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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Multiple Updates to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Program Administrative Rules.

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RULES:
410-122-0010, 410-122-0040, 410-122-0080, 410-122-0090, 410-122-0180, 410-122-0182, 410-122-0184, 410-122-0200, 410-122-0202, 410-122-0203, 410-122-0205, 410-122-0211, 410-122-0250, 410-122-0300, 410-122-0320, 410-122-0325, 410-122-0330, 410-122-0340, 410-122-0365, 410-122-0380, 410-122-0515, 410-122-0525, 410-122-0560, 410-122-0580, 410-122-0620, 410-122-0630, 410-122-0658, 410-122-0678, 410-122-0710, 410-122-0730

AMEND: 410-122-0010

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Definitions rule. These updates added definitions for terms referenced in rule revisions and those which overlap and are referenced in other OAR Chapter 410 Division rules. For example, updated the term “EPSDT beneficiary” to OAR Chapter 410 Division 151‘s definition for consistency and clarity.

CHANGES TO RULE:

410-122-0010
Definitions ¶

In addition to the definitions in OAR 410-120-0000, the following definitions in these rules apply: ¶
(1) "Activities of Daily Living (ADL's)" means activities related to personal care including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing that are necessary to maintain or improve the client's health. ¶
(2) "Acquisition Cost" has the meaning given to the term in OAR Chapter 410 Division 120. ¶
(3) "Buy-up" means 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 standard walker. ¶
~~(3) "Consecutive Months" means any period of continuous use where no more than a 60-day break occurs. ¶~~
(44) "Complex Rehabilitation Technology" has the meaning given in 2025 Oregon Laws Chapter 258, Section 2. ¶
(5) "Consecutive Months" means any period of continuous use where no more than a 60-day break occurs. ¶
(6)/"Division" means the Health Systems Division within the Authority. The Division is responsible for

coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs. ¶
(7) "DMEPOS" is an acronym for durable medical equipment, prosthetics, orthotics, and supplies. ¶
(8) "Durable Medical Equipment" means ~~/~~equipment and appliances that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, can be reusable or removable, ~~/~~and is appropriate for use in any non-institutional setting in which normal life activities take place. Some examples include wheelchairs, crutches, and hospital beds.¶
~~(5) "Division" means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.~~ ¶
(~~6~~9) "EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment program which provides comprehensive and preventive health care services to OHP clients ~~under the age of 21~~ in accordance with federal regulations and as defined in OAR ~~410, Division 151.~~ ¶
(~~7~~Chapter 410 Division 151. ¶
(10) "EPSDT Beneficiary" has the meaning given that term in OAR Chapter 410 Division 120 and OAR Chapter 410 Division 151. ¶
(11) "Healthcare Professionals" has the meaning given that term in OAR Chapter 410 Division 120. ¶
(12) "Home" for purposes of purchase, rental, and repair of durable medical equipment (DME) means a place of permanent residence such as an assisted living facility, 24-hour residential care facility, adult foster home, child foster home, or a private home. This does not include hospitals, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, any setting that exists primarily for the purpose of providing medical/nursing care, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Separate payment may not be made to DME providers for equipment and medical supplies provided to a client when the cost of such items is already included in the capitated (per diem) rate paid to a facility or organization. ¶
(~~8~~13) "Instrumental activities of daily living (IADLs)" means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community. ¶
(14) "Licensed Practitioner of the Healing Arts (LPHA)" means a physician or other practitioner licensed in the State of Oregon who is authorized within the scope of the LPHA's practice, as defined under state law, to diagnose and treat individuals with physical or mental disabilities or psychosocial, emotional, and behavioral disorders. ¶
(15) "Lifetime Need" means 99 months or more. ¶
(~~9~~16) "Manufacturer Part Number (MPN)" means: ¶
(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. ¶
(1~~0~~7) "Medical Records" means the practitioner's office records, hospital records, nursing facility records, home health agency records, records from other healthcare professionals, and diagnostic and test reports. This documentation must be made available to the Health Systems Division (Division) upon request. ¶
(1~~1~~8) "Medical Supplies" means health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing. ¶
(1~~2~~9) "Medically Appropriate" has the meaning given that term in OAR ~~410-120-0000 for clients age 21 and older and OAR 410-151-0001 for clients under age 21.~~¶
(~~13~~Chapter 410 Division 120 for adult beneficiaries and OAR Chapter 410 Division 151 for EPSDT beneficiaries. ¶
(20) "Medically Necessary" has the meaning given that term in OAR ~~410-120-0000 for clients over the age of 21 and OARR 410-151-0001 for clients under age 21.~~¶
(~~14~~Chapter 410 Division 120 for adult beneficiaries and OAR Chapter 410 Division 151 for EPSDT beneficiaries. ¶
(21) "Mobility-related Activities of Daily Living (MRADL's)" means personal care activities including, but not limited to, tasks such as toileting, ~~eat~~feeding, dressing, grooming, and bathing. ~~¶~~
(~~15~~ in customary locations.¶
(22) "Morbidity" means a diseased state, often used in the context of a "morbidity rate" (i.e., the rate of disease or proportion of diseased people in a population). In common clinical usage, any disease state including diagnosis and

complications is referred to as morbidity. ¶
(~~16~~23) "Morbidity Rate" means the rate of illness in a population. The number of people ill during a time period is divided by the number of people in the total population. ¶
~~(17) "The Division Maximum Allowable Rate" means the maximum amount paid by the Division for a service. ¶~~
(~~18~~24) "Practitioner" means an individual 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. /For ordering and provision of durable medical equipment, prosthetics, orthotics and medical suppliers this includes both physicians and non-physician practitioners (i.e., physician associate, nurse practitioners, and certified nurse specialists) as defined in section 1861 of the Social Security Act). ¶
(~~19~~25) "Prosthetic and Orthotic Devices" means devices that replace all or part of an internal body organ, including ostomy bags and supplies directly related to ostomy care and replacement of such devices and supplies. Prosthetic and orthotic devices also include leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the client's physical condition. ¶
(2~~0~~6) "Purchase price" means: ¶
(a) Delivery; ¶
(b) Assembly; ¶
(c) Adjustments, if needed; and ¶
(d) Training in the use of the equipment or supply. ¶
(2~~1~~7) "Rental fees" means: ¶
(a) Delivery; ¶
(b) Training in the use of the equipment; ¶
(c) Pick-up; ¶
(d) Routine service, maintenance, and repair; and ¶
(e) Moving equipment to a new residence, if coverage is to continue. ¶
(2~~2~~8) "Technician" means 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. ¶
(23~~9~~) "~~Licensed Practitioner of the Healing Arts (LPHA)" means a physician or other practitioner licensed in the State of Oregon who is authorized within the scope of the LPHA's practice, as defined under state law, to diagnose and treat individuals with physical or mental disabilities or psychosocial, emotional, and behavioral disorders~~The Division Maximum Allowable Rate" means the maximum amount paid by the Division for a service. ¶
(30) "Young Adults with Special Health Care Needs (YSHCN)"/has the meaning given that term in OAR Chapter 410 Division 120 and OAR Chapter 410 Division 200.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-122-0040

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Prior Authorizations rule. These updates included removing reference to obsolete linked information and added language to comply with the passing of SB 549 during the 2025 Legislative Session.

CHANGES TO RULE:

410-122-0040
Prior Authorization ¶

(1) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers shall obtain prior authorization (PA) for Healthcare Common Procedure Coding System (HCPCS) Level II codes as specified in rule, unless otherwise noted. ¶
(~~2~~a) Providers shall request PA as follows ~~(see the DMEPOS Supplemental Information for contact information)~~: ¶
(~~a~~A) For Medically Fragile Children's Unit (MFCU) clients, from the Department of Human Services (Department) MFCU; ¶
(~~b~~B) For clients enrolled in a Coordinated Care Organization (CCO), from the CCO; ¶
(~~c~~C) For clients enrolled in a prepaid health plan (PHP), from the PHP; ¶
(~~d~~D) For all other clients, from the Health Systems Division./ ¶
(~~3~~b) For DMEPOS provided after normal working hours, providers must submit PA requests within five working days from the initiation of service. ¶
(~~4~~c) See OAR 410-120-1320 for more information about PA. ¶
(2) Effective January 1, 2026, the Division shall provide notice of determination no later than 72 hours following receipt of PA requests for costs to repair complex rehabilitation technology as defined in Section 2 of Enrolled SB 549 (2025). The 72-hour period of time shall be determined by the time and date stamp on the receipt of request.
Statutory/Other Authority: ORS 414.065, SB 549 (2025)
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0080

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Conditions of Coverage, Limitations, and Restrictions rule. These updates included clarifying FDA language for readability and for consistency with overlapping program areas and removed an example provided in reference to "precautionary reasons" for clarity.

CHANGES TO RULE:

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

(1) For ~~clients under the age of 21~~EPSDT beneficiaries (as defined in OAR 410-151-0001) and clients in the Young Adults with Special Health Care Needs or "YSHCN" program (as defined in OAR 410-200-0455): The EPSDT program covers all medically necessary and medically appropriate services needed to correct or ameliorate health conditions, or to improve the client's ability to grow, develop, or participate in school, regardless of placement on or inclusion in the Prioritized List of Health Services. Coverage for medical equipment and supplies shall not be denied without an individual review for medical necessity and medical appropriateness, as defined in OAR 410-151-0001. ¶
(2) For clients age 21 and older: The Division may pay for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) when the item meets all criteria in these rules, including all of the following conditions. The item: ¶
(a) Is either approved ~~for marketing and~~, registered, or listed as a medical device by the Food and Drug Administration (FDA), ~~when FDA approval is required for~~and the item~~, and~~ is otherwise generally considered to be safe and effective for the intended purpose. In the event of delay in FDA approval and/or registration, the Division shall review purchase options on a case-by-case basis; ¶
(b) Is medically appropriate and medically necessary for the client, as defined in OAR 410-120-0000; ¶
(c) Is primarily and customarily used to serve a medical purpose; ¶
(d) Is generally not useful to an individual in the absence of medical disability, illness, or injury; ¶
(e) Is suitable for use in a client's home or any non-institutional setting in which normal life activities take place; ¶
(f) Specifically for durable medical equipment, the item can withstand repeated use and can be reusable or removable; ¶
(g) Meets the coverage criteria as specified in this division and subject to service limitations of the Division rules; ¶
(h) Is requested in relation to a diagnosis and treatment pair that is above the funding line and consistent with treatment guidelines on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List of Health Services or List) or qualify for coverage under ~~/~~OAR 410-141-3820(11);~~/~~ ¶
(i) Is included in the Oregon Health Plan (OHP) client's benefit package of covered services; ¶
(j) Is the least costly, medically appropriate item that meets the medical needs of the client; ¶
(k) Coverage is not restricted to items covered by the Medicare program. ¶
(3) Conditions for Medicare-Medicaid Services: ¶
(a) If Medicare is the primary payer and Medicare denies payment, an appeal to Medicare must be filed timely prior to submitting the claim to the Division for payment. If Medicare denies payment based on failure to submit a timely appeal, the Division may reduce any amount the Division determines could have been paid by Medicare; ¶
(b) If Medicare denies payment on appeal, the Division shall apply DMEPOS coverage criteria in this rule to determine whether the item or service is covered under the OHP; ¶
(c) Providers are not required to bill Medicare for items that are statutorily excluded and therefore not recognized as part of a covered Medicare benefit (e.g., incontinence supplies, bath equipment, adaptive car seats, standing frames). Prior authorization criteria for these services/items must still be met. ¶
(4) The Division may not cover DMEPOS items when the item or the use of the item is: ¶
(a) Not primarily medical in nature (e.g., personal hygiene items, sporting and fitness equipment, equipment used with the primary intent to physically restrain an individual); ¶
(b) For personal comfort or convenience of the client or caregiver; ¶
(c) A self-help device; ¶
(d) Not therapeutic or diagnostic in nature; ¶
(e) Used for precautionary reasons ~~(e.g., pressure-reducing support surface for prevention of decubitus ulcers)~~; ¶
(f) Inappropriate for client use in the home or non-institutional setting (e.g., institutional equipment like an oscillating bed); ¶

(g) For a purpose where the medical effectiveness is not supported by evidence-based clinical practice guidelines; or ¶
(h) Reimbursed as part of the bundled rate in a nursing facility as described in OAR 411-070-0085 or as part of a home and community-based care waiver service or by any other public, community, or third-party resource. ¶
(5) Codes that are identified in these rules or in fee schedules are provided as a mechanism to facilitate payment for covered items and supplies consistent with OAR 410-122-0186, but codes do not determine coverage. If prior authorization is required, the request for reimbursement shall document that prior authorization was obtained in compliance with the rules in this division. ¶
(6) DMEPOS providers shall have documentation on file that supports coverage criteria are met. ¶
(7) Billing records shall demonstrate that the provider has not exceeded any limitations and restrictions in the DMEPOS rules. The Division may require additional claim information from the provider consistent with program integrity review processes. ¶
(8) Documentation described in sections (5), (6), and (7) above shall be made available to the Division upon request. ¶
(9) The Division fee schedule provides a list of HCPCS codes that may be covered when criteria are met. Coverage may be provided for HCPCS codes that do not appear on the fee schedule with an individual medical appropriateness review as outlined in this rule. ¶
(10) Some benefit packages do not cover equipment and supplies (see OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System). ¶
(11) Buy-ups are prohibited. Advanced Beneficiary Notices (ABN) constitute a buy-up and is prohibited. Refer to the Division General Rules (chapter 410, division 120) for specific rules on buying up. ¶
(12) Equipment purchased by the Division for a client becomes the property of the client. ¶
(13) Rental charges starting with the initial date of service, regardless of payer, apply to the purchase price. ¶
(14) A provider who supplies rented equipment shall continue furnishing the same item throughout the entire rental period, except under documented reasonable circumstances. ¶
(15) Before renting, providers must consider purchase for long-term requirements. ¶
(16) The Division may not pay DMEPOS providers for medical supplies separately while a client is under a home health plan of care and covered home health care services. ¶
(17) The Division may not pay DMEPOS providers for medical supplies separately while a client is under a hospice plan of care where the supplies are included as part of the written plan of care and for which payment may otherwise be made by Medicare, the Division, or other carrier. ¶
(18) Separate payment may not be made to DMEPOS providers for equipment and medical supplies provided to a client when the cost of the items is already included in the capitated (per diem) rate paid to a facility or organization. ¶
(19) Certain specified medical equipment and supplies require a face-to-face examination as described in these rules consistent with federal regulations at 42 CFR 440.70. See OAR 410-122-0090 for the face-to-face requirements. ¶
(20) Non-contiguous out-of-state DMEPOS providers may seek Medicaid payment only under the following circumstances: ¶
(a) Medicare/Medicaid clients: ¶
(A) For Medicare covered services and then only Medicaid payment of a client's Medicare cost-sharing expenses for DMEPOS services when all of the following criteria are met: ¶
(i) Client is a qualified Medicare beneficiary (QMB); ¶
(ii) Service is covered by Medicare; ¶
(iii) Medicare has paid on the specific code. Prior authorization is not required. ¶
(B) Services not covered by Medicare: ¶
(i) Only when the service or item is not available in the State of Oregon, and this is clearly substantiated by supporting documentation from the prescribing practitioner and maintained in the DMEPOS provider's records; ¶
(ii) Some examples of services not reimbursable to a non-contiguous out-of-state provider include but are not limited to incontinence supplies, grab bars; ¶
(iii) Services billed must be covered under the OHP; ¶
(iv) Services provided and billed to the Division shall be in accordance with all applicable Division rules. ¶
(b) Medicaid-only clients: ¶
(A) For a specific Oregon Medicaid client who is temporarily outside Oregon and only when the prescribing practitioner has documented that a delay in service may cause client harm; ¶
(B) For foster care or subsidized adoption children placed out of state; ¶
(C) Only when the service or item is not available in the State of Oregon, and this is clearly substantiated by supporting documentation from the prescribing practitioner and maintained in the DMEPOS provider's records; ¶
(D) Services billed must be covered under the OHP; ¶

(E) Services provided and billed to the Division shall be in accordance with all applicable Division rules. ¶
(21) An individual medical appropriateness review shall be conducted by the Division or CCO on requests for any DMEPOS item, related supplies, or services that are not already identified as covered by the Division in these rules or the Division fee schedule: ¶
(a) The DME supplier must submit clinical documentation from the prescribing practitioner that is client-specific and demonstrates there is no equally effective, less costly covered item or service that meets the client's medical needs; ¶
(b) The client's prescribing practitioner must certify that the less costly alternatives have been tried and failed or could be reasonably expected to fail or is inappropriate for the client; ¶
(c) Documentation must support that the requested item or service is medically appropriate and medically necessary as defined in OAR ~~410-120-0000 for clients age 21 and older and OAR 410-151-0001 for clients under the age of 21 and clients in the~~ Chapter 410 Division 120 for adult beneficiaries and OAR Chapter 410 Division 151 for EPSDT beneficiaries. An EPSDT beneficiary is an individual under the age of 21 who is covered by the Oregon Health Plan (OHP) or an individual in the Young Adults with Special Health Care Needs (YSHCN) program as defined in OAR 410-200-0455; ¶
(d) Requests under this section for clients enrolled in CCOs shall be directed to the CCO in which the client is enrolled, in accordance with OAR 410-122-0040(2). ¶
(22) See General Rules OAR 410-120-1200 Excluded Services and Limitations for more information on general scope of coverage and limitations.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-122-0090

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Face to Face Encounter Requirements rule. These updates included replacing a link to the CMS potential Face to Face requirements with the updated required list for clarity.

