	16	RP	
E0165	Commode chair, stationary, with detachable arms ■ Covered if necessary to facilitate transferring the client ■ Covered if the client has a body configuration that requires extra width		PC	RT	16	RP	
E0166	Commode chair, mobile, with detachable arms ■ Covered if necessary to facilitate transferring the client ■ Covered if the client has a body configuration that requires extra width		PC	RT	16	RP	
E0167	Pail or pan for use with commode chair ■ Replacement only ■ Not covered at same time as E0163, E0164, E0165, E0166		PC				
E0168	Commode chair, extra-wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each ■ Width of 23 inches or more and/or capable of supporting clients who weigh 300 pounds or more	PA	PC	RT	16	RP	

Code	Description	PA	PC	RT	MR	RP	NF
E0244	Raised toilet seat		PC				
E0275	Bedpan, standard metal or plastic		PC				
E0276	Bedpan, fracture metal or plastic		PC				
E0325	Urinal, male, jug-type, any material		PC				
E0326	Urinal, female, jug-type, any material		PC				

410-122-0620 Miscellaneous Supplies

Procedure Codes – Table 122-0620.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0620 Miscellaneous Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4206	Syringe with needle, sterile 1cc, each ■ Also used for.3cc or.5cc sterile syringe with needle		PC				
A4207	Syringe with needle, sterile, 2cc, each		PC				
A4208	Syringe with needle, sterile, 3cc, each		PC				
A4209	Syringe with needle, sterile, 5cc or greater, each		PC				
A4213	Syringe, sterile, 20cc or greater, each		PC				
A4215	Needle only, sterile, any size, each		PC				
A4244	Alcohol or peroxide, per pint		PC				
A4245	Alcohol wipes, per box		PC				
A4246	Betadine or phisohex solution, per4 pint		PC				
A4247	Betadine or iodine swabs/wipes, per box		PC				
A4250	Urine test or reagent strips or tablets (100 tablets or strips)		PC				
A4320	Irrigation tray with bulb or piston syringe, any purpose		PC				
A4322	Irrigation syringe, bulb or piston, each		PC				
A4330	Perianal fecal collection pouch with adhesive, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A4455	Adhesive remover or solvent (for tape, cement or other adhesive) ■ One unit of service equals one oz. of liquid or spray		PC				
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope		PC				
A4663	Blood pressure cuff only		PC				
A4670	Automatic blood pressure monitor ■ Covered only if no one in residence is available to safely and accurately use or assist with standard blood pressure equipment and client or caregiver must be able to demonstrate ability to use equipment and correctly interpret results	PA	PC				
A4773	Hemostix, per bottle		PC				
E0191	Heel or elbow protector, each		PC				
E0370	Air pressure elevator for heel		PC				
E0701	Helmet with face guard and soft interface materials, prefabricated		PC				NF
E0776	IV pole		PC	RT	16	RP	
L8501	Tracheostomy speaking valve ■ See the OMAP Speech/Hearing Services rules for billing instructions		PC				NF
S8265	Haberman feeder for cleft lip/palate		PC				
V5266	Battery for use in hearing device ■ Limited to 60 batteries per calendar year		PC				NF

410-122-0625 Surgical Dressing

Procedure Codes -- Table 122-0625.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0625 Surgical Dressing

