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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 36-2025
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED
03/31/2025 9:03 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Amend payment methodology language complying with Oregon's state plan amendment effective 10/01/2024.

EFFECTIVE DATE: 03/31/2025 THROUGH 09/26/2025

AGENCY APPROVED DATE: 03/31/2025

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Filed By:
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NEED FOR THE RULE(S):

OHA needs to amend this rule to reflect the updated FFS DMEPOS payment methodology resulting from our State Plan Amendment which was approved by CMS in December and is retroactively effective 10/01/2024. OHA has completed the work to load the new rates into our payment systems (MMIS) and has add the updated rates to the FFS Medical-Dental Fee Schedule quarterly update for March.

JUSTIFICATION OF TEMPORARY FILING:

(1) The specific consequences that result from the failure to immediately amend this rule is direct harm and/or denial or delay in payment and delivery of DME equipment to Oregon Health Plan members due to a mismatch between this OAR, our published fee-schedule, and our payment system settings.
(2) Oregon Health Plan members who need DME equipment.
(3) Failure to take this rulemaking action would cause harm to Medicaid beneficiaries, especially those enrolled in CCOs. Without this emergency rule, the DME suppliers who provide equipment, products, and supplies to our CCO beneficiaries will continue to or begin to withhold certain DMEPOS products from these beneficiaries and therefore continue to disrupt care or cause a disruption in their care.
(4) This Emergency rule will inform and reassure DME suppliers of the updated payment methodology and assist in maintaining and expanding coverage of DMEPOS products to Medicaid beneficiaries now.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Oregon's State Plan https://www.medicaid.gov/medicaid/medicaid-state-planamendments?search_api_fulltext=ID:173496

AMEND: 410-122-0186

RULE TITLE: Payment Methodology

RULE SUMMARY: Oregon Health Plan - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Payment

Methodology Rule. In accordance with Oregon's state plan (effective 10-01-2024), this amendment is for revising language to clarify the payment methodology changes to durable medical equipment, prosthetics, orthotics, and supplies that are covered by the Oregon Health Plan.

RULE TEXT:

(1) Effective October 1, 2024, the Division utilizes a payment methodology for covered durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that is generally based on the 2024 Medicare fee schedule.

(a) The Division fee schedule amount is 80 percent of 2024 Medicare Fee Schedule for items covered by Medicare and the Division using a state-wide average of the rural and urban Medicare rates except for:

(A) Complex Rehabilitation items and services other than power wheelchairs, fee schedule amounts are 88 percent of 2024 Medicare Fee Schedule (See Table 122-0186-2 for list of Complex Rehabilitation codes subject to this pricing); and

(B) Rental rates for Group 1 power wheelchairs (K0813-K0816) and Group 2 power wheelchairs with no added power option (K0820-K0829) fee schedule amounts are 55 percent of 2024 Medicare Fee Schedule; and

(C) Group 2 power wheelchairs (K0835-K0843) and Group 3 power wheelchairs (K0848-K0864) fee schedule amounts are 58.7 percent of 2024 Medicare Fee Schedule; and

(D) Unlisted procedures, codes not listed on the 2024 Medicare Fee Schedule, are based upon 75% of Manufacturer's Suggested Retail Price (MSRP). If MSRP is not available, payment is acquisition cost plus 20%.

(b) For new codes added by the Center for Medicare and Medicaid Services (CMS), payment shall be based on the most current Medicare fee schedule and shall follow the same payment methodology as stated in section (1)(a)(A-D) of this rule. For new codes that do not appear on the current Medicare fee schedule, payment shall be based on the actuarial calculations used for rate setting for the CCO rate for the service and shall be published as a single state-wide rate;

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

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

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

(c) The actual charge submitted.

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

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

(a) Seventy-five (75) percent of manufacturer's suggested retail price (MSRP) verifiable with quote from the manufacturer that clearly states the amount indicated is MSRP. If MSRP is not available, acquisition cost plus twenty (20) percent, verifiable with quote, invoice, or bill from the manufacturer that clearly states the amount indicated is acquisition cost; or

(b) Actual charge submitted by the provider.

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

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

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

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

(6) The DMEPOS provider shall submit verification for items billed with miscellaneous codes A4649, E1399, and K0108 when no specific Healthcare Common Procedure Coding System (HCPCS) code is available, unless otherwise stated in these rules (e.g. standing frames, bath equipment, adaptive car seats). Providers may submit verification from an organization such as the Medicare Pricing, Data Analysis and Coding (PDAC) contractor.

(7) The Division may review items that exceed the maximum allowable on a case-by-case basis and may ask the provider

to submit the following documentation for reimbursement:
(a) Documentation which supports that the client meets all of the coverage criteria for the less costly alternative; and,
(b) A comprehensive evaluation by a licensed clinician (who is not an employee of or otherwise paid by a provider) that clearly explains why the less costly alternative is not sufficient to meet the client's medical needs, and;
(c) The expected hours of usage per day, and;
(d) The expected outcome or change in the client's condition.
(8) PA is not required for codes A4649, E1399, and K0108 when the cost is $150.00 or less per each unit:
(a) Only items that have received an official product review coding decision from an organization such as PDAC with codes A4649, E1399, or K0108 shall be billed to the Division unless otherwise stated in these rules (e.g. standing frames, bath equipment, adaptive car seats). These products may be listed in the PDAC Durable Medical Equipment Coding System Guide (DMECS) DMEPOS Product Classification Lists;
(b) Subject to service limitations of the Division's rules;
(c) The amount billed to the Division may not exceed seventy-five (75) percent of MSRP. The provider must retain documentation of the quote, invoice, or bill to allow the Division to verify through audit procedures.
(9) For rented equipment, the equipment is considered paid for and owned by the client when the Division fee schedule allowable is met or the actual charge from the provider is met, whichever is lowest. The provider must transfer title of the equipment to the client.
[ED. NOTE: To view attachments referenced in rule text, click here for PDF copy.]

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065