CHANGES TO RULE:

410-122-0090
Face-to-Face Encounter Requirements (for Fee-For-Service Clients) ¶

(1) For initial ordering of DME items identified in section (9) of this rule and for those DME items identified as requiring a face-to-face visit in Division 122 rules, an in-person or telehealth face-to-face encounter that is related to the primary reason the client requires the medical equipment or supplies must occur no more than six (6) months prior to the start of services. ¶
(2) Telehealth encounters used to satisfy the face-to-face encounter requirement for a DMEPOS item must meet the requirements outlined in the ~~HERC~~Prioritized List of Health Services Telehealth, Teleconsultations, and Online/Telephonic Services Ancillary Guideline ~~n~~Note ~~A5~~.¶
(3) The face-to-face encounter shall be conducted and documented by one of the following practitioners: ¶
(a) A physician; ¶
(b) A nurse practitioner or clinical nurse specialist, as authorized by State law; ¶
(c) A physician associate, as authorized by and in accordance with State law; ¶
(d) A licensed practitioner of the healing arts acting within the scope of practice authorized under State law; ¶
(4) The practitioner responsible for ordering the services must document the face-to-face encounter and clinical findings supporting that the client was evaluated or treated for a condition that supports the need for the DME items ordered within six months prior to completing the written order; ¶
(5) If a dually eligible client is evaluated for medical equipment or supplies under Medicare and transitions to Medicaid, the Medicare face-to-face encounter documentation shall meet the Medicaid face-to-face requirement. ¶
(6) The DME supplier shall maintain and provide documentation of the qualifying face-to-face encounter, written order/prescription, and the supporting documentation when the item requires prior authorization or at the Division's request. ¶
(7) The supporting documentation shall include subjective and objective client-specific information used for diagnosing, treating, and managing a clinical condition for which the DMEPOS is ordered. ¶
(8) The DME supplier shall have documentation on file that supports all coverage criteria in the DMEPOS rules are met. ¶
(9) The ~~table at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/FINAL-RULE-MASTER-LIST-of-DMEPOS-Subject-to-Frequent-Unnecessary-Utilization-2018-03-30.pdf identifies the DME items subject to these face-to-face requirements~~list of required DME items subject to face-to-face requirements is posted and maintained by CMS. Please refer to the CMS.gov website for an active link to this list.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-122-0180

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Healthcare Common Procedure Coding System Level II Coding rule. These updates included clarifying the frequency at which CMS releases new, revised, and discontinued HCPCS codes for clarity and adding PDAC requirement language for clarity.

CHANGES TO RULE:

410-122-0180
Healthcare Common Procedure Coding System Level II Coding ¶

(1) The Healthcare Common Procedure Coding System (HCPCS) level II is a comprehensive and standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing. For each alphanumeric HCPCS code, there is descriptive terminology that identifies a category of like items. These codes are used primarily for billing purposes. The Centers for Medicare and Medicaid Services (CMS) maintain and distribute HCPCS Level II Codes. ¶
(2) HCPCS is a system for identifying items and services. It is not a methodology or system for making coverage or payment determinations. The existence of a code does not, of itself, determine coverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or revision of HCPCS codes are made independently of the process for making coverage and payment determinations for medical items or services. Items billed ~~that do not have a~~with a miscellaneous or not otherwise classified HCPCS code ~~will~~may be reviewed by the Division on a case-by-case basis ~~to ensure rule 410-122-0080 is appropriately applied to item billed.~~in accordance with Chapter 410 Division 122 rules. ¶
(3) The Division uses the HCPCS Level II Code Set to ensure that claims are processed in an orderly and consistent manner. ¶
(4) When requesting authorization and submitting claims, DMEPOS providers must use ~~these~~HCPCS codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. ¶
(5) This rule division may not contain all code updates needed to report medical services and supplies. ¶
(6) For the most up-to-date information on code additions, changes, or deletions, refer to the fee schedule posted on the Division Web site. ¶
(7) The Division fee schedule is updated quarterly and lists the current HCPCS codes in an alphanumeric index. ¶
(8) Newly established temporary codes and effective dates for their use are also posted on the Division website at https://www.oregon.gov/~~OHA/HSD/OHP/P~~oha/hsd/ohp/pages/~~F~~fee-~~S~~schedule.aspx. ¶
(9) CMS updates ~~permanent national codes annually on January 1st.¶~~
~~(10) CMS may add, change, or delete temporary national~~new, revised, and discontinued HCPCS codes on a quarterly basis. ¶
(1~~1~~0) The Medicare Pricing, Data Analysis and Coding (PDAC) contractor ~~is responsible for assisting DMEPOS providers and manufacturer~~assists in determining which HCPCS code shall be used to describe and bill DMEPOS items.¶
~~[Publications: Publications referenced are available from the agency.]~~ Refer to the product classification list on the PDAC contractor website for appropriate HCPCS codes.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 413.042, 414.065

AMEND: 410-122-0182

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Legend rule. This update included revising language in reference to “13” months rented for clarity.

CHANGES TO RULE:

410-122-0182
Legend ¶

This rule is retroactive and applies to services rendered on or after Jan.uary 1, 2009. ¶
(1) The Division uses abbreviations in the tables within this division. ¶
(2) This rule explains the meaning of these abbreviations. ¶
(3) PA - Prior authorization (PA): "PA" indicates that PA is required, even if the client has private insurance. See OAR 410-122-0040 for more information about PA requirements. ¶
(4) PC - Purchase: "PC" indicates that purchase of this item is covered for payment by the Division. ¶
(5) RT - Rent: "RT" indicates that the rental of this item is covered for payment by the Division. ¶
(6) MR - Months Rented: ¶
(a) "13" - Indicates up to 13 consecutive months of continuous rental, ~~when~~unless otherwise noted in Division 122 rules, and determined when either the Division fee schedule purchase price is met for the item, when the usual purchase price is reached, or the actual charge is met (whichever is lowest); at which time, the equipment is considered paid for and owned by the client. The provider must then transfer title of the equipment to the client;¶
(b) For any other rental situation~~,~~ where the Division fee schedule lists a purchase price and this purchase price is met for the item, when the usual purchase price is reached or the actual charge is met (whichever is lowest), the equipment is considered paid for and owned by the client. The provider must then transfer title of the equipment to the client. ¶
(7) RP - Repair: "RP" indicates that repair of this item is covered for payment by the Division. ¶
(8) NF - Nursing Facility: "NF" indicates that this procedure code is covered for payment by the Division when the client is a resident of a nursing facility.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0184

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Repairs, Servicing, Replacement, Delivery, and Dispensing rule. These updates included revising language pertaining to reasonable useful lifetime of DME, updating prior authorization requirements for clarity, updating/adding definitions to various repair and miscellaneous HCPCS codes for clarification, amending contact timeframes to comply with federal guidance, amending non-covered language to comply with federal guidelines, and adding repair guidance regarding replacement parts and components for clarity.

CHANGES TO RULE:

410-122-0184
Repairs, Servicing, Replacement, Delivery, and Dispensing ¶

(1) For indications and limitations of coverage and medical appropriateness, the Division may cover reasonable and necessary repairs, servicing, and replacement of medically appropriate, covered durable medical equipment, prosthetics, and orthotics, including those items purchased or in use before the client enrolled with the Division:/ ¶
(a) Repairs:/ ¶
(A) To repair means to fix or mend and to put the equipment back in good condition after damage or wear to make the equipment serviceable;/ ¶
(B) Repairs (parts and labor) of DMEPOS items are performed on the base item. The replacement of parts or components that make up the base item is considered a repair;/ ¶
(C) 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 may be made for the amount of the excess;/ ¶
(~~C~~D) Payment for repairs is not covered when:/ ¶
(i) The skill of a technician is not required;/ ¶
(ii) The equipment has been previously denied;/ ¶
(iii) Equipment is being rented, including separately itemized charges for repair;/ ¶
(iv) Equipment, parts and labor are covered under a manufacturer's or supplier's warranty./ ¶
(~~D~~E) Code K0739 may not be used on an initial claim for equipment. Payment for any labor involved in assembling, preparing, or modifying the equipment on an initial claim is included in the allowable rate./ ¶
(b) Servicing:/ ¶
(A) Additional payment for routine periodic servicing, such as testing, cleaning, regulating, and checking the client's equipment is not covered. However, more extensive servicing that, based on the manufacturers' recommendations may only be performed by authorized technicians, may be covered for medically appropriate client-owned equipment;/ ¶
(B) Payment for maintenance/service is not covered for rented equipment. Providers must maintain, repair, or replace rented equipment at no charge to the Division or the client during the authorized rental period. The Division may authorize payment for covered servicing of capped rental items after six months have passed from the end of the final paid rental month. Use the corresponding Healthcare Common Procedure Coding System (HCPCS) code for the equipment in need of servicing at no more than the rental fee schedule allowable amount;/ ¶
(C) Up to one (1) month's rental shall be reimbursed at the level of either the equipment provided, or the equipment being repaired, whichever is less costly;/ ¶
(D) Maintenance and servicing that includes parts and labor covered under a manufacturer's or supplier's warranty is not covered./ ¶
(i) Providers must notify clients of warranty coverage and honor all warranties under applicable State law, whether it is a warranty from the manufacturer or the supplier. All equipment under warranty shall be repaired or replaced at no charge to the Division or the client in accordance with ORS 646A.460 to 646A.476.-// ¶
(ii) If the dispensing provider is unable to fulfill the warranty and the equipment continues to be medically appropriate, the provider is responsible for any costs incurred to have a different provider repair or replace the equipment.// ¶
(c) Replacement refers to the provision of an identical or nearly identical item:/ ¶
(A) Temporary Replacement: One (1) month's rental of temporary replacement equipment (K0462) may be reimbursed when client-owned equipment, such as a wheelchair, is being repaired. The equipment in need of repair must be unavailable for use for more than one (1) day;/ ¶
(B) Permanent Replacement: Situations involving the provision of medically appropriate items when there is a

change in the client's condition that warrants a new device, the client has outgrown the equipment, or when reasonable wear and tear renders the item non-functioning and not repairable, and there is coverage for the specific item identified in chapter 410, division 122;/ ¶
(C) Equipment that the client owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster./ ¶
(D) Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment:/ ¶
(i) Reasonable useful lifetime of DME is no less than five (5) years; unless otherwise specified in Chapter 410, Division 122 rules;/ ¶
(ii) Computation of the useful lifetime is based on when the equipment is delivered to the client, not the age of the equipment;/ ¶
(iii) Replacement of the base item due to wear is not covered during the reasonable useful lifetime of the equipment;/ ¶
(iv) During the reasonable useful lifetime, repair up to the cost of replacement (but not actual replacement for medically appropriate equipment owned by the client) may be covered./ ¶
(E) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment may not be covered./ ¶
(d) Delivery:/ ¶
(A) Providers may deliver directly to the client or the authorized designee;/ ¶
(B) Providers, their employees, or anyone else having a financial interest in the delivery of an item may not sign and accept an item on behalf of a client;/ ¶
(C) Provider shall have documentation on file containing a description of the item delivered to the client to determine the accuracy of claims coding including, but not limited to, an invoice or statement in the provider records.-// ¶
(D) A provider may deliver DMEPOS to a client in a hospital or nursing facility for the purpose of fitting or training the client in its proper use. This may be done up to two (2) days prior to the client's anticipated discharge to home. On the claim, bill the date of service as the date of discharge and specify the place of service as the client's home. The item must be for subsequent use in the client's home;/ ¶
(E) A provider may deliver DMEPOS to a client's home in anticipation of a discharge from a hospital or nursing facility. The provider may arrange for actual delivery approximately two (2) days prior to the client's anticipated discharge to home. On the claim, bill the date of service as the date of discharge and specify the place of service as the client's home;/ ¶
(F) No payment is made on dates of service the client receives training or fitting in the hospital or nursing facility for a particular DMEPOS item./ ¶
(e) For Dispensing Refills:/ ¶
(A) For DMEPOS products that are supplied as refills to the original order, providers must contact the client or designee prior to dispensing the refill to check the quantity on hand and continued need for the product;/ ¶
(B) Contact with the client or designee regarding refills must take place no sooner than thirty (30) calendar days prior to the expected end of the current supply./Contact with the client or designee regarding refills may only take place no sooner than approximately fourteen (14) calendar days prior to the delivery/shipping date;/ ¶
(C) For subsequent deliveries of refills, the provider shall deliver the DMEPOS product no sooner than ten (10) calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. The Division shall allow for the processing of claims for refills delivered/shipped prior to the client exhausting their supply, but the provider must not dispense supplies that exceed a client's expected utilization;/ ¶
(D) Supplies dispensed are based on the practitioner's order. Regardless of utilization, a provider may not dispense more than a three (3) -month quantity of supplies at a time. This three (3) -month dispensing restriction for supplies may be further limited by rule limitations of coverage;/ ¶
(E) The provider may not automatically ship, dispense, or deliver a quantity of supplies on a predetermined regular basis, even if the client or designee has "authorized" this in advance;/ ¶
(F) Shipping and handling charges are not covered as this is included in the allowable rate for the DMEPOS product./ ¶
(f) The following services are not ~~covered:~~eligible for reimbursement:/ ¶
(A) Pick-up, delivery, shipping, and handling charges for DMEPOS, whether rented or purchased including travel time:/ ¶
(i) These costs are included in the calculations for allowable rates;/ ¶
(ii)These charges are not billable to the client./ ¶
(B) Supplies used with DME or a prosthetic device prior to discharge from a hospital or nursing facility;/ ¶
(C) Surgical dressings, urological supplies, or ostomy supplies applied in the hospital or nursing facility, including