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4450	Tape, non-waterproof, per 18 square inches		PC				
A4452	Tape, waterproof, per 18 square inches		PC				
A4462	Abdominal dressing holder, each		PC				
A4927	Gloves, non-sterile, per 100 ■ Limited to 200 pair per month		PC				
A4930	Gloves, sterile, per pair, limited to sterile procedure only		PC				
A6010	Collagen based wound filler, dry form, per gram of collagen		PC				
A6011	Collagen based wound filler, gel/paste, per gram of collagen		PC				
A6021	Collagen dressing, pad size 16 sq. in. or less, each		PC				
A6022	Collagen dressing, pad size more than 16 sq. in., but less than or equal to 48 sq. in., each		PC				
A6023	Collagen dressing, pad size more than 48 sq. in., each		PC				
A6024	Collagen dressing, wound filler, per 6 in.		PC				
A6025	Gel sheet for dermal or epidermal application, (e.g., silicone, hydro-gel, other), each		PC				
A6154	Wound pouch, each		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6196	Alginate dressing, wound cover, pad size 16 sq. inches or less, each dressing		PC				
A6197	Alginate dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing		PC				
A6198	Alginate dressing, wound cover, pad size more than 48 sq. inches, each dressing		PC				
A6199	Alginate dressing, wound filler ■ One unit of service = six inches		PC				
A6200	Composite dressing, pad size 16 sq. inches or greater, but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6201	Composite dressing, pad size more than 16 sq. inches, but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6202	Composite dressing, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6203	Composite dressing, pad size 16 sq. inches or less, with any size adhesive border, each dressing		PC				
A6204	Composite dressing, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6205	Composite dressing, pad size more than 48 sq. inches, with any size adhesive border, each dressing		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6206	Contact layer, 16 sq. inches, or less, each dressing		PC				
A6207	Contact layer, more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing		PC				
A6208	Contact layer, more than 48 sq. inches, each dressing		PC				
A6209	Foam dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6210	Foam dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6211	Foam dressing, wound cover, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6212	Foam dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing		PC				
A6213	Foam dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6214	Foam dressing, wound cover, pad size more than 48 sq. inches, with any size adhesive border, each dressing		PC				
A6215	Foam dressing, wound filler ■ One unit of service = one gram		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6217	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6219	Gauze, non-impregnated, non-sterile, pad size 16 sq. inches, or less, with any size adhesive border, each dressing		PC				
A6220	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6221	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. inches, with any size adhesive border, each dressing		PC				
A6222	Gauze, impregnated with other than water, normal saline, or hydro-gel, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6223	Gauze, impregnated with other than water, normal saline, or hydro-gel, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6224	Gauze, impregnated with other than water, normal saline, or hydro-gel, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6231	Gauze, impregnated, hydro-gel, for direct wound contact, pad size 16 sq. inches or less, each dressing		PC				
A6232	Gauze, impregnated, hydro-gel, for direct wound contact, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing		PC				
A6233	Gauze, impregnated, hydro-gel, for direct wound contact, pad size more than 48 sq. inches, each dressing		PC				
A6234	Hydrocolloid dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6235	Hydrocolloid dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6236	Hydrocolloid dressing, wound cover, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6237	Hydrocolloid dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing		PC				
A6238	Hydrocolloid dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6239	Hydrocolloid dressing, wound cover, pad size more than 48 sq. inches, with any size adhesive border, each dressing		PC				
A6240	Hydrocolloid dressing, wound filler, paste ■ One unit of service = one ounce		PC				
A6241	Hydrocolloid dressing, wound filler, dry form ■ One unit of service = one gram		PC				
A6242	Hydro-gel dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6243	Hydro-gel dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6244	Hydro-gel dressing, wound cover, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6245	Hydro-gel dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing		PC				
A6246	Hydro-gel dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6247	Hydro-gel dressing, wound cover, pad size more than 48 sq. inches, with any size adhesive border, each dressing		PC				
A6248	Hydro-gel dressing, wound filler, gel ■ One unit of service = one fluid ounce		PC				
A6251	Specialty absorptive dressing, wound cover, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				
A6252	Specialty absorptive dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6253	Specialty absorptive dressing, wound cover, pad size more than 48 sq. inches without adhesive border, each dressing		PC				
A6254	Specialty absorptive dressing, wound cover, pad size 16 sq. inches or less, with any size adhesive border, each dressing		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6255	Specialty absorptive dressing, wound cover, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, with any size adhesive border, each dressing		PC				
A6256	Specialty absorptive dressing, wound cover, pad size more than 48 sq. inches with any size adhesive border, each dressing		PC				
A6257	Transparent film, 16 sq. inches or less, each dressing		PC				
A6258	Transparent film, more than 16 sq. inches but less than or equal to 48 sq. inches, each dressing		PC				
A6259	Transparent film, more than 48 sq. inches, each dressing		PC				
A6261	Wound filler, not elsewhere classified, gel/paste ■ One unit of service = one fluid ounce	PA	PC				
A6262	Wound filler, not elsewhere classified, dry form ■ One unit of service = one gram	PA	PC				
A6266	Gauze, impregnated, other than water or normal saline, or zinc paste, any width ■ One unit of service = one linear yard)		PC				
A6402	Gauze, non-impregnated, sterile, pad size 16 sq. inches or less, without adhesive border, each dressing		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6403	Gauze, non-impregnated, sterile, pad size more than 16 sq. inches but less than or equal to 48 sq. inches, without adhesive border, each dressing		PC				
A6404	Gauze, non-impregnated, sterile, pad size more than 48 sq. inches, without adhesive border, each dressing		PC				
A6410	Eye pad, sterile, each		PC				
A6411	Eye pad, non-sterile, each		PC				
A6512	Eye patch, occlusive, each		PC				
A6441	Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard		PC				
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard		PC				
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard		PC				
A6444	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per yard		PC				
A6445	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard		PC				
A6446	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard		PC				