items worn home by the client./ ¶
(2) Documentation Requirements:/ ¶
(a) For repairs, servicing, and temporary replacement, a new practitioner's order is not required;/ ¶
(b) Submit the following documentation with the prior authorization (PA) request:/ ¶
(A) For repairs and servicing:/ ¶
(i) Narrative description, manufacturer and brand name/model name and number, serial number, and original date of purchase for the covered equipment in need of repair;/ ¶
(ii) Itemized statement of parts needed for repair including the estimated date of service, manufacturer's name (if billing for parts, include manufacturer's name and part number for each part), product name, part number, manufacturer's suggested retail price or manufacturer's invoice price, and estimated labor time; and/ ¶
(iii) Justification of the client's medical need for the item and statement that the client owns the equipment in need of repair./ ¶
(B) For temporary replacement:/ ¶
(i) Narrative description, manufacturer and brand name/model name and number, serial number, and original date of purchase for the covered equipment in need of repair;/ ¶
(ii) Narrative description, manufacturer and brand name/model name, and number of the replacement equipment;/ ¶
(iii) Itemized statement of parts needed for repair including the estimated date of service, manufacturer's name (if billing for parts, include manufacturer's name and part number for each part), product name, part number, manufacturer's suggested retail price or manufacturer's invoice price, and estimated labor time;/ ¶
(iv) Justification of the client's medical need for the item and statement that the client owns the equipment in need of repair; and/ ¶
(v) Description of why the repair takes more than one (1) day to complete./ ¶
(C) For permanent replacement, see specific coverage criteria in chapter 410, division 122 for more information;/ ¶
(D) For proof of delivery, DMEPOS providers shall:/ ¶
(i) Maintain proof of delivery documentation to the client in their records for seven (7) years;/ ¶
(ii) Maintain documentation that supports conditions of coverage in this rule are met;/ ¶
(iii) Make proof of delivery documentation available to the Division upon request./ ¶
(c) Proof of delivery requirements are based on the method of delivery;/ ¶
(d) A signed and dated delivery slip is required for items delivered directly by the provider to the client or designee. The delivery slip must include the following:/ ¶
(A) When a designee signs the delivery slip, their relationship to the client must be noted and the signature legible;/ ¶
(B) The client or designee's signature with the date the items were received;/ ¶
(C) Client's name;/ ¶
(D) Quantity, brand name, serial number, and a detailed description of the items being delivered;/ ¶
(E) The date of signature on the delivery slip must be the date the DMEPOS item is received by the client or designee; and/ ¶
(F) The date the client receives the item is the date of service./ ¶
(e) If the provider uses a delivery or shipping service or mail order, ~~an example of~~ proof of delivery ~~would~~must include the service's tracking slip and the provider's own shipping invoice:/ ¶
(A) The provider's shipping invoice must include the:/ ¶
(i) Client's name;/ ¶
(ii) Quantity, brand name, serial number, and a detailed description of the items being delivered;/ ¶
(iii) Delivery service's package identification number associated with each individual client's package with a unique identification number and delivery address, including the actual date of delivery, if possible; and/ ¶
(iv) The shipping date must be used as the date of service, unless the actual date of delivery is available, then use this date as the date of service./ ¶
(B) The delivery service's tracking slip must reference:/ ¶
(i) Each client's packages; and/ ¶
(ii) The delivery address and corresponding package identification number given by the delivery service./ ¶
(f) Providers m~~ay~~ust utilize a signed and dated return postage-paid delivery or shipping invoice from the client or designee as a form of proof of delivery that must contain the following information:/ ¶
(A) Client's name;/ ¶
(B) Quantity, brand name, serial number, and a detailed description of items being delivered;/ ¶
(C) Required signatures from either the client or the designee./ ¶
(g) Delivery to nursing facilities or hospitals:/ ¶
(A) The date of service is the date the DMEPOS item is received by the nursing facility if delivered by the DMEPOS

provider;/ ¶
(B) The date of service is the shipping date (unless the actual delivery date is known and documented) if the DMEPOS provider uses a delivery or shipping service./ ¶
(h) For those clients who are residents of an assisted living facility, a twenty-four (24) hour residential facility, an adult foster home, a child foster home, a private home or other similar living environment, providers must ensure supplies are identified and labeled for use only by the specific client for whom the supplies or items are intended./ ¶
(3) Procedure codes:/ ¶
(a) Replacement parts for wheelchair repair are billed using the specific HCPCS code, if one exists, or code K0108 (other accessories);/ ¶
(b) K0739~~:~~ - Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes;/ ¶
(A) Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes;/ ¶
(B) This code is used for services not covered by other codes or combination of codes in reference to the repairs of DMEPOS./ ¶
(c) K0108 - ~~Other wheelchair accessories - PA;~~Wheelchair component or accessory, not otherwise specified - PA is required when the billed charge for an item is greater than $150;/ ¶
(d) E1399 - Durable medical equipment, miscellaneous, - PA is required when the billed charge for an item is greater than $150;/ ¶
(~~d~~e) K0462 - Temporary replacement for client-owned equipment being repaired, any type~~.~~ - No PA required./
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-122-0200

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Pulse Oximeter for Home Use rule. These updates included clarifying and defining which type of home oximeter is eligible for coverage, identifying prior authorization requirements, and adding a reference to coverage table for guidance and clarity.

CHANGES TO RULE:

410-122-0200
Pulse Oximeter for Home Use ¶

(1) Indications and limitations of coverage and medical appropriateness: ¶
(a) The Division may cover a tamper-proof (calibrated, preset, and sealed) pulse oximeter for home use when all of the following criteria are met: ¶
(A) The client has frequently fluctuating oxygen saturation levels that are clinically significant; ¶
(B) Measurements are integral in dictating acute therapeutic intervention; ¶
(C) The absence of readily available saturation measurements represents an immediate and demonstrated health risk; ¶
(D) The client has a caregiver trained to provide whatever care is needed to reverse the low oxygen saturation level ordered by the practitioner; ¶
(b) Some examples of when a home pulse oximeter may be covered include the following: ¶
(A) When weaning a client from home oxygen or a ventilator; ¶
(B) When a change in the client's physical condition requires an adjustment in the liter flow of their home oxygen needs; ¶
(C) To determine appropriate home oxygen liter flow for ambulation, exercise, or sleep; ¶
(D) To monitor a client on mechanical ventilation at home; ¶
(E) To monitor a client with a tracheostomy at home; ¶
(F) To periodically re-assess the need for long-term oxygen in the home; ¶
(~~F~~G) Infants with chronic lung disease (e.g., bronchopulmonary dysplasia); ¶
(~~G~~H) Premature infants on active therapy for apnea; ¶
(~~H~~I) When a client exhibits a certain unstable illness and has compromised or potentially compromised respiratory status~~;~~ or airways; ¶
(~~I~~J) When evidence-based clinical practice guidelines support the need; ¶
(c) Home pulse oximetry for indications other than those listed above may be covered on a case-by-case basis upon medical review by the Division's Policy Unit; ¶
(d) The durable medical equipment prosthetics, orthotics and supplies (DMEPOS) provider is responsible to ensure the following services for home pulse oximetry ~~rental~~ are provided: ¶
(A) For purchase or rental of a pulse oximeter for home use: ¶
(i) Training ~~regarding~~client or caregiver on the use and care of the equipment and ~~care of the client as it relates to the equipment, including progressive intervention and cardiopulmonary resuscitation (CPR) training prior to use of the equipment by the client~~developing an emergency plan, such as dialing immediate emergency services, are performed at the time of delivery or prior to equipment usage; and ¶
(ii) A follow-up ~~home visit~~telephone call or home visit is conducted within the first 30 days of equipment setup to ensure ~~a CPR/emergency area has been designated; and¶~~
~~(B) For rental of a pulse oximeter for home use:¶~~
~~(i) Monthly telephone follow-up and support to ensure caregivers are using the equipment as ordered by the practitioner; and~~client's continuation and proper use of the equipment; ¶
(B) For rental of a pulse oximeter for home use: ¶
(~~i~~ii) 24-hour/7 day a week respiratory therapist on-call availability for troubleshooting, exchanging of malfunctioning equipment, etc.; and ¶
(~~ii~~iii) The allowable rental fee includes all equipment, supplies, services, including all probes, routine maintenance, and necessary training for the effective use of the pulse oximeter; ¶
(e) The Division may cover replacement probes for a client-owned covered oximeter~~:~~ as ordered by the treating practitioner for continued use: ¶
(A) The Division ~~wi~~shall reimburse for the least costly alternative for payment of probes, whether disposable or reusable, which meets the medical need of the client; ¶

(B) A reusable probe must be used when it is the least costly alternative, rather than a disposable probe, unless the client's medical records clearly substantiates why a reusable probe is contraindicated; ¶
(C) Disposable probes (oxisensors) may be reused on the same client as long as the adhesive attaches without slippage; ¶
(f) The use of home pulse oximetry for indications considered experimental and investigational, including the following, are not covered: ¶
(A) Asthma management; ¶
(B) When used alone as a screening/testing technique for suspected obstructive sleep apnea; ¶
(C) Routine use (e.g., client with chronic, stable cardiopulmonary condition). ¶
(2) Documentation Requirements: ¶
(a) Submit the following documentation for prior authorization (PA) review: ¶
(A) An order from the treating practitioner that clearly specifies the medical appropriateness for home pulse oximetry testing; ¶
(B) Documentation of signs/symptoms/medical condition exhibited by the client, that require continuous pulse oximetry monitoring as identified by the need for oxygen titration, frequent suctioning or ventilator adjustments, etc.; ¶
(C) Plan of treatment that identifies a trained caregiver is available to perform the testing, document the frequency and the results and implement the appropriate therapeutic intervention, when necessary; ¶
(D) For probes for a client-owned oximeter, documentation that of which type of probes are prescribed and why the probes requested are the least costly alternative; ¶
(E) Other medical records that corroborate conditions for coverage are met as specified in this rule; ¶
(b) History and physical exam and progress notes must be available for review by the Division, upon request. ¶
(3) Procedure Codes: ¶
(a) A4606 - Oxygen probe for use with client-owned oximeter device, replacement:; ¶
(b) E0445 - Oximeter device for measuring blood oxygen levels non-invasively:; ¶
(A) PAFor adults, PA is required; ¶
(B) The Division will purchase or rent on a monthly basis; ¶
(C) The Division will repair a client-owned, covered pulse oximeter when cost effective; ¶
(D) Item considered purchased after seven (7) months of rent; ¶
(E) Quantity (units) is one on a given date of service. ¶
(4) Refer to Coverage Table OAR 410-122-0203-1.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0202

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Positive Airway Pressure (PAP) Devices for Adult Obstructive Sleep Apnea rule. These updates included restructuring and formatting the OAR content to align with other Division 122 OARs, adding reference to Prioritized List Guideline Note 27 and Diagnostic Guideline Note D8 for coverage guidance, and revising of language relating to coverage criteria and continued use for clarity.

CHANGES TO RULE:

410-122-0202
Positive Airway Pressure (PAP) Devices for Adult Obstructive Sleep Apnea ¶

(1) ~~The Division may cover a positive airway pressure (PAP) device for treatment of obstructive sleep apnea (OSA) when:~~Indications and limitations of coverage and medical appropriateness: ¶
(a) The Division may cover the initial three (3) month trial period of a positive airway pressure (PAP) device for treatment of obstructive sleep apnea (OSA)/when the client meets the conditions of coverage in OAR 410-122-0080 and when all the following guidelines and criteria are met: ¶
(~~a~~A) The client has a face-to-face clinical evaluation by the treating practitioner prior to a sleep test to assess the client for obstructive sleep apnea; ~~and~~ ¶
(~~b~~B) The client has a home sleep test or a polysomnogram performed in a facility-based laboratory ~~or a home sleep test that demonstrates positive diagnosis of OSA with either of the following:¶~~
~~(A) The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour; or¶~~
~~(B) The AHI or RDI is between 5 and 14 events with additional symptoms including one or more of the following:¶~~
~~(i) Excessive day~~to test for obstructive sleep apnea and the type of sleep test performed meets all CMS requirements for a valid sleep test and in accordance with Prioritized List of Health Services Diagnostic Testing for Obstructi~~m~~ve ~~s~~Sleep~~iness as documented by a score of greater than 10 on the Epworth Sleepiness Scale or day~~ Apnea (OSA) Guideline Note; ¶
(C) The client demonstrates a positi~~m~~ve ~~sleepiness interfering with ADLs that is not attributable to another modifiable sedating condition (e.g. narcotic dependence); or¶~~
~~(ii) Documented hypertension; or¶~~
~~(iii) Ischemic heart disease; or¶~~
~~(iv) History of stroke.~~diagnosis of OSA, as defined in the Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note; and ¶
(~~c~~D) The client or their caregiver has received instruction from the supplier ~~of the PAP device and accessories~~ in the proper use and care of the ~~equipment.¶~~
~~(d) The client meets criteria listed in section (2) of this rule for the particular device to be used.~~PAP device equipment and accessories. ¶
(~~2~~b) ~~Continuous Positive Airway Pressure (CPAP) or Auto-titrating Continuous Positive Airway Pressure (APAP) devices:¶~~
~~(a) A CPAP/APAP device (E0601) may be covered for clients with OSA when criteria in (1)(a)-(c) are met;¶~~
~~(b) A three-~~Prior Authorization (PA) is not required for PAP device (E0601) rental and the purchase of prescribed accessories during the initial three (3) month trial ~~(rental) period for PAP devices is required to determine benefit and ongoing coverage of the device;¶~~
~~(c) Rental charges apply toward purchase.~~period. The DMEPOS provider is responsible to ensure all requirements in this rule are met. ¶
(~~3~~c) ~~Respiratory Assist devices:¶~~
~~(a) A respiratory assist~~A Bi-level Positive Airway Pressure (BiPAP) device ~~(RAD)~~ without backup rate (E0470) may be covered for ~~clients with OSA when:~~treatment of OSA when the following criteria are met: ¶
(A) Criteria in (1)(a)(A)-(~~c~~D) of this rule ~~are met,;~~ and ¶
(B) A C~~PAP/APAP device (E0601) has been tried and proven ineffective~~ontinuous Positive Airway Pressure (CPAP) or Automatic Positive Airway Pressure (APAP) device (E0601) has been tried and proven ineffective or there is documentation of medical contraindication to E0601 devices as determined by the treating practitioner. Ineffective use is defined as documented failure to meet therapeutic goals using a CPAP/APAP device during the titration period of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure settings); ¶

(~~b~~C) If a CPAP/APAP device is tried and found ineffective during the initial facility-based titration or three~~-~~ (3) month home trial, substitution of a ~~RAD~~BiPAP does not require a new face-to-face clinical evaluation or sleep test; ¶
(~~c~~D) If a CPAP/APAP device has been used for more than three (3) months and the client is switched to a ~~RAD~~BiPAP, a clinical re-evaluation must occur, but a new sleep test is not required. A new three~~-~~ (3) month trial ~~would~~shall begin for use of the ~~RAD;¶~~
~~(d) Coverage, coding, and documentation requirements for the use of RADs for diagnoses other than OSA are addressed in 410-122-0205 Respiratory Assist Devices.¶~~
~~(e) A RAD with backup rat~~BIPAP. ¶
(d) PA is not required for BiPAP device (E0471~~0~~) ~~is not medically indicated for the treatment of obstructive sleep apnea.¶~~
~~(4) For a client using a PAP device prior to Oregon He~~rental and purchase of prescribed accessories during the initial th~~ Plan (OHP) enrollment, continuing coverage for the device and related accessories may be authorized on a case-by-case basis by the appropriate authorizing uni~~ree (3) month trial period. The DMEPOS provider is responsible to ensure all requirements in this rule are met. ¶
(~~5~~2) Continued Coverage of PAP device~~:¶~~
~~(a) O~~ (PA Required): ¶
(a) Purchase or ongoing rental of a PAP device (E04~~70~~601 or E0~~601~~470) beyond the three-month trial period ~~is an option in lieu of purchase when medically appropriate, cost effective, and conditions of coverage have been met;¶~~
~~(b) Continued coverage of a PAP device (E0470 or E0601) beyond the first~~may be covered when the conditions of coverage have been met per the Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note. The DMEPOS provider must submit the following documentation, with request for authorization, prior to th~~ree months of therapy requires that,~~e fourth (4th) date of service: ¶
(A) A face-to-face re-evaluation visit conducted by the treating practitioner no sooner than the thirty-first (31st) day but no later than the ninety-first (91st) day after initiating therapy~~,~~ th~~e treating practitioner shall conduct a face-to-face clinical re-evaluation and document that the client is benefiting from PAP therapy;~~at supports client's clinical benefit, compliance, and demonstrates symptoms of OSA are improved; and ¶
(B) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage. PAP compliance report data can be documented by the treating practitioner in the clinical re-evaluation. Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period anytime during the first three months of initial usage; ¶
(~~c~~C) If the clinical re-evaluation by the treating practitioner does not occur until after the ninety-first (91st) day but the re-evaluation demonstrates ~~that~~ the client is ~~benefiting from PAP therapy as defined in criteria, continued coverage of the PAP device will commence with~~compliant, as defined in this rule, and benefiting from PAP therapy at the ~~dat~~time of th~~ateir~~ re-evaluation~~;¶~~
~~(d) If~~, the provider shall submit a ~~C~~PAP/APAP ~~has been used more than three months and the client is switched to a RAD, then t~~ request for continued coverage. The request for authorization shall include the following documentation: ¶
(i) The clinical re-evaluation ~~shall occur between the 31st and 91st day following ini~~with the treating practiation ~~of the RAD;¶~~
~~(e) Clients who fail the 3-month trial may be eligible to re-qualify for a PAP device but must have both:¶~~
~~(i) Face-to-face clinical re-evaluation by the treating practitioner to determine etiology of the failure to respond to PAP therapy; and¶~~
~~(ii) Repeat sleep test in a facility-based setting if deemed necessary~~er that demonstrates the client is compliant, as defined in this rule, and benefiting from the PAP therapy at the time of the re-evaluation; and ¶
(ii) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage, at the time of the client's re-evaluation. PAP compliance report data can be documented by the treating practitioner~~. This may be a repeat diagnostic titration or split-night study.¶~~
~~(6) Accessories:¶~~
~~(a) Accessories used with a PAP device are covered when the coverage criteria for the device are met;~~ in the clinical re-evaluation. Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period prior to client's re-evaluation. ¶
(~~b~~D) ~~Accessories are separately reimbursable at~~If there is a break in billing of sixty (60) days or more between ~~time of initial issue~~end of the trial period and ~~w~~then replaced~~;¶~~
~~(c) Either a non-heated (E0561) or heated (E0562) humidifier is covered when ordered by the treating practitioner for use with a covered PAP device (E0470, E0601);¶~~
~~(d) The following represents the usual maximum number of accessories expected to be medically appropriate:¶~~
~~(A) A4604 - 1 per 3 months;¶~~

~~(B) A7027 - 1 per 3 months;¶~~
~~(C) A7028 - 2 per month;¶~~
~~(D) A7029 - 2 per month;¶~~
~~(E) A7030 - 1 per 3 months;¶~~
~~(F) A7031 - 1 per month;¶~~
~~(G) A7032 - 2 per month;¶~~
~~(H) A7033 - 2 per month;¶~~
~~(I) A7034 - 1 per 3~~quest to purchase or continue renting the PAP device, the provider shall also supply current objective evidence of adherence to use of the PAP device from the date the prior authorization request to resume coverage is submitted; ¶
(i) Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period; ¶
(ii) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the thirteenth (13th) consecutive month~~s~~; ¶
(~~J~~b) ~~A7035 - 1 per 6 months;¶~~
~~(K) A7036 - 1 per 6 months;¶~~
~~(L) A7037 - 1 per 3 months;¶~~
~~(M) A7038 - 2 per month;¶~~
~~(N) A7039 - 1 per 6 months;¶~~
~~(O) A7046 - 1 per 6 months.¶~~
~~(7) Payment Authorization:¶~~
~~(a) From the initial date of service through the second date of service,~~If objective data does not support compliance and efficacy, extending the trial period beyond the third month may be approved on a case-by-case basis by the appropriate authorizing unit. To ask for an exception, the DMEPOS provider must submit the following documentation with the prior authorization ~~(PA) is not required for PAP device rental and related accessories. The provider is responsible to ensure all rule requirements are~~ request: ¶
(A) Documentation of a face-to-face visit with the treating practitioner clearly specifying a treatment plan with measurable goals to improve adherence to treatment; and ¶
(~~b~~B) ~~Payment authorization (i.e., a payment authorization number for billing) is required~~Objective evidence of PAP use, including a PAP summary report through direct download of usage; ¶
(C) The trial perio~~r to submitting claims and will be given once all required documentation has been received and any o~~d may extend up to a maximum of two (2) months to allow the client to achieve compliance, as defined in this rule, and ther-ap~~plicable rule requirements have been met;¶~~
~~(c) Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040;¶~~
~~(d) All subsequent services s~~eutic benefit; ¶
(D) Purchase or ongoing rental of a PAP device (E0601 or E0470) beyond the two (2) month extended trial period may be covered when the conditions for continued coverage have been met. Submit the following documentartiong with ~~the third date of service require PA;~~request for prior authorization: ¶
(e~~j~~) ~~An order refill does not have to be approv~~ face-to-face clinical re-evaluation conducted by the ~~order~~treating practitioner~~. However, a client or their caregiver must request specific ongoing PAP supplies and accessories, subject to rule limitations and requirements, before they are dispensed. The DMEPOS provider shall not automatically dispense a quantity of supplies and accessories on a predetermined regular basis, even if the client has "authorized" this in advance;~~ which documents the following: ¶
(I) Client is compliant and benefiting from PAP therapy; and ¶
(II) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage; ¶
(ii) Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period anytime during the two (2) month extended rental period. ¶
(f~~E~~) ~~It is the provider's responsibility to monitor appropriate and effective use of the device as ordered by the treating practitioner. When~~f there is a break in billing of sixty (60) days or more between the end of the extended trial period and the requ~~ipment is not being used as prescribed, the provider shall stop billing for the equipment and related accessories and supplies.~~est to purchase or continue renting the PAP device, the provider shall also supply current objective evidence of adherence to use of the PAP device from the date the prior authorization request to resume coverage is submitted; ¶
(~~8~~i) ~~Guidelines:¶~~
~~(a) Polysomnog~~Adherence to ther~~a~~phy is ~~the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with practitioner review, interpretation, and report. It shall include sleep staging, which is defined to include a 1-4 lead electroencephalogram (EEG), electro-oculogram (EOG), submental electromyogram (EMG) and an electrocardiogram (ECG). It shall also include at least the~~

following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry. It may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment;¶
(b) Polysomnographic and home studies shall be ordered by the client's treating practitioner, conducted by an entity that qualifies as a Medicare provider of sleep tests, and in compliance with all applicable state regulatory requirements;¶
(c) Polysomnographic studies and home sleep tests shall be scored according to the recommended rules as described in the American Academy of Sleep Medicine (AASM) Manual for Scoring of Sleep and Associated Events;¶
(d) Polysomnographic studies may not be performed by a DMEPOS provider;¶
(e) Home sleep tests are performed unattended in the client's home using a portable monitoring device that meets the following criteria:¶
(A) Type II device - Monitors and records a minimum of seven (7) channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory movement/effort, and oxygen saturation; or¶
(B) Type III device - Monitors and records a minimum of four (4) channels: respiratory movement/effort, airflow, ECG/heart rate, and oxygen saturations; or¶
(C) Type IV device - Monitors and records a minimum of three (3) channels, one of which is airflow; or¶
(D) Other - Devices that monitor and record a minimum of three (3) channels that include actigraphy, oximetry, and peripheral arterial tone;¶
(f) For all PAP devices, clients who undergo a home sleep study shall, prior to having the test, receive instruction on how to properly apply a portable sleep monitoring device. This instruction shall be provided by the entity conducting the home sleep test and may not be performed by a DME supplier.¶
(g) No aspect of a home sleep test, including but not limited to delivery and/or pickup of the device, may be performed by the DME supplier.¶
(h) Apnea is defined as the cessation of airflow for at least 10 seconds and documented on a polysomnogram or home sleep monitoring equipment;¶
(i) Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline and with at least a 4 percent decrease in oxygen saturation;¶
(j) The apnea-hypopnea index (AHI) is defined as the average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device. Respiratory effort related arousals (RERAs) are not included in the calculation of the AHI;¶
(k) The respiratory disturbance index (RDI) is defined as the average number of apneas plus hypopneas per hour of recording without the use of a positive airway pressure device. Respiratory effort related arousals (RERAs) are not included in the calculation of the RDI;¶
(L) If the AHI or RDI is calculated based on less than two hours of sleep or recording time, the total number of recorded events used to calculate the AHI or RDI (respectively) shall be at least the number of events that would have been required in a two-hour period (i.e., must reach >30 events without symptoms or >10 events with symptoms);¶
(m) Adherence to therapy is defined as use of PAP four hours or more per night on 70 percent of nights during a consecutive thirty-day period anytime during the first three months of initial usage.¶
(9) Documentation Requirements:¶
(a) Initial coverage:¶
(A) For CPAP/APAP device, submit the facility-based polysomnogram report or home sleep study report that supports a diagnosis of OSA prior to the third date of service;¶
(B) For a RAD, submit specific documentation from the treating practitioner that a CPAP was tried and shown to be ineffective;¶
(b) For extended rental use or purchase of a PAP device beyond the first three months of initial therapy, submit the following documentation no sooner than the 61st day after initiating therapy and prior to the fourth date of service:¶
(A) Documentation of the face-to-face clinical re-evaluation by the treating practitioner that supports clinical benefit including client tolerance, compliance and efficacy, and demonstrates symptoms of OSA are improved; and¶
(B) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage date; or¶
(C) When objective data does not support compliance and efficacy, a face-to-face visit with the treating practitioner clearly specifying a treatment plan with measurable goals to improve adherence to treatment; and¶
(D) Any other medical documentation that supports indications of coverage;¶
(E) If a CPAP/APAP device has been used more than three months and the client is switched to a RAD,

~~documentation of adherence to therapy shall be submitted during the three-month trial with the RAD;¶~~
~~(c) For a client using a PAP device prior to OHP enrollment, submit the following:¶~~
~~(A) Documentation of clinical benefit including client tolerance, compliance and efficacy, and that symptoms of OSA are improved from the client's treating practitioner; and¶~~
~~(B) A facility-based polysomnogram report or home sleep test as described in this rule and scored as described in (1)(b) that supports a diagnosis of OSA, if available.¶~~
~~(10) Table 122-0202 - PAP Devices.¶~~
~~[ED. NOTE: Tables referenced are available from the agency.]~~defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period; ¶
(ii) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the thirteenth (13th) consecutive month. ¶
(c) Clients who fail their PAP trial, may be eligible to re-qualify for a PAP device trial but must have both: ¶
(A) Face-to-face clinical re-evaluation by the treating practitioner to determine etiology of the failure to respond to PAP therapy; and ¶
(B) Repeat sleep test in a facility-based setting if deemed necessary by the treating practitioner. This may be a repeat diagnostic titration or split night study in accordance with the Prioritized List of Health Services Diagnostic Testing for Obstructive Sleep Apnea (OSA) Guideline Note. ¶
(d) For a client using a PAP device prior to Oregon Health Plan (OHP) enrollment, continuing coverage for the device and related accessories may be authorized on a case-by-case basis upon submission and review of the following required documentation: ¶
(A) Record of initial delivery date when the PAP equipment was dispensed; and ¶
(B) Documentation from the client's treating practitioner to support the diagnosis of OSA and that coverage criteria in this rule are met in accordance with the Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note; and ¶
(C) A facility-based polysomnogram report or home sleep test that meets all CMS requirements for a valid sleep test in accordance with the Prioritized List of Health Services Diagnostic Testing for Obstructive Sleep Apnea (OSA) Guideline Note; and ¶
(D) Objective evidence of client's ongoing adherence to PAP therapy at the time the prior authorization for continued coverage is requested. Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period. ¶
(e) The continued rental of PAP equipment and the purchase of related accessories shall not be reimbursed, under any circumstance, when client is not using the equipment or non-compliant with its use; ¶
(A) It is the provider's responsibility to monitor appropriate and effective use of the device as ordered by the treating practitioner; and ¶
(B) When the equipment is not being used as prescribed or member is non-compliant with its use, it is the provider's responsibility to stop billing for the continued rental of the equipment and the purchase of related accessories and supplies. ¶
(3) Accessories: ¶
(a) Either a non-heated (E0561) or heated (E0562) humidifier is covered and reimbursed separately when ordered by the treating practitioner for use with a covered PAP device (E0470, E0601). No PA is required; ¶
(b) Accessories are separately reimbursable at the time of initial issue and when replaced. For replacement of accessories beyond initial issue: ¶
(A) Suppliers are required to verify the PAP or BiPAP device is still in use; ¶
(B) Regardless of utilization, a supplier must not dispense more than a three (3) month quantity of accessories; ¶
(C) Automatic shipments on a pre-determined basis, even if authorized by the client or designee, are not allowed. An order refill does not have to be approved by the ordering practitioner. However, a client or their caregiver must request specific ongoing PAP supplies and accessories, subject to rule limitations and requirements, before they are dispensed. The DMEPOS provider shall not automatically dispense a quantity of supplies and accessories on a predetermined regular basis, even if the client has "authorized" this in advance; ¶
(c) The following represents the usual maximum number of accessories expected to be medically appropriate: ¶
(A) A4604 - 1 per 3 months; ¶
(B) A7027 - 1 per 3 months; ¶
(C) A7028 - 2 per month; ¶
(D) A7029 - 2 per month; ¶
(E) A7030 - 1 per 3 months; ¶
(F) A7031 - 1 per month; ¶
(G) A7032 - 2 per month; ¶
(H) A7033 - 2 per month; ¶
(I) A7034 - 1 per 3 months; ¶

(J) A7035 - 1 per 6 months; ¶
(K) A7036 - 1 per 6 months; ¶
(L) A7037 - 1 per 3 months; ¶
(M) A7038 - 2 per month; ¶
(N) A7039 - 1 per 6 months; ¶
(O) A7046 - 1 per 6 months. ¶
(4) Replacement of PAP Device: ¶
(a) For PAP devices initially covered through the Oregon Health Plan, a replacement PAP may be covered on a case-by-case basis in accordance with OAR 410-122-0184. The DMEPOS provider must submit the following documentation with the PA request: ¶
(A) An order for the replacement PAP device from the treating practitioner; and ¶
(B) A face-to-face clinical evaluation by the treating practitioner that documents the present medical need for replacement and confirms the beneficiary continues to use and benefit from the PAP device. ¶
(b) For PAP devices not initially covered through the Oregon Health Plan, a replacement PAP may be covered on a case-by-case basis in accordance with OAR 410-122-0184. The DMEPOS provider must submit records to support the client meets criteria in (1)(a)(A)-(D) of this rule and the following documentation with the PA request: ¶
(A) An order for the replacement PAP device from the treating practitioner; ¶
(B) A face-to-face clinical evaluation by the treating practitioner that documents the present medical need for replacement and confirms the beneficiary continues to use and benefit from the PAP device; and ¶
(C) Name of prior DMEPOS provider and the date the PAP device was initially issued. ¶
(5) Prior authorization is obtained from the same authorizing authority as specified in OAR 410-122-0040. PA is required for the following: ¶
(a) All subsequent rentals or purchase of a PAP device starting with the fourth (4th) month date of service; ¶
(b) Quantities of PAP accessories that exceed their usual maximum number as defined in (3)(c)(A-O); ¶
(c) A replacement PAP device. ¶
(6) Mandibular advancement devices (oral appliances) may be covered for those for whom CPAP fails or is contraindicated. A face-to-face clinical evaluation with the treating practitioner is required to document the presence of either condition and the medical necessity for the device. If a custom fabricated device is prescribed, the practitioner's evaluation must also include why a less costly prefabricated device will not meet the client's needs. No PA is required. ¶
(7) Reimbursement: ¶
(a) Rental charges apply toward purchase; ¶
(b) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the thirteenth (13th) consecutive month; ¶
(c) Equipment is considered purchased either upon completion of the capped rental period, after the Division fee schedule purchase price is met, or when the actual charge from the provider is met, whichever is less; ¶
(d) Accessories are separately reimbursable at the time of initial issue. ¶
(8) Documentation Requirements: ¶
(a) For services requiring PA, submit documentation that supports coverage criteria and guidelines in this rule are met; ¶
(b) Medical records and documentation to support the client meets criteria and conditions of coverage in this rule must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request. ¶
(9) For children and youth 18 years old or younger: the Division may cover a positive airway pressure (PAP) device for treatment of obstructive sleep apnea (OSA) when the criteria and conditions of coverage in the Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note are met. ¶
(10) A Respiratory Assist Device (RAD) with backup rate (E0471) is not medically indicated for the treatment of obstructive sleep apnea. Coverage, coding, and documentation requirements are addressed in OAR 410-122-0205 Respiratory Assist Devices. ¶
(11) Table 122-0202 - PAP Devices.
Statutory/Other Authority: ORS 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0202 Positive Airway Pressure (PAP) Devices

For the code legend see OAR 410-122-0182

* See section (5) of this rule for authorization requirements.