Code	Description	PA	PC	RT	MR	RP	NF
A6447	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard		PC				
A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard		PC				
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard		PC				
A6452	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard		PC				
A6453	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard		PC				
A6454	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard		PC				
A6455	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard		PC				
A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven width greater than or equal to three inches and less than five inches, per yard		PC				

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) Incontinent supplies are not covered for clients under age 3.

(3) The limits shown for each code are based on medical appropriateness. When requesting an amount above the limits shown, you must submit documentation supporting why the higher amount is medically appropriate.

(4) Briefs are not covered for nocturnal enuresis.

(5) Washable briefs/protective underwear (A4536) and disposable briefs (A4525, A4526, A4527, A4528, A4531, A4532 and A4534) may be covered at the same time when the disposable briefs are used for trips (i.e., visit to the doctor, physical therapist, etc.). The number of units must not exceed the limit.

(6) Procedure Codes – Table 122-0630-1.

(7) Disposable Protective Underwear:

(a) Indications and Coverage: Covered when the client has:

(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.

(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 122-0630-2.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0630-1 Incontinent Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
Miscellaneous							
A4335	Incontinent supply – miscellaneous ■ Limited to 360 units per month, of any combination of incontinence products, except underpads ■ Including, but not limited to: ◆ Disposable belted undergarments ◆ Disposable slip-on™ undergarments	PA	PC				
A4535	Disposable liner/shield for incontinence, each ■ Including but not limited to: pant liner, insert, insert pad, shield, pad, guard, booster pad, or belt-less undergarment ■ Limited to 360 units per month, of any combination of incontinence products, except underpads	PA	PC				
A4554	Disposable underpads, all sizes (e.g., Chuxs) each ■ Limited to 150 units per month ■ Not covered at the same time as code A4537 ■ Limited to use for fecal incontinence, urinary incontinence, and draining wounds	PA	PC				
A4927	Gloves, non-sterile, per 100 (50 pairs)		PC				

Code	Description	PA	PC	RT	MR	RP	NF
	■ Limited to 400 units (200 pairs) per month						
	■ Not covered for feeding, washing or doing laundry						
A4535	Disposable liner/shield for incontinence, each	PA	PC				
	■ Including but not limited to: pant liner, insert, insert pad, shield, pad, guard, booster pad, or belt-less undergarment						
	■ Limited to 360 units per month, of any combination of incontinence products, except underpads						
Disposable Child-Sized Supplies							
A4529	Child-sized incontinence product, diaper, small/medium size, each	PA	PC				
	■ Limited to 360 units per month, of any combination of incontinence products, except underpads						
A4530	Child-sized incontinence product, diaper, large size, each	PA	PC				
	■ Limited to 360 units per month, of any combination of incontinence products, except underpads						
A4531	Child-sized incontinence product, brief, small/medium size, each	PA	PC				
	■ Limited to 100 units per month						
A4532	Child-sized incontinence product, brief, large size, each	PA	PC				
	■ Limited to 100 units per month						
Disposable Adult-Sized Supplies							
A4521	Adult-sized incontinence product, diaper, small size, each	PA	PC				