Code	Description	PA	PC	RT	MR	RP	NF
*E0601	Continuous airway pressure device (CPAP)		PC	RT	13	RP	NF
*E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)		PC	RT	13	RP	NF
Accessories for PAP Devices							
*A4604	Tubing with integrated heating element for use with positive airway pressure device, each		PC				NF
*A7027	Combination oral/nasal mask used with continuous positive airway pressure device, each		PC				NF
*A7028	Oral cushion for combination oral/nasal mask, replacement only, each		PC				NF
*A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair		PC				NF
*A7030	Full face mask used with positive airway pressure device, each		PC				NF
*A7031	Face mask interface, replacement for full face mask, each		PC				NF
*A7032	Cushion for use on nasal mask interface, replacement only, each		PC				NF
*A7033	Pillow for use on nasal		PC				NF

For the code legend see OAR 410-122-0182

* See section (7) of this rule for authorization requirements.

Code	Description	PA	PC	RT	MR	RP	NF
	cannula type interface, replacement only, pair						
*A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap		PC				NF
*A7035	Headgear used with positive airway pressure device		PC				NF
*A7036	Chinstrap used with positive airway pressure device		PC				NF
*A7037	Tubing used with positive airway pressure device		PC				NF
*A7038	Filter, disposable, used with positive airway pressure device		PC				NF
*A7039	Filter, non-disposable, used with positive airway pressure device		PC				NF
*A7044	Oral interface used with positive airway pressure device, each		PC				NF
*A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only		PC				NF
*A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each		PC		13		NF
*E0561	Humidifier, non-heated, used with positive airway pressure device		PC	RT	13	RP	NF
*E0562	Humidifier, heated, used with positive airway pressure device		PC	RT	13	RP	NF

AMEND: 410-122-0203

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Oxygen and Oxygen Equipment rule. These updates included removing obsolete references to supplemental information that no longer exists, adding a reference to Table 122-0203-02, clarifying testing requirements, and removing obsolete CMS guidelines for clarity.

CHANGES TO RULE:

410-122-0203
Oxygen and Oxygen Equipment ¶

(1) Indications and limitations of coverage and medical appropriateness: The Division may cover home oxygen therapy services. Refer to Table 122-0203-1 and the following guidelines: ¶
(a) For children under age 21 when the treating practitioner has determined oxygen services to be medically appropriate; or ¶
(b) For adults aged 21 years of age and older who are fully dual-eligible clients (Medicare clients who are also eligible for Medicaid/Oregon Health Plan (OHP); See definition in General Rules, OAR 410-120-0000), the Division may cover oxygen services as follows: ¶
(A) If Medicare paid on the claim for the oxygen equipment, the Division may provide reimbursement; ¶
(B) If Medicare denied payment on the claim for the oxygen equipment, the Division shall not provide reimbursement in accordance with Medicare rules and regulations; ¶
(C) Refer to ~~the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplemental Information~~Table 122-0203-2 for additional details on Medicare's reimbursement limitation of 36 monthly rental payments; ¶
(c) For adults 21 years of age and older who are not eligible for Medicare (only eligible for Medicaid/OHP), P~~A~~rior Authorization (PA) is required and all of the following conditions must be met: ¶
(A) The treating practitioner has ordered and evaluated the results of a qualifying blood gas study performed at the time of need; and ¶
(B) The client's blood gas study meets the criteria stated below; and ¶
(C) The qualifying blood gas study was performed by a treating practitioner or by a qualified provider or supplier of laboratory services; and ¶
(D) The provision of oxygen and oxygen equipment shall improve the client's condition. ¶
(d) Group I criteria include any of the following: ¶
(A) An arterial partial pressure of oxygen (PO2) at or below 55 mm Hg or an arterial oxygen saturation (e.g. peripheral pulse oximetry reading) at or below 88 percent taken at rest (awake) while breathing room air; or ¶
(B) An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation (e.g. peripheral pulse oximetry reading) at or below 88 percent, taken during sleep for a client who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation (e.g. peripheral pulse oximetry) at or above 89 percent while awake. In this instance, oxygen and oxygen equipment is only necessary during sleep; or ¶
(C) A decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation (e.g. peripheral pulse oximetry reading) more than ~~5~~five (5) percent from baseline saturation, taken during sleep and associated with symptoms of hypoxemia such as impairment of cognitive processes and nocturnal restlessness or insomnia (not all-inclusive).In this instance, oxygen and oxygen equipment is only necessary during sleep; or ¶
(D) An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation (e.g. peripheral pulse oximetry reading) at or below 88 percent, taken during exercise for a client who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation (e.g. peripheral pulse oximetry reading) at or above 89 percent during the day while at rest. In this instance, portable oxygen and oxygen equipment is only necessary while awake and during exercise; ¶
(e) Group II criteria ~~include any of the following:¶~~
~~(A):~~ An arterial PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent; and any of the following: ¶
(~~i~~A) Dependent edema suggesting congestive heart failure; or ¶
(~~ii~~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 ¶
(~~iii~~C) Erythrocythemia with a hematocrit greater than 56 percent; ¶

(f) Group III criteria: ¶
~~(A)~~ Initial coverage of home oxygen therapy and oxygen equipment is necessary for clients in Group III, if all of the following conditions are met: ¶
(~~i~~A) Absence of hypoxemia defined in Group I and Group II above, and ¶
(~~ii~~B) A covered medical condition with distinct physiologic, cognitive, and/or functional symptoms documented in high-quality, peer-reviewed literature to be improved by oxygen therapy; ¶
(g) ~~For all the sleep oximetry criteria, the five minutes does not have to be continuous;~~¶
~~(h)~~ When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria were met; ¶
(~~i~~h) If an ABG test at rest/awake is nonqualifying, but an exercise or sleep oximetry test on the same day is qualifying, the oximetry test result shall ~~/~~determine coverage; ¶
(~~j~~i) Oxygen therapy and related services, equipment or supplies are not considered medically appropriate or medically necessary for any of the following: ¶
(A) Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments; ¶
(B) Dyspnea without cor pulmonale or evidence of hypoxemia; ¶
(C) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO2 shall ~~/~~improve the oxygenation of tissues with impaired circulation; ¶
(D) Terminal illnesses that do not affect the ability to breathe; ¶
(E) Emergency or stand-by oxygen systems for clients who are not regularly using oxygen since these services are precautionary and not therapeutic in nature; ¶
(F) Topical hyperbaric oxygen chambers (A4575); ¶
(G) When furnished by an airline (responsibility of the client); ¶
(H) When provided/used outside the United States and its territories. ¶
(2) Testing Specifications: ¶
(a) The term blood gas study in this policy refers to both arterial blood gas (ABG) studies and pulse oximetry: ¶
(A) An ABG is the direct measurement of the PO2 on a sample of arterial blood. The PO2 is reported as mm Hg. ¶
(B) An oximetry test is the indirect measurement of arterial oxygen saturation (e.g. peripheral pulse oximetry reading) using a sensor on the ear or finger. The saturation is reported as a percent; ¶
(C) An overnight oximetry is a stand-alone pulse oximetry continuously recorded overnight. It does not include oximetry results done as part of other overnight testing such as polysomnography or home sleep testing; ¶
(b) The qualifying blood gas study must be one that complies with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B; ¶
(c) All oxygen qualification testing must be performed by a qualified practitioner or other medical professional qualified to conduct oximetry: ¶
(A) A DMEPOS provider is not considered a qualified provider or a qualified laboratory for purposes of this policy; ¶
(B) Division shall not accept blood gas studies either performed or paid for by a DMEPOS provider; ¶
(C) This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests; ¶
(d) When oxygen is covered based on an oximetry study obtained during exercise, there must be documentation of three oximetry studies performed within the same testing session in the client's medical record: ¶
(A) Testing at rest without oxygen; ¶
(B) Testing during exercise without oxygen; and ¶
(C) Testing during exercise with oxygen applied, to demonstrate the improvement of the hypoxemia; ¶
(e) All three tests must be performed in person by a treating practitioner or other medical professional qualified to conduct exercise oximetry testing; ¶
(f) Only the qualifying test value (i.e., testing during exercise without oxygen) is used for qualification. All three (3) tests must be available upon request by the Division; ¶
(g) The qualifying blood gas study may be performed while the client is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria. ¶
(3) Obstructive Sleep Apnea (OSA), Polysomnography and Home Sleep Tests: ¶
(a) Home oxygen therapy and oxygen equipment with a PAP device is covered when criteria for both Oxygen and Oxygen Equipment and Positive Airway Pressure (PAP) devices for the treatment of Obstructive Sleep Apnea are met; and ¶
(b) For clients with OSA, it is required that the OSA be appropriately and sufficiently treated before oxygen saturation results obtained during sleep testing are considered qualifying for oxygen therapy and oxygen

equipment. This means that the OSA must be sufficiently treated such that the underlying condition resulting in hypoxemia is unmasked. This must be demonstrated before the oxygen saturation results are obtained during polysomnography are considered qualifying for oxygen therapy and oxygen equipment; and ¶
(c) For clients with OSA, a qualifying oxygen saturation test may only occur during a titration polysomnographic study (either split night or stand-alone). The titration PSG is one in which all of the following criteria are met: ¶
(A) The titration is conducted over a minimum of two (2) hours; and ¶
(B) During titration: ¶
(i) The AHI/RDI is reduced to less than or equal to an average of ten (10) events per hour; or ¶
(ii) If the initial AHI/RDI was less than an average of ten (10) events per hour, the titration demonstrates further reduction in the AHI/RDI; and ¶
(C) Nocturnal oximetry conducted for the purpose of oxygen therapy qualification may only be performed after optimal PAP settings have been determined and the client is using the PAP device at those settings; and ¶
(D) The nocturnal oximetry conducted during the PSG demonstrates an oxygen saturation of less than or equal to 88 percent; ¶
(d) Overnight oximetry performed as part of home sleep testing or as part of any other home testing is not considered eligible to be used for qualification for reimbursement of home oxygen and oxygen equipment. ¶
(4) Portable Oxygen Systems: ¶
(a) A portable oxygen system may be covered if the client is mobile within the home for Groups I and II, and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen is not covered; ¶
(b) If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system. See exception in (6) below; ¶
(c) If a portable oxygen system is covered, the DMEPOS provider must provide whatever quantity of oxygen the client uses; the reimbursement is the same, regardless of the quantity of oxygen dispensed. ¶
(5) Liter flow greater than 4four (4) LPM: ¶
(a) If initial oxygen coverage criteria for Group 1, II, and III have been met, the Division ~~wi~~shall pay a higher allowance for a stationary system for a flow rate of greater than 4four (4) LPM only when: ¶
(A) Basic oxygen coverage criteria have been met; and ¶
(B) A blood gas study performed while the client is on 4four (4) LPM meets Group I or II criteria; ¶
(b) Payment is limited to the standard fee schedule allowance if a flow rate greater than 4four (4) LPM is billed and the coverage criteria for the higher allowance are not met. ¶
(6) Documentation Requirements: The DMEPOS provider shall maintain and provide record of the face-to-face encounter and written order/prescription in addition to the qualifying documentation which supports conditions of coverage and testing requirements as specified in this rule are met; ¶
(a) The written order for home oxygen must be completed, signed, and dated by the treating practitioner, not the DMEPOS provider, prior to delivery. The DMEPOS provider may use a written confirmation of other details of the oxygen order, or the treating practitioner can enter the other details directly, such as the means of oxygen delivery (cannula, mask, etc.) and the specifics of varying oxygen flow rates and/or non-continuous use of oxygen. /There must be a treating practitioner's signed and dated order for each item billed. Items billed before a signed and dated order has been received by the DMEPOS provider must be submitted with an EY modifier added to each affected Healthcare Common Procedure Coding System (HCPCS) code; ¶
(b) The following special instructions apply to replacement equipment: ¶
(A) Initial date should be the date that the replacement equipment is initially needed. This is generally understood to be the date of delivery of the oxygen equipment; ¶
(B) A treating practitioner's order is needed to reaffirm the medical necessity of the item for replacement of an item; ¶
(C) Claims for the initial rental month (and only the initial rental month) must have the RA modifier (Replacement of DME item) added to the HCPCS code for the equipment when there is replacement due to reasonable useful lifetime or replacement due to damage, theft, or loss; ¶
(D) Claims for the initial rental month must include a narrative explanation of the reason why the equipment was replaced and supporting documentation must be maintained in the DMEPOS provider's files; ¶
(c) In the following situations, a new order must be obtained and kept on file by the DMEPOS provider; however,-a repeat blood gas study ~~are~~is not required: ¶
(A) Prescribed maximum flow rate changes but remains within one of the following: ¶
(i) Less than 1 LPM; ¶
(ii) 1-4 LPM; ¶
(iii) Greater than 4 LPM; ¶
(B) Change from one type of stationary system to another (i.e., concentrator, liquid, gaseous); ¶
(C) Change from one type of portable system to another (i.e., gaseous or liquid tanks, portable concentrator,

transfilling system). ¶
(d) Documentation for continued coverage and payment of oxygen and oxygen equipment after initial coverage must include evidence in the medical record documenting: ¶
(A) Group I: While there is no formal requirement for re-evaluation and retesting, providers shall ensure that once qualified for home oxygen therapy, the oxygen therapy and oxygen equipment remain reasonable and necessary; ¶
(B) Group II: ¶
(i) Evaluation and documentation of a repeat qualifying blood gas test by the treating practitioner between the 61st/and 90th/days after initiation of therapy; and, ¶
(ii) A new written order by the treating practitioner. ¶
(C) Group III: ¶
(i) Evaluation and documentation of a repeat qualifying blood gas test by the treating practitioner between the 61st/and 90th/days after initiation of therapy; and, ¶
(ii) A new written order by the treating practitioner. ¶
(e) Reimbursement ends unless continued payment and documentation coverage requirements in this rule are met. This documentation must be kept on file with the DMEPOS provider and available to the Division upon request. ¶
(7) Oxygen contents: ¶
(a) The Division allowance for rented oxygen systems includes oxygen contents necessary for one (1) month; ¶
(b) Stationary oxygen contents (E0441, E0442) are separately payable only when the coverage criteria for home oxygen have been met and they are used with a client-owned stationary gaseous or liquid system respectively; ¶
(c) Portable contents (E0443, E0444) are separately payable only when the coverage criteria for home oxygen have been met and: ¶
(A) The client owns a concentrator and rents or owns a portable system; or ¶
(B) The client rents or owns a portable system and has no stationary system (concentrator, gaseous, or liquid); ¶
(C) If the criteria for separate payment of contents are met, they are separately payable regardless of the date that the stationary or portable system was purchased; ¶
(d) Refer to Table 122-0203-2 for oxygen contents that may be reimbursable for dual-eligible clients. ¶
(8) Oxygen accessory items: ¶
(a) The allowance for rented systems includes, but is not limited to, the following accessories: ¶
(A) Transtracheal catheters (A4608); ¶
(B) Cannulas (A4615); ¶
(C) Tubing (A4616); ¶
(D) Mouthpieces (A4617); ¶
(E) Face tent (A4619); ¶
(F) Masks (A4620, A7525); ¶
(G) Oxygen tent (E0455); ¶
(H) Humidifiers (E0550, E0555, E0560); ¶
(I) Nebulizer for humidification (E0580); ¶
(J) Regulators (E1353); ¶
(K) Stand/rack (E1355); ¶
(b) The DMEPOS provider must provide any accessory ordered by the practitioner; ¶
(c) Accessories are not separately payable. ¶
(9) Billing for miscellaneous oxygen items: ¶
(a) Only rented oxygen systems (E0424, E0431, E0434, E0439, E1390RR, E1405 RR, E1406RR, E1392RR) are considered for coverage; ¶
(b) For gaseous or liquid oxygen systems or contents, report one unit of service for one (1) month rental. Do not report in cubic feet or pounds; ¶
(c) Use the appropriate modifier if the prescribed flow rate is less than ~~1~~one (1) LPM (QE) or greater than 4four (4) LPM (QF or QG). Division only accepts these modifiers with stationary gaseous (E0424) or liquid (E0439) systems or with an oxygen concentrator (E1390, E1391). Do not use these modifiers with codes for portable systems or oxygen contents; ¶
(d) Use Code E1391 (oxygen concentrator, dual delivery port) in situations in which two (2) clients are both using the same concentrator. In this situation, this code must only be requested for one (1) of the clients; ¶
(e) For E1405 and E1406 (oxygen and water vapor enriching systems), products must be coded as published by the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare and Medicaid Services; ¶
(f) Code E1392 describes a portable oxygen concentrator system. Use E1392 when billing the Division for the portable equipment add-on fee for clients using lightweight oxygen concentrators that can function as both the client's stationary equipment and portable equipment. A portable concentrator: ¶

(A) Weighs less than 10 pounds; ¶
(B) Is capable of delivering 85 percent or greater oxygen concentration; and ¶
(C) Is capable of providing at least two hours of remote portability at a ~~2~~two (2) LPM order equivalency; ¶
(g) ~~C~~The Medicare Pricing, Data Analysis and Coding (PDAC) contract ~~the PDAC for guidance on the correct coding of these item~~or assists DMEPOS providers and manufacturers in determining which HCPCS code shall be used to describe DMEPOS items. Refer to the product classification list on the PDAC contractor website for appropriate Healthcare Common Procedure Coding System (HCPCS) codes. ¶
(10) Table 122-0203-1, Oxygen and Oxygen Equipment. ¶
(11) Table 122-0203-2, Oxygen Contents.~~¶~~
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0203-1 Oxygen Equipment and Supplies

For the code legend, see OAR 410-122-0182

Prior authorization (PA) is required for adults 21 years of age and older who are not eligible for Medicare (only eligible for Medicaid/OHP) effective January 1, 2023. Services for children under the age of 21 and dual eligible clients (those Medicare clients who are also eligible for Medicaid/OHP) do not require PA.

Code	Description	PA	PC	RT	MR	RP
E0424	Stationary compressed gaseous oxygen system rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing	PA		RT		
E0425	Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	PA	PC			RP
E0430	Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing	PA	PC			RP
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	PA		RT		
E0433	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge	PA		RT		
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing	PA		RT		
E0435	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adaptor	PA	PC			RP

Code	Description	PA	PC	RT	MR	RP
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	PA		RT		
E0440	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	PA	PC			
E0441	Stationary oxygen contents, gaseous, 1 month's supply = 1 unit	PA	PC			
E0442	Stationary oxygen contents, liquid, 1 month's supply = 1 unit	PA	PC			
E0443	Portable oxygen contents, gaseous, 1 month's supply = 1 unit	PA	PC			
E0444	Portable oxygen contents, liquid, 1 month's supply = 1 unit	PA	PC			
E0445	Oximeter device for measuring blood oxygen levels non-invasively	PA	PC	RT	7	RP
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories					
E0447	Portable oxygen contents, liquid, 1 month's supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 liters per minute	PA	PC			
E1390	Oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate, per month • All equipment and supplies needed for the operation of the concentrator are included in the rental fee	PA		RT		

E1391	Oxygen concentrator, dual delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate, each, per month • All equipment and supplies needed for the operation of the concentrator are included in the rental fee	PA		RT		
E1392	Portable oxygen concentrator, rental, per month	PA		RT		
E1405	Oxygen and water vapor enriching system with heated delivery	PA		RT		
E1406	Oxygen and water vapor enriching system without heated delivery	PA		RT		
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing	PA		RT		
A4575	Topical hyperbaric oxygen chamber, disposable	PA	PC			
A4606	Oxygen probe for use with oximeter device, replacement	PA	PC			
A4608	Transtracheal oxygen catheter, each	PA	PC			
A4615	Cannula, nasal	PA	PC			
A4616	Tubing, (oxygen), per foot	PA	PC			
A4617	Mouthpiece	PA	PC			
A4619	Face tent	PA	PC			
A4620	Variable concentration mask	PA	PC			
A7525	Tracheostomy mask, each	PA	PC			
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code	PA	PC			
E0455	Oxygen tent, excluding croup or pediatric tents, per month	PA		RT	13	
E0550	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery	PA	PC	RT	13	RP

	• Not to be billed in addition to E0424, E0431, E0434, E0439, E0450, E0455, E0460, E1400, E1401, E1402, E1403, E1404, E1405 or E1406					
E0555	Humidifier, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter • Not to be billed in addition to E0424, E0431, E0434, E0439, E0450, E0455, E0460, E1400, E1401, E1402, E1403, E1404, E1405 or E1406	PA	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	PA	PC	RT		RP
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter	PA	PC	RT		RP
E1352	Oxygen accessory, flow regulator capable of positive inspiratory pressure	PA	PC			RP
E1353	Regulator (yoke or other)	PA	PC			RP
E1354	Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each	PA	PC			
E1355	Stand/rack for oxygen tank	PA	PC			
E1356	Oxygen accessory, battery pack/cartridge for portable concentrator, any type, replacement only, each	PA	PC			
E1357	Oxygen accessory, battery charger for portable concentrator, any type, replacement only, each	PA	PC			
E1358	Oxygen accessory, DC power adapter for portable concentrator, any type, replacement only, each	PA	PC			

Table 122-0203-2 Oxygen Contents

Equipment Furnished in Month 36 (Dual-eligible clients (Medicare clients eligible for Medicaid/OHP)	Monthly Contents Payment after 36 Mo Stationary Cap
Oxygen Concentrator (E1390, E1391, E1392)	None
Portable Gaseous Transfilling Equipment (K0738)	None
Portable Liquid Transfilling Equipment (E0433)	None
Stationary Gaseous Oxygen System (E0424)	Stationary Gaseous Contents (E0441)
Stationary Liquid Oxygen System (E0439)	Stationary Liquid Contents (E0442)
Portable Gaseous Oxygen System (E0431)	Portable Gaseous Contents (E0443)
Portable Liquid Oxygen System (E0434)	Portable Liquid Contents (E0444)

AMEND: 410-122-0205

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Respiratory Assist Devices rule. These updates included updating criteria to current federal guidelines, removing coverage guidelines from the coverage table into the body of the administrative rule text for accessibility and clarity, and restructuring OAR formatting to match the Div 122 rule formatting for consistency.

CHANGES TO RULE:

410-122-0205
Respiratory Assist Devices ¶

(1) Indications and limitations of coverage and medical appropriateness: The Division may cover the initial three (3) month trial period of a respiratory assist device (RAD) for clients who are diagnosed with one of the following clinical disorders: Restrictive Thoracic Disorders, Severe Chronic Obstructive Pulmonary Disease (COPD), Central Sleep Apnea (CSA), Complex Sleep Apnea (CompSA), or Hypoventilation Syndrome; and when the criteria for each specific clinical disorder and the following guidelines are met: ¶
(2) 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~~3) Indications and Coverage - General: ¶
(a) The "treating ~~prescribing~~ practitioner" must be one who is qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of respiratory assist devices (RAD); ¶
(b) For the purpose of this policy, polysomnographic studies must be performed in a sleep study laboratory, and not in the home or in a mobile facility. The sleep study laboratory must comply with all applicable state and federal regulatory requirements; ¶
(c) For the purpose of this policy, arterial blood gas, sleep oximetry and polysomnographic studies may not be performed by a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider. For purposes of this policy's coverage and payment guidelines, a DMEPOS provider is not considered a qualified provider or supplier of these tests; ¶
(~~d~~4) I~~f there is d~~ndications and Coverage - Coverage criteria for RAD devices per diagnosed condition: ¶
(a) Restrictive Thoracic Disorders: ¶
(A) A bilevel device without backup rate (E0470) or a respiratory assist device with a backup rate (E0471) is c~~ontinuation of usage of~~vered when criteria i-iii are met: ¶
(i) There is documentation in the client's medical record of a neuromuscular disease (for example, amyotrophic lateral sclerosis (ALS), or a severe thoracic cage abnormality (for example, post thoracoplasty for TB); ¶
(ii) One of the following: ¶
(I) An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2 is greater than or equal to 45 mm Hg, or ¶
(II) Sleep oximetry demonstrates oxygen saturation less than or equal to 88 percent for greater than or equal to five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours), done while breathing the client's prescribed recommended FIO_2, or ¶
(III) For a neuromuscular disease (only), either maximal inspiratory pressure is less than 60 cm H@O or forced vital capacity is less than 50 percent predicted; ¶
(iii) Chronic obstructive pulmonary disease does not contribute significantly to the client's pulmonary limitation. ¶
(B) If all of the above criteria are met, either an E0470 or an E0471 device ~~at any time, the provider is expected to ascertain this, and stop billing for the equipment and related accessories and supplies.¶~~
~~(3) Coverage criteria for E0470~~will be covered for the first three months of therapy. ¶
(b) Severe COPD: ¶
(A) An E0470 device is covered if criteria i - iii are met: ¶
(i) An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, is greater than or equal to 52 mm Hg. ¶
(ii) Sleep oximetry demonstrates oxygen saturation less than or equal to 88 percent for greater than or equal to a cumulative five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours), done while breathing oxygen at two (2) LPM or the client's prescribed FIO_2 (whichever is higher). ¶
(iii) Prior to initiating therapy, sleep apnea and treatment with a continuous positive airway pressure device (CPAP) has been considered and ruled out. (Note: Formal sleep testing is not required if there is sufficient

information in the medical record to demonstrate that the beneficiary does not suffer from some form of sleep apnea (Obstructive Sleep Apnea (OSA), CSA and/or CompSA) as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation). ¶
(B) For severe COPD clients who qualified for an E0470 device, an E0471 started any time after a period of initial use of an E0470 device is covered if both criteria i and ii are met: ¶
(i) An arterial blood gas PaCO2, done while awake and breathing the client's prescribed FIO2, shows that the client's PaCO2 worsens greater than or equal to seven (7) mm Hg compared to the original result from criterion (A)(i), (above). ¶
(ii) A facility-based PSG demonstrates oxygen saturation less than or equal to 88 percent for greater than or equal to a cumulative five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours) while using an E0470 device that is not caused by obstructive upper airway events - i.e., AHI less than five (5). ¶
(C) For severe COPD clients who qualified for an E0470 device, and E0471 devices - Table 122-0205-1.¶
(4) Documentation:¶
(a) The following documentation must be submitted with the request for prior authorization (PA) and the original kept on file by the provider:¶
(A) An order for all equipment and accessories including the client's diagnosis, an ICD-10-CM code signed and dated by the treating prescribing practitioner; will be covered if, at a time no sooner than 61 days after initial issue of the E0470 device, both of the following criteria i and ii are met: ¶
(i) An arterial blood gas PaCO2 is done while awake and breathing the client's prescribed FIO2, still remains greater than or equal to 52 mm Hg. ¶
(ii) Sleep oximetry while breathing with the E0470 device, demonstrates oxygen saturation less than or equal to 88 percent for greater than or equal to a cumulative five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours), done while breathing oxygen at two (2) LPM or the client's prescribed FIO2 [whichever is higher]. ¶
(c) Central Sleep Apnea or Complex Sleep Apnea ¶
(A) An E0470 or E0471 device is covered when, prior to initiating therapy, a complete facility-based, attended PSG is performed documenting the following (i and ii): ¶
(i) Diagnosis of CSA or CompSA; and ¶
(ii) Significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the client's prescribed FIO2. ¶
(B) If all of the above criteria are met, either an E0470 or an E0471 device will be covered for the first three (3) months of therapy. ¶
(d) Hypoventilation Syndrome ¶
(A) An E0470 device is covered if both criteria i and ii and either criteria iii or iv are met: ¶
(i) Initial arterial blood gas PaCO2, done while awake and breathing the client's prescribed FIO2, is greater than or equal to 45 mm Hg; ¶
(ii) Spirometry shows an FEV1/FVC greater than or equal to 70 percent; ¶
(iii) Arterial blood gas PaCO2, done during sleep or immediately upon awakening, and breathing the client's prescribed FIO2, shows the client's PaCO2 worsened greater than or equal to seven (7) mm Hg compared to the original result in criterion (A)(i) (above); ¶
(iv) Facility-based PSG or HST demonstrates oxygen saturation less than or equal to 88 percent for greater than or equal to five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours) that is not caused by obstructive upper airway events - i.e., AHI less than five (5). ¶
(B) An E0471 device is covered for a client with hypoventilation syndrome if both criteria i, ii, and either criteria iii or iv are met: ¶
(i) A covered E0470 device is being used; ¶
(ii) Spirometry shows an FEV1/FVC greater than or equal to 70 percent; ¶
(iii) Arterial blood gas PaCO2, done while awake, and breathing the client's prescribed FIO2, shows that the client's PaCO2 worsens greater than or equal to seven (7) mm Hg compared to the arterial blood gas (ABG) result performed to qualify the client for the E0470 device; ¶
(iv) Facility-based PSG or HST demonstrates oxygen saturation less than or equal 88 percent for greater than or equal to five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours) that is not caused by obstructive upper airway events - i.e., AHI less than five (5) while using an E0470 device. ¶
(5) Continued Coverage: Prior authorization (PA) is required for ongoing rental of a RAD device beyond the third (3rd) month and may be covered when the conditions for continued coverage in this rule are met. Submit the following documentation with request for authorization prior to the (4th) fourth month date of service: ¶
(a) Evaluation completed by the prescribing practitioner no sooner than sixty-one (61) days after initiating use of the RAD device, stating the client is compliantly using the RAD device an average of four (4) hours per twenty-four (24) hour period and the client is benefiting from its use; and ¶