Code	Description	PA	PC	RT	MR	RP	NF
	■ Limited to 360 units per month, of any combination of incontinence products, except underpads						
A4522	Adult-sized incontinence product, diaper, medium size, each	PA	PC				
	■ Limited to 360 units per month, of any combination of incontinence products, except underpads						
A4523	Adult-sized incontinence product, diaper, large size, each	PA	PC				
	■ Limited to 360 units per month, of any combination of incontinence products, except underpads						
A4524	Adult-sized incontinence product, diaper, extra large size, each	PA	PC				
	■ Limited to 360 units per month, of any combination of incontinence products, except underpads						
A4533	Youth-sized incontinent product, diaper, each	PA	PC				
	■ Limited to 360 units per month, of any combination of incontinence products, except underpads						
Disposable Protective Underwear							
A4525	Adult-sized incontinence product, brief, small size, each	PA	PC				
	■ Limited to 100 units per month						
A4526	Adult-sized incontinence product, brief, medium size, each	PA	PC				
	■ Limited to 100 units per month						
A4527	Adult-sized incontinence product, brief, large size, each	PA	PC				

Code	Description	PA	PC	RT	MR	RP	NF
	■ Limited to 100 units per month						
A4528	Adult-sized incontinence product, brief, extra large size, each	PA	PC				
	■ Limited to 100 units per month						
A4534	Youth-sized incontinence product, briefs, each	PA	PC				
	■ Limited to 100 units per month						
Washable Incontinent Supplies							
A4536	Protective underwear, washable, any size, each	PA	PC				
	■ Limited to 12 units per 12 months						
A4537	Underpad, reusable, washable, any size, each	PA	PC				
	■ Limited to 8 units per 12 months						
	■ Not covered at the same time as code A4554						
Diaper Service							
A4538	Diaper service, reusable diaper, each diaper	PA	PC				
	■ Not covered at the same time as disposable products						
	■ Limited to 360 units per month, of any combination of incontinence products, except underpads						
	■ Quantity delivered by provider must match prior authorized units						
	■ Service provider must document proof of delivery to the client. Delivery receipt must show signature as well as name of signer.						

Table 122-0630-2 Incontinent Supplies

How to count units/pieces when requesting prior authorization (PA) – *Sample*

Container description	Individual pieces (count)	Units considered for PA
1 box of diapers	10	10
1 box of gloves	100 pieces (50 pairs)	100

410-122-0640 Eye Prostheses

(1) Indications and Coverage:

(a) An eye prosthesis is indicated for a client (adult or child) with absence or shrinkage of an eye due to birth defect, trauma or surgical removal;

(b) Polishing and resurfacing will be allowed on a yearly basis;

(c) Replacement is covered every five years with extensions allowed when documentation supports medical appropriateness for more frequent replacement.

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

(3) Procedure Codes – Table 122-0640.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0640 Eye Prostheses

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
V2623	Prosthetic eye, plastic, custom		PC				NF
V2624	Polishing/Resurfacing of ocular prosthesis		PC				NF
V2625	Enlargement of ocular prosthesis		PC				NF
V2626	Reduction of ocular prosthesis		PC				NF
V2627	Scleral cover shell		PC				NF
V2628	Fabrication and fitting of ocular conformer		PC				NF
V2629	Prosthetic eye, other type		PC				NF

410-122-0660 Orthotics and Prosthetics

(1) Indications and Coverage:

(a) All of the orthotic and prosthetic “L” codes and any temporary “S” or “K” codes have been removed from the rules except for:

(A) OAR 410-122-0470 Supports and Stockings;

(B) OAR 410-122-0255 External Breast Prosthesis, and;

(C) OAR 410-122-0680 Facial Prosthesis.

(b) Use the current HCPCS Level II Guide for current codes and descriptions;

(c) For adults, follow Medicare current guidelines for determining coverage;

(d) For children, the prescribing practitioner must determine and document medical appropriateness.

(2) Prior Authorization is required for the following codes:

(a) L1499;

(b) L2999;

(c) L3649;

(d) L3999;

(e) L5999;

(f) L7499;

(g) L8499;

(h) L9900.

(3) Codes Not Covered -- Table 122-0660.