(b) Objective evidence of adherence to use of the RAD device, including a summary of RAD compliance report through a direct download of usage. ¶
(6) Accessories: ¶
(a) Either a non-heated (E0561) or heated (E0562) humidifier is covered and reimbursed separately when ordered by the treating practitioner for use with a covered RAD device. No PA is required; ¶
(b) For replacement of accessories beyond initial issue: ¶
(A) Suppliers are required to verify the RAD device is still in use; ¶
(B) Regardless of utilization, a supplier must not dispense more than a three (3) month quantity of accessories; ¶
(BC) ~~Summary of events from the polysomnogram, if required in this rule under the indications and coverage section or Table 122-0205-1;~~Automatic shipments on a pre-determined basis, even if authorized by the client or designee, are not allowed. An order refill does not have to be approved by the ordering practitioner. However, a client or their caregiver must request specific ongoing PAP supplies and accessories, subject to rule limitations and requirements, before they are dispensed. The DMEPOS provider shall not automatically dispense a quantity of supplies and accessories on a predetermined regular basis, even if the client has "authorized" this in advance; ¶
(c) The following represents the usual maximum number of accessories expected to be medically appropriate: ¶
(A) A4604 - 1 per 3 months; ¶
(B) A7027 - 1 per 3 months; ¶
(C) A7028 - 2 per month; ¶
(D) A7029 - 2 per month; ¶
(E) A7030 - 1 per 3 months; ¶
(F) A7031 - 1 per month; ¶
(G) A7032 - 2 per month; ¶
(H) A7033 - 2 per month; ¶
(I) A7034 - 1 per 3 months; ¶
(J) A7035 - 1 per 6 months; ¶
(K) A7036 - 1 per 6 months; ¶
(L) A7037 - 1 per 3 months; ¶
(M) A7038 - 2 per month; ¶
(N) A7039 - 1 per 6 months; ¶
(O) A7046 - 1 per 6 months. ¶
(7) Reimbursement: ¶
(a) Rental charges apply toward purchase; ¶
(b) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the thirteenth (13th) consecutive month; ¶
(c) Equipment is considered purchased upon completion of the capped rental period, after the Division fee schedule purchase price is met, or when the actual charge from the provider is met, whichever is less; ¶
(d) When the RAD is not being used as prescribed or client is non-compliant with its use, the DMEPOS provider shall stop billing for the continued rental of the equipment and the purchase of related accessories and supplies. ¶
(8) Documentation: ¶
(a) The following documentation must be submitted with the request for PA and the original kept on file with the DMEPOS provider: ¶
(A) An order for all equipment and accessories including the client's diagnosis, an ICD-10-CM code signed and dated by the treating practitioner; ¶
(B) Summary of events from the polysomnogram; ¶
(C) Arterial blood gas results, if required under the indications and coverage section ~~or Table 122-0205-1~~; ¶
(D) Sleep oximetry results, if required under the indications and coverage section ~~or Table 122-0205-1~~; ¶
(E) Treating ~~prescribing~~ practitioner statement regarding medical symptoms characteristic of sleep-associated hypoventilation, including, but not limited to daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, and dyspnea; ¶
(F) Other treatments that have been tried and failed. To be submitted in addition to the above at the fourth ~~month review;¶~~
~~(b) A copy of the Evaluation of Respiratory Assist Device (Division 2461) completed and signed by the client, family member or caregiver;~~(4th) month review; ¶
(~~c~~b) Clients currently using BiPapS and BiPap ST are not subject to the new criteria. ¶
(~~5~~9) Table 122-0205-1, ~~Respiratory Assist Devices.¶~~
~~(6) Table 122-0205-2, Procedure Codes.¶~~
~~[ED. NOTE: Tables referenced are available from the agency.]~~Procedure Codes.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0205-1 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 three months		PC				NF
A7031	Face mask interface, replacement for full face mask, each • One per month		PC				NF
A7032	Replacement cushion for nasal application device, each • Two per month		PC				NF
A7033	Replacement cushion for nasal application device, pair • Two per month		PC				NF
A7034	Nasal application device, used with positive airway pressure device • One per 3 months		PC				NF
A7035	Headgear, used with positive airway pressure device • One per 6 months		PC				NF
A7036	Chin strap, used with positive airway pressure device • One per 6 months		PC				NF
A7037	Tubing, used with positive airway pressure device • One per 3 months		PC				NF
A7038	Filter, disposable, used with positive airway pressure device • 2 per month		PC				NF
A7039	Filter, non-disposable, used with positive airway pressure device • 1 per 6 months		PC				NF
A7044	Oral, interface used with positive airway pressure device, each • 1 per 6 months		PC				NF

A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each • 1 per 6 months		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 respiratory therapy services and training necessary for the effective use of the RAD	PA	PC	RT	13	RP	NF
E0561	Humidifier, non-heated, used with positive airway pressure device	PA	PC	RT	13	RP	NF
E0562	Humidifier, heated, used with positive airway pressure device	PA	PC	RT	13	RP	NF
S8186	Swivel adapter		PC				NF

AMEND: 410-122-0211

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Cough Stimulating Device rule. These updates included restructuring the content of the OAR to match Div 122 formatting for consistency, adding clarifying language regarding what types of services and supplies are included in the rental/purchase of the equipment, and identifying items which are separately reimbursable for clarity.

CHANGES TO RULE:

410-122-0211
Cough Stimulating Device ¶

(1) Indications and Limitations of Coverage and Medical Appropriateness: The Division ~~of Medical Assistance Programs (Division)~~ may cover a cough stimulating device, alternating positive and negative airway pressure, for a client who meets the following criteria: ¶
(a) The client has been diagnosed with a neuromuscular disease as identified by one of the following diagnosis codes: ¶
(A) Late effects of acute poliomyelitis; ¶
(B) Cystic fibrosis; ¶
(C) Werdnig-Hoffmann disease-anterior horn cell disease unspecified; ¶
(D) Multiple sclerosis - quadriplegia and quadriparesis; ¶
(E) Myoneural disorders; ¶
(F) Disorders of diaphragm; ¶
(G) Fracture of vertebral column, cervical, or dorsal (thoracic); ¶
(H) Late effect of spinal cord injury; ¶
(I) Late effect of injury to a nerve root or roots, spinal plexus or plexuses and other nerves of trunk; ¶
(J) Spinal cord injury without evidence of spinal bone injury, cervical or dorsal (thoracic); and ¶
(b) Standard treatment such as chest physiotherapy (e.g., chest percussion and postural drainage, etc.) has been tried and documentation supports why these modalities were not successful in adequately mobilizing retained secretions; or ¶
(c) Standard treatment such as chest physiotherapy (e.g., chest percussion and postural drainage, etc.) is contraindicated and documentation supports why these modalities were ruled out; and ¶
(d) The condition is causing a significant impairment of chest wall or diaphragmatic movement, such that it results in an inability to clear retained secretions. ¶
(2) Pr~~ocedure Code:¶~~
~~(a) E0482 (cough stimulating device, alternating positive and negative airway pressure) prior authorization required;¶~~
~~(b~~ior Authorization (PA): ¶
(a) PA is required for the cough stimulating device (E0482); ¶
(b) Submit specific documentation from the treating practitioner that supports coverage criteria in this rule are met and may include, but is not limited to, evidence of any of the following: ¶
(A) Poor, ineffective cough; ¶
(B) Compromised respiratory muscles from muscular dystrophies or scoliosis; ¶
(C) Diaphragmatic paralysis; ¶
(D) Frequent hospitalizations or emergency department/urgent care visits due to pneumonias. ¶
(3) Reimbursement: ¶
(a) The Division ~~wi~~shall purchase or rent on a monthly basis (limited to the lowest cost alternative); ¶
(~~c~~b) The cough stimulating device (E0482) is considered purchased after no more than ten (10) months of rent; ¶
(~~d~~c) ~~E0482 may be covered for a client residing in a nursing facility;~~The Division may cover replacement of the interface (A7020) once every six (6) months with continued use of a client-owned cough stimulating device. ¶
(4) Payment includes: ¶
(~~e~~a) The rental fee includes all equipment, supplies (including the interface), services, routine maintenance, and necessary training for the effective use and operation of the device.~~;~~ ¶
(~~3~~b) ~~Documentation R~~The initial purchase fee includes all equi~~rep~~ments~~: Submit specific documentation from the treating practitioner that supports coverage criteria in this rule are met and may include, but is not limited to, evidence of any of the following:¶~~
~~(a) Poor, ineffective cough;~~, supplies (including the interface), services, and necessary training for the effective use

and operation of the device. ¶
(5) E0482 may be covered for a client residing in a nursing facility. ¶
(6) Documentation Requirements: ¶
(a) For services requiring prior authorization, submit documentation that supports coverage criteria in this rule are met; ¶
(b) Documentation and medical records to support the client meets all criteria and conditions of coverage in this rule must be kept on file with the DMEPOS provider and shall be available to the Division upon request. ¶
(~~b~~7) ~~Compromis~~Proced-ure~~respiratory muscles from muscular dystrophies or scoliosis;~~¶
~~(c) Diaphragmatic paralysis;~~ Codes: ¶
(a) E0482- Cough stimulating device, alternating positive and negative airway pressure - PA ¶
(~~d~~b) ~~Frequent hospitalizations or emergency department/urgent care visits due to pneumonias~~A7020- Interface for cough stimulating device, includes all components, replacement only.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0250

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Breast Pumps rule. These updates included adding reference to the HERC guideline note 140 for clarity, adding pump supplies, quantities, and identifiable HCPCS codes in support of guideline note coverage for clarity, and adding clarification regarding reimbursement.

CHANGES TO RULE:

410-122-0250
Breast Pumps ¶

(1) Indications and limitations of coverage and medical appropriateness: ¶
(a) ~~T~~In accordance with Prioritized List of Health Services Breastfeeding Support and Supplies Guideline Note, the Division may cover a breast pump and supplies for postpartum women when a pump is necessary to establish or maintain milk production in order to maximize availability of breast milk to the baby; ¶
(b) For cases in which there is a medical indication for breast pumps, the pumps shall be supplied whenever possible within 24 hours to allow for continued milk production; ¶
(c) The client or caregiver shall receive instruction from the supplier in the proper use and care of the breast pump within 48 hours of receiving the equipment; ¶
(d) The rental of a hospital grade breast pump (E0604) may be covered for up to three (3) months when prescribed for use in the home; ¶
(e) A breast pump shall not be provided until a need is determined following birth; ¶
(~~d~~f) A breast pump shall not be provided if it is known that mother is using a substance that is contraindicated while breastfeeding and does not plan to stop its use; ¶
(~~e) Reimbursement for a single-user electric breast pump (E0603) includes all parts necessary for pumping. A separate kit is not need~~g) Replacement supplies may be covered when medically necessary and for the continued operation of the breast pump (E0602, E0603, E0604); ¶
(A) Reimbursement of medically necessary replacement supplies are limited to replacement tubing, replacement adapter, replacement cap for breast pump bottle, replacement breast shield and protector, replacement polycarbonate bottle, replacement locking ring, replacement membrane and valve, and a disposable collection and storage bag for breast milk (any size, any type); ¶
(B) The following represents the usual number of supplies expected to be medically appropriate; however, the quantity and frequency of replacement supplies shall be determined by the treating practitioner: ¶
(i) A4281 - 2 sets per year; ¶
(ii) A4282 - 2 sets per year; ¶
(iii) A4283 - 2 sets per year; ¶
(iv) A4284 - 2 sets per year; ¶
(v) A4285 - 2 sets per year; ¶
(vi) A4286 - 2 sets per year; ¶
(vii) A4287 - 186 per month ¶
(viii) A4649 - Valves and membranes, 1 pair = 1 unit, - 6 pairs per year ¶
(2) Prior Authorization (PA): A PA is obtained from the same authorizing authority as specified in OAR 410-122-0040. PA is required for ~~separately reimbursable~~the following: ¶
(a) Replacement of the breast pump due to loss, theft, or irreparable damage in accordance with OAR 410-122-0184; ¶
(b) Replacement supplies not identified in this rule; ¶
(c) Rental of a hospital grade breast pump (E0604) beyond the third month; ¶
(~~f~~3) The following services are not co~~vered:~~nsidered medically necessary: ¶
(~~A~~a) Accessories~~;~~ not necessary for the operation of a breast pump (for example, travel bags, nursing bras, bra pads, breast feeding pillows, etc.); ¶
(~~B~~b) An electric breast pump for the comfort and convenience of the mother; ¶
(~~C~~c) ~~Supplemental Nutrition System (SNS);~~Purchase of heavy-duty hospital grade breast pumps; ¶
(d) Replacement parts covered under the manufacturer's and/or supplier's warranty. ¶
(4) Reimbursement: ¶
(a) Reimbursement for the purchase of a single-user electric breast pump (E0603) includes all parts and supplies necessary for the operation of the electric pump;/ ¶

(~~D~~b) ~~Heavy duty, hospital grade breast pumps;~~Reimbursement for the purchase of a manual breast pump (E0602) includes all parts and supplies necessary for the operation of the manual pump; ¶
(c) Reimbursement for the rental of a hospital grade breast pump (E0604) includes all parts and supplies necessary for the operation of the hospital grade pump; ¶
(~~E~~d) Replacement ~~parts.~~supplies, other than breast shields, are not reimbursable at the time of purchase or rental; ¶
(~~2~~e) ~~Medical records which support conditions of coverage as specified in this rule are met~~Rental charges apply to purchase; ¶
(f) Reimbursement is limited to the purchase of one (1) breast pump per pregnancy; ¶
(5) Documentation: ¶
(a) For services requiring prior authorization, submit documentation that supports coverage criteria in this rule are met; ¶
(b) Medical records and documentation to support the client meets criteria and conditions of coverage in this rule must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request. ¶
(~~3~~6) Procedure Codes: ¶
(a) E0602 - Breast pump, manual, any type - ~~the Division shall~~purchase only; ¶
(b) E0603 - Breast pump, electric (AC and/or DC), any type - purchase~~;~~ only; ¶
(~~b~~c) E060~~3~~4 - Breast pump, hospital grade, electric (AC and/or DC), any type~~:~~ - rental only; ¶
(d) A4281 - Tubing for breast pump, replacement; ¶
(e) A4282 - Adapter for breast pump, replacement; ¶
(f) A4283 - Cap for breast pump bottle, replacement; ¶
(g) A4284 - Breast shield and splash protector for use with breast pump, replacement; ¶
(h) A4285 - Polycarbonate bottle for use with breast pump, replacement; ¶
(i) A4286 - Locking ring for breast pump, replacement; ¶
(j) A4287 - Disposable collection and storage bag for breast milk, any size, any type; ¶
(k) A4649 - Valve and membrane, replacement.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0300

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Light Therapy rule. These updates included revising criteria to support Prioritized List Guideline Note 21 for clarity, clarifying length of rentals for clarity, restructuring the content to match Div 122 formatting for consistency, and adding applicable procedure codes and definitions for all devices & supplies for clarity.