(4) Reimbursement:

(a) The hospital is responsible for reimbursing the provider for orthotics and prosthetics provided on an inpatient basis;

(b) Evaluations, office visits, fittings and materials are included in the service provided;

(c) Evaluations will only be reimbursed as a separate service when the provider travels to a client's residence to evaluate the client's need;

(d) All covered orthotic and prosthetic codes are also covered if client resides in a nursing facility except:

(A) L1500;

(B) L1510, and;

(C) L1520.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0660 Orthotics and Prosthetics

Codes Not Covered

L1844	L5780	L6825	L7020	L7360
L2750	L5781	L6875	L7025	L7362
L2780	L5782	L6881	L7030	L7364
L3031	L5822	L6882	L7035	L7366
L3251	L5824	L6920	L7040	L7367
L5610	L5828	L6925	L7045	L7368
L5613	L5830	L6930	L7170	L7500
L5614	L5847	L6935	L7180	L7520
L5722	L5848	L6940	L7185	L7900
L5724	L5980	L6945	L7186	L8510
L5726	L5989	L6950	L7190	L8511
L5728	L6025	L6955	L7191	L8512
L8010	L6310	L6960	L7260	L8513
L8500	L6360	L6965	L7261	L8514
L8501	L6638	L6970	L7266	L8614
L8505	L6646	L6975	L7272	L8619
L8507	L6648	L7015	L7274	

410-122-0678 Dynamic Adjustable Extension/Flexion Device

Procedure Codes – Table 122-0678

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0678 Dynamic Adjustable Extension/Flexion Device

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E1800	Dynamic adjustable elbow extension/flexion device, includes soft interface material		PC	RT	16		NF
E1802	Dynamic adjustable forearm pronation/supernator device, includes soft interface material		PC	RT	16		NF
E1805	Dynamic adjustable wrist extension/flexion device, includes soft interface material		PC	RT	16		NF
E1810	Dynamic adjustable knee extension/flexion device, includes soft interface material		PC	RT	16		NF
E1815	Dynamic adjustable ankle extension/flexion device, includes soft interface material		PC	RT	16		NF
E1820	Replacement soft interface material, dynamic adjustable extension/flexion device		PC				NF
E1825	Dynamic adjustable finger extension/flexion device, includes soft interface material		PC	RT	16		NF
E1830	Dynamic adjustable toe extension/flexion device, includes soft interface material		PC	RT	16		NF
E1840	Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material		PC	RT	16		NF

410-122-0680 Facial Prostheses

(1) Indications and Coverage:

(a) Covered when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect;

(b) Adhesives, adhesive remover and tape used in conjunction with a facial prosthesis are covered. Other skin care products related to the prosthesis, including but not limited to cosmetics, skin cream, cleansers, etc., are not covered;

(c) The following services and items are included in the allowance for a facial prosthesis:

(A) Evaluation of the client;

(B) Pre-operative planning;

(C) Cost of materials;

(D) Labor involved in the fabrication and fitting of the prosthesis;

(E) Modifications to the prosthesis made at the time of delivery of the prosthesis or within 90 days thereafter;

(F) Repair due to normal wear or tear within 90 days of delivery;

(G) Follow-up visits within 90 days of delivery of the prosthesis.

(d) Modifications to a prosthesis that occur more than 90 days after delivery of the prosthesis and that are required because of a change in the client’s condition are covered;

(e) Repairs are covered when there has been accidental damage or extensive wear to the prosthesis that can be repaired. If the expense for repairs exceeds the estimated expense for a replacement prosthesis, no payments can be made for the amount of the excess;

(f) Follow-up visits which occur more than 90 days after delivery and which do not involve modification or repair of the prosthesis are non-covered services;

(g) Replacement of a facial prosthesis is covered in cases of loss or irreparable damage or wear or when required because of a change in the client's condition that cannot be accommodated by modification of the existing prosthesis;

(h) When a prosthesis is needed for adjacent facial regions, a single code must be used to bill for the item, whenever possible. For example, if a defect involves the nose and orbit, this should be billed using the hemi-facial prosthesis code and not separate codes for the orbit and nose. This would apply even if the prosthesis is fabricated in two separate parts.

(2) Documentation: The following must be submitted for prior authorization (PA):

(a) An order for the initial prosthesis and/or related supplies which is signed and dated by the ordering prescribing practitioner must be kept on file by the prosthetist/supplier and submitted with request for PA;

(b) A separate prescribing practitioner order is not required for subsequent modifications, repairs or replacement of a facial prosthesis;

(c) A new prescribing practitioner order is required when different supplies are ordered;

(d) A photograph of the prosthesis and a photograph of the client without the prosthesis must be retained in the supplier's record and must be submitted with the PA request;

(e) When code L8048 is used for a miscellaneous prosthesis or prosthetic component, the authorization request must be accompanied by a clear description and a drawing/copy of photograph of the item provided and the medical appropriateness;

(f) Requests for replacement, repair or modification of a facial prosthesis must include an explanation of the reason for the service;

(g) When replacement involves a new impression/moulage rather than use of a previous master model, the reason for the new impression/moulage must be clearly documented in the authorization request.

(3) Procedure Codes – Table 122-0680.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0680 Facial Prostheses

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A4364	Adhesive liquid, or equal, any type, per ounce		PC				NF
A4365	Adhesive remover wipes, any type, per box of 50		PC				NF
L8040	Nasal prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores all or part of the nose ■ It may include the nasal septum	PA	PC				NF
L8041	Mid-facial prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores part or all of the nose plus significant adjacent facial tissue/structures, but does not include the orbit or any intra-oral maxillary component ■ Adjacent facial tissue/structures include one or more of the following: ◆ Soft tissue of the cheek, ◆ Upper lip, or ◆ Forehead	PA	PC				NF
L8042	Orbital prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores the eyelids and the hard and soft tissue of the orbit ■ It may also include the eyebrow	PA	PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
	■ This code does not include the ocular prosthesis component						
L8043	Upper facial prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores the orbit plus significant adjacent facial tissue/structures, but does not include the nose or any intra-oral maxillary component ■ Adjacent facial tissue/structures include one or more of the following: soft tissue of the cheek or forehead ■ This code does not include the ocular prosthesis component	PA	PC				NF
L8044	Hemi-facial prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores part or all of the nose plus the orbit plus significant adjacent facial tissue/structures, but does not include any intra-oral maxillary component ■ This code does not include the ocular prosthesis component	PA	PC				NF
L8045	Auricular prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores all or part of the ear	PA	PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
L8046	Partial facial prosthesis provided by a non-physician ■ A removable superficial prosthesis which restores a portion of the face but which does not specifically involve the nose, orbit or ear	PA	PC				NF
L8047	Nasal septal prosthesis provided by a non-physician ■ A removable superficial prosthesis which occludes a hole in the nasal septum but which does not include superficial nasal tissue	PA	PC				NF
L8048	Unspecified maxillofacial prosthesis, provided by a non physician ■ Used for a facial prosthesis that is not described by a specific code, L8040-L8047 ■ Used for any materials used for modification or repairs or for a component which is used to attach prosthesis to a bone-anchored implant or to an internal prosthesis (e.g., maxillary obturator) ■ Not to be used for implanted prosthesis anchoring components	PA	PC				NF

Code	Description	PA	PC	RT	MR	RP	NF
L8049	Repair or modification of maxillofacial prosthesis, labor component, 15-minute increments provided by a non-physician ■ Use for time used for laboratory modification or repair and prosthetic evaluation services associated with repair or modification, only after 90 days from the date of delivery of the prosthesis ■ Evaluation not associated with repair or modification is not covered	PA				RP	NF

410-122-0700 Negative Pressure Wound Therapy

(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 sub-atmospheric pressure to a wound using an electrical pump to intermittently or continuously convey sub-atmospheric 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 sub-atmospheric 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 – Non-blanchable 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) Exclusions from coverage – An NPWT pump and supplies are not covered when one or more of the following are present:

(a) The presence in the wound of necrotic tissue with eschar, if debridement is

not attempted;

(b) Untreated osteomyelitis within the vicinity of the wound;

(c) Cancer present in the wound;

(d) The presence of a fistula to an organ or body cavity within the vicinity of the wound.

(4) Initial Coverage – A NPWT pump and supplies are covered for:

(a) Ulcers and wounds in the home or nursing facility when the client has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology;

(b) A complete wound therapy program described by criterion 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.

(5) Continued Coverage – For consideration of continued coverage for negative pressure wound therapy (NPWT), a licensed medical professional must, on a regular basis:

(a) Directly assess the wound(s) being treated with the NPWT pump; and

(b) Supervise or directly perform the NPWT dressing changes;

(c) On at least a monthly basis, document changes in the ulcer's dimensions and characteristics.

(6) NPWT pump and supplies will be denied as not medically appropriate with any of the following, whichever occurs earliest:

(a) Criteria in section 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.

(7) NPWT Criterion:

(a) 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:

(A) Documentation in the client's medical record of evaluation, care, and wound measurements by a licensed medical professional; and

(B) Application of dressings to maintain a moist wound environment; and

(C) Debridement of necrotic tissue if present; and

(D) Evaluation of and provision for adequate nutritional status.

(b) 2 – For Stage III or IV pressure ulcers:

(A) The client has been appropriately turned and positioned; and

(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;

(C) The client's moisture and incontinence have been appropriately managed.

(c) 3 – For neuropathic (for example, diabetic) ulcers:

(A) The client has been on a comprehensive diabetic management program; and

(B) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.

(d) 4 – For venous insufficiency ulcers:

(A) Compression bandages and/or garments have been consistently applied; and

(B) Leg elevation and ambulation have been encouraged.

(e) 5 – Preoperative myocutaneous flap or graft:

(A) Accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments;

(B) Other conditions of the client that will not allow for healing times achievable with other topical wound treatments.

(8) 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.

(9) Procedure Codes: Table 122-0700.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0700 Negative Pressure Wound Therapy

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
A6550	Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each	PA	PC				NF
A6551	Canister set for negative pressure wound therapy electrical pump, stationary or portable, each	PA	PC				NF
E2402	Negative pressure wound therapy	PA	PC				NF

410-122-0720 Pediatric Wheelchairs

(1) Indications and Coverage:

(a) The purchase, rental, or modification of a pediatric wheelchair is covered whenet:

(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 back-up 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 the requested wheelchair. OMAP is not responsible for adapting living quarters;

(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 – Table 122-0720.

(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.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-04

Table 122-0720 Pediatric Wheelchairs

For the code legend see OAR 410-122-0182

* *Covered if supplied for client-owned chair*

Code	Description	PA	PC	RT	MR	RP	NF
E1011	Modification to pediatric wheelchair, width adjustment package (not to be dispensed with initial chair)	PA	PC	RT	16	RP	*
E1012	Integrated seating system, planar, for pediatric wheelchair	PA	PC	RT	16	RP	*
E1013	Integrated seating system, contoured, for pediatric wheelchair	PA	PC	RT	16	RP	*
E1014	Reclining back, addition to pediatric wheelchair	PA	PC	RT	16	RP	*
E1025	Lateral thoracic support, non contoured, for pediatric wheelchair, each (includes hardware)	PA	PC	RT	16	RP	*
E1026	Lateral thoracic support, contoured, for pediatric wheelchair, each (includes hardware)	PA	PC	RT	16	RP	*
E1027	Lateral/anterior support, for pediatric wheelchair, each includes hardware)	PA	PC	RT	16	RP	*
Pediatric Tilt-in Space							
E1231	Wheelchair pediatric size, tilt-in space, rigid, adjustable, with seating system	PA	PC	RT	16	RP	*
E1232	Wheelchair pediatric size, tilt-in space, folding, adjustable, with seating system	PA	PC	RT	16	RP	*
E1233	Wheelchair pediatric size, tilt-in space, rigid, adjustable, without seating system	PA	PC	RT	16	RP	*

** Covered if supplied for client-owned chair*

Code	Description	PA	PC	RT	MR	RP	NF
E1234	Wheelchair pediatric size, tilt-in space, folding, adjustable, without seating system	PA	PC	RT	16	RP	*
E1235	Wheelchair pediatric size, rigid, adjustable, with seating system	PA	PC	RT	16	RP	*
E1236	Wheelchair pediatric size, folding, adjustable, with seating system	PA	PC	RT	16	RP	*
E1237	Wheelchair pediatric size, rigid, adjustable, without seating system	PA	PC	RT	16	RP	*
E1238	Wheelchair pediatric size, folding, adjustable, without seating system	PA	PC	RT	16	RP	*