CHANGES TO RULE:

410-122-0300
Light Therapy ¶

(1) Indications and limitations of coverage and medical appropriateness: The Division may cover home phototherapy when medically appropriate and for the following conditions: ¶
(a) For a term or near-term infant whose elevated bilirubin is not due to a primary hepatic disorder or other hemolytic disorder that requires inpatient care and the American Academy of Pediatrics Clinical Practice Guidelines for management of hyperbilirubinemia with phototherapy are met; ~~T~~/the Practice Guidelines are available at ~~/~~https://publications.aap.org/pediatrics/article/150/3/e2022058859/188726/Clinical-Practice-Guideline-Revision-Management-of?autologincheck=redirected ¶
(b) For severe inflammatory skin conditions identified in the Health Evidence Review Commission's Prioritized List of Health Services~~, guideline note 21.~~ Severe Inflammatory Skin Disease Guideline Note./ ¶
(2) Prior Authorization (PA): ¶
(a) Ultraviolet light therapy systems (E0691, E0692, E0693, E0694); ¶
(b) Refer to the Prioritized List of Health Services Severe Inflammatory Skin Disease Guideline Note for coverage guidelines. ¶
(3) Reimbursement: ¶
(a) Reimbursement for the monthly rental of a phototherapy light (E0202) includes supplies, instruction, training, and twenty-four (24) hour on-call service necessary for the operation and effective use of the equipment; ¶
(b) Reimbursement for the monthly rental or purchase of the ultraviolet light therapy systems includes supplies, instruction, and training necessary for the operation and effective use of the equipment; ¶
(c) Rental charges apply to purchase.¶
(~~2~~4) Documentation Requirements: ¶
(a) For services that require PA: Submit documentation for review that supports conditions of coverage as specified in this rule are met; ¶
(b) ~~For services that do not require PA: M~~Documentation and medical records t~~hat~~o support the client meets all criteria and conditions of coverage ~~as specified in this rule are met shall be~~in this rule must be kept on file with the DMEPOS provider and shall be made available to the Division upon request. ¶
~~(3) E0202 includes equipment rental, supplies, delivery, set-up, pick-up, training, instru~~5) Procedure Codes: ¶
(a) E0202 - Phototherapy (bilirubin) light with photometer ¶
(b) E0691 - Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less ¶
(c) E0692 - Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, ~~and 24 hour on-call service necessary for the effective use of the equipment.¶~~
~~(4) Table 122-0300 L~~4 foot panel ¶
(d) E0693 - Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel/ ¶
(e) E0694 - Ultraviolet multidirectional light ~~T~~therapy.~~¶~~
~~[ED. NOTE: Tables referenced are available from the agenc~~ system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection ¶
(f) A4633 - Replacement bulb/lamp for ultraviolet light therapy system, each ¶
(6) Table122-0300 Light Therapy.~~]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0300 Light Therapy

For the code legend see OAR 410-122-0182.

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

AMEND: 410-122-0320

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Manual Wheelchair Base rule. These updates included removing references to rules which are no longer present in OARs, editing of numbers and lettering conventions to comply with SOS rule writing standards, updating language for clarity and coverage guidance, and adding reference to PDAC for coding verification guidance.

CHANGES TO RULE:

410-122-0320
Manual Wheelchair Base ¶

(1) Indications and limitations of coverage and medical appropriateness: ¶
(a) The Division may cover a manual wheelchair when conditions of coverage in OAR 410-122-0080~~(1)~~ and all of the following criteria are met: ¶
(A) The client has a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living (MRADLs) in or out of the home. MRADLs include but are not limited to tasks such as eating, toileting, grooming, dressing, and bathing. A mobility limitation is one that: ¶
(i) Prevents the client from accomplishing an MRADL entirely; ¶
(ii) Places the client at reasonably determined heightened risk of morbidity or mortality secondary to attempts to perform an MRADL; or ¶
(iii) Prevents the client from completing an MRADL within a reasonable time frame. ¶
(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation; ¶
(C) If the client shall be using the wheelchair in the home, the home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for use of the manual wheelchair that is being requested; ¶
(D) Use of a manual wheelchair shall significantly improve the client's ability to participate in their MRADLs. For clients with severe cognitive or physical impairments, participation in MRADLs may require the assistance of a caregiver; ¶
(E) The client is willing to use the requested manual wheelchair on a regular basis; ¶
(F) The client has either: ¶
(i) Sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the requested manual wheelchair during a typical day. Proper assessment of upper extremity function shall consider limitations of strength, endurance, range of motion, coordination, presence of pain, and deformity or absence of one or both upper extremities; or ¶
(ii) A caregiver who is available, willing, and able to provide assistance with the wheelchair. ¶
(b) The Division may authorize a manual wheelchair for any of the following situations, only when conditions of coverage as specified in section (1)(a) of this rule are met: ¶
(A) When the wheelchair can be reasonably expected to improve the client's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits, and the client is compliant with treatment: ¶
(i) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a manual wheelchair ~~will~~may be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs, a manual wheelchair may be considered for coverage; ¶
(ii) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of manual wheelchair coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a manual wheelchair. ¶
(B) For a purchase request, when a client's current wheelchair is no longer medically appropriate, or repair and modifications to the wheelchair exceed replacement cost; ¶
(C) When a covered, client-owned wheelchair is in need of repair, the Division may pay for one (1) month's rental of a wheelchair. ~~(See~~ in accordance with OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing.~~)~~ ¶
(c) The Division may not reimburse for another wheelchair if the client has a medically appropriate wheelchair, regardless of payer; ¶
(d) If the client shall be using the wheelchair in the home, the home must be able to accommodate and allow for the effective use of the requested wheelchair. The Division does not reimburse for adapting living quarters; ¶

(e) The Division may not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves; ¶
(f) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair, as well as support services such as ~~emergency services,~~ delivery, set-up, pick-up and delivery for repairs/modifications, education, ~~and~~ ongoing assistance with the use of the wheelchair; and if provided, emergency services; ¶
(g) The Division may cover an adult tilt-in-space wheelchair (E1161) when a client meets all of the following conditions (A-I): ¶
(A) A standard base with a reclining back option will not meet the client's needs; ¶
(B) Requires assistance with transfers; ¶
(C) The client's plan of care addresses the need to change position at frequent intervals, and the client is not left in the tilt position most of the time; and ¶
(D) Has one of the following: ¶
(i) High risk of skin breakdown; ¶
(ii) Poor postural control, especially of the head and trunk; ¶
(iii) Hyper/hypotonia; ¶
(iv) Need for frequent changes in position and has poor upright sitting. ¶
(E) The client must have a specialty evaluation, conducted within six (6) months prior to the start of services, that was performed by a licensed/certified medical professional, such as a PT or OT, or treating practitioner who has specific training and experience in rehabilitation wheelchair evaluations and documents the medical necessity for the wheelchair and its special features, including a description of the client's mobility needs within the home and community. The PT, OT, or treating practitioner billing or rendering services must not have a financial relationship with the DMEPOS provider; ¶
(F) Tilt-n-space wheelchairs must be supplied by a DMEPOS provider that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the client; ¶
(~~F~~G) The ATP must be employed by the provider in a full-time, part-time, or contracted capacity as is acceptable by state law. The ATP, if part-time or contracted, must be under the direct control of the provider; ¶
(~~G~~H) Documentation must be complete and detailed enough so a third party ~~would~~shall be able to understand the nature of the provider's ATP involvement, if any, in the evaluation; ¶
(~~H~~I) The ATP may not conduct the provider evaluation at the time of delivery of the wheelchair to the client's residence; ¶
(h) One month's rental for a manual adult tilt-in-space wheelchair (E1161) may be covered for a client residing in a nursing facility when all of the following conditions are met: ¶
(A) The anticipated nursing facility length of stay is thirty (30) days or less; ¶
(B) The conditions of coverage for a manual tilt-in-space wheelchair as described in section (1) (g) (A)-(~~H~~I) are met; ¶
(C)The client is expected to have an ongoing need for this same wheelchair after discharge from the nursing facility; ¶
(D) Coverage is limited to one month's rental. ¶
(i) The Division may cover a standard hemi (low seat) wheelchair (K0002) when a client requires a lower seat height (17" to 18") because of short stature or needing assistance to place his feet on the ground for propulsion; ¶
(j) The Division may cover a lightweight wheelchair (K0003) when a client: ¶
(A) Cannot self-propel in a standard wheelchair using arms or legs; and ¶
(B) Can and does self-propel in a lightweight wheelchair. ¶
(k) High-strength lightweight wheelchair (K0004): ¶
(A) The Division may cover a high-strength lightweight wheelchair (K0004) when a client: ¶
(i) Self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; or ¶
(ii) Requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair and spends at least two (2) hours per day in the wheelchair. ¶
(B) If the expected duration of need is less than three (3) months (e.g., post-operative recovery), a high-strength lightweight wheelchair is rarely medically appropriate. ¶
(~~I~~I) The Division may cover an ultra-lightweight wheelchair (K0005) when criteria (A) or (B) are met and (C) and (D) are met: ¶
(A) The client must be a full-time manual wheelchair user; or ¶
(B) The client must require individualized fitting and adjustments for one or more features such as, but not limited

to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a K0001, K0002, K0003 or K0004 manual wheelchair; and ¶
(C) The client must have a specialty evaluation, conducted within six (6) months prior to the start of services, that was performed by a licensed/certified medical professional, such as a PT or OT, or ~~physician~~treating practitioner who has specific training and experience in rehabilitation wheelchair evaluations and documents the medical necessity for the wheelchair and its special features, including a description of the client's mobility needs within the home and community. Th~~is~~e PT, OT, or treating practitioner billing or rendering services must not have a financial relationship with the DMEPOS provider. Documentation may include what types of activities the client frequently encounters and whether the client is fully independent in the use of the wheelchair. Describe the features of the K0005 base that are needed compared to the K0004 base; and ¶
(D) The wheelchair must be supplied by a DMEPOS provider that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the client; ¶
(m) The Division may cover a heavy-duty wheelchair (K0006) when a client weighs more than 250 pounds or has severe spasticity; ¶
(n) The Division may cover an extra heavy-duty wheelchair (K0007) when a client weighs more than 300 pounds; ¶
(o) For a client residing in a nursing facility, an extra heavy-duty wheelchair (K0007) may only be covered when a client weighs more than 350 pounds; ¶
(p) For more information on coverage criteria regarding repairs and maintenance, see 410-122-0184 Repairs, Maintenance, Replacement and Delivery; ¶
(q) The wheelchair requested must be the most appropriate and least costly alternative that shall meet the client's medical and functional needs. ¶
(2) Coding Guidelines: ¶
(a) Adult manual wheelchairs (K0001-K0007, K0009, E1161) have a seat width and a seat depth of 15" or greater; ¶
(b) For codes K0001-K0007 and K0009, the wheels must be large enough and positioned so that the user can self-propel the wheelchair; ¶
(c) In addition, specific codes are defined by the following characteristics: ¶
(A) Adult tilt-in-space wheelchair (E1161): ¶
(i) Ability to tilt the frame of the wheelchair greater than or equal to 20 degrees from horizontal while maintaining the same back-to-seat angle; and ¶
(ii) Lifetime warranty on side frames and crossbraces; ¶
(iii) Wheelchairs with less than 20 degrees of tilt must not be coded based upon the tilt feature. The appropriate base product must be coded as K0001-K0007. Coding as E1161 or K0108 is inappropriate coding. ¶
(B) Standard wheelchair (K0001): ¶
(i) Weight: Greater than 36 pounds; ¶
(ii) Seat height: 19" or greater; and ¶
(iii) Weight capacity: 250 pounds or less. ¶
(C) Standard hemi (low seat) wheelchair (K0002): ¶
(i) Weight: Greater than 36 pounds; ¶
(ii) Seat height: Less than 19"; and ¶
(iii) Weight capacity: 250 pounds or less. ¶
(D) Lightweight wheelchair (K0003): ¶
(i) Weight: 34-36 pounds; and ¶
(ii) Weight capacity: 250 pounds or less. ¶
(E) High strength, lightweight wheelchair (K0004): ¶
(i) Weight: Less than 34 pounds; and ¶
(ii) Lifetime warranty on side frames and crossbraces. ¶
(F) Ultra-lightweight wheelchair (K0005): ¶
(i) Weight: Less than 30 pounds; ¶
(ii) Adjustable rear axle position; and ¶
(iii) Lifetime warranty on side frames and crossbraces. ¶
(G) Heavy duty wheelchair (K0006) has a weight capacity greater than 250 pounds; ¶
(H) Extra heavy-duty wheelchair (K0007) has a weight capacity greater than 300 pounds. ¶
(d) Coverage of all adult manual wheelchairs includes the following features: ¶
(A) Seat width: 15"-19"; ¶
(B) Seat depth: 15"-19"; ¶
(C) Arm style: Fixed, swing-away, or detachable, fixed height; ¶

(D) Footrests: Fixed, swing-away, or detachable. ¶
(e) Codes K0003-K0007 and E1161 include any seat height; ¶
(f) For individualized wheelchair features that are medically appropriate to meet the needs of a particular client, use the correct codes for the wheelchair base, options and accessories (see OAR 410-122-0340 Wheelchair Options/Accessories); ¶
(g) For wheelchair frames that are modified in a unique way to accommodate the client, submit the code for the wheelchair base used and submit the modification with code K0108 (wheelchair component or accessory, not otherwise specified); ¶
(h) Manual wheelchair bases (K0001-K0007, K0009) include construction of any type material, including but not limited to, titanium, carbon, or any other lightweight high strength material. Providers shall not bill for construction materials. Billing for construction material is considered incorrect coding and unbundling. ¶
(3) Documentation requirements: ¶
(a) Functional mobility evaluation: ¶
(A) Providers must submit medical documentation that supports conditions of coverage in this rule are met for purchase and modifications of all covered, client-owned manual wheelchairs except for K0001, K0002, or K0003 (unless modifications are required); ¶
(B) Information must include but is not limited to: ¶
(i) The practitioner's face-to-face examination in accordance with OAR 410-122-0090. The face-to-face examination must occur no more than six (6) months prior to the start of services.; ¶
(ii) Medical justification needs assessment, order, and specifications for the wheelchair completed by a physical therapist (PT), occupational therapist (OT), or treating practitioner. The person billing or rendering services who provides this information must have no direct or indirect financial relationship, agreement, or contract with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider requesting authorization; ¶
(iii) Client identification and complex rehab technology supplier identification information that may be completed by the DMEPOS provider; and ¶
(iv) Signature and date by the treating practitioner and the PT or OT. ¶
(C) If the information on this form includes all the elements of an order, the provider may submit the completed form in lieu of an order. ¶
(b) Additional documentation: ¶
(A) Information from a PT, OT, treating practitioner that specifically indicates: ¶
(i) A brief description of the client's impairment in functional mobility that establishes that they have a mobility limitation and how it interferes with the performance of or participation in activities of daily living; ¶
(ii) Why an appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation. ¶
(B) Pertinent information from a PT, OT, or treating practitioner about the following elements that support coverage criteria are met for a manual wheelchair; only relevant elements need to be addressed: ¶
(i) Symptoms; ¶
(ii) Related diagnoses; ¶
(iii) History: ¶
(I) How long the condition has been present; ¶
(II) Clinical progression; ¶
(III) Interventions that have been tried and the results; ¶
(IV) Past use of walker, manual wheelchair, power-operated vehicle (POV), or power wheelchair and the results. ¶
(iv) Physical exam: ¶
(I) Weight; ¶
(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs; ¶
(III) Presence of abnormal tone or deformity of arms, legs, or trunk; ¶
(IV) Neck, trunk, and pelvic posture and flexibility; ¶
(V) Sitting and standing balance. ¶
(v) Functional assessment indicating any problems with performing the following activities including the need to use a cane, walker, or the assistance of another individual: ¶
(I) Transferring between a bed, chair, and a manual wheelchair or power mobility device; ¶
(II) Walking around their home or community including information on distance walked, speed, and balance. ¶
(C) Documentation from a PT, OT, or treating practitioner that clearly distinguishes the client's abilities and needs within the home and community; ¶
(D) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions, and options; ¶
(E) Detailed information about client-owned equipment (including serial numbers), as well as any other equipment being used or available to meet the client's medical needs, including how long it has been used by the client and why it cannot be grown (expanded) or modified, if applicable; ¶

(F) If the client shall be using the wheelchair in the home, the DMEPOS provider or practitioner must perform an on-site, written evaluation of the client's living quarters prior to delivery of the wheelchair. This assessment must support that the client's home can accommodate and allow for the effective use of a wheelchair. This assessment must include but is not limited to evaluation of physical layout, doorway widths, doorway thresholds, surfaces, counter/table height, accessibility (e.g., ramps), electrical service, etc.; and ¶
(G) All HCPCS codes, including the base, options and accessories, whether prior authorization (PA) is required or not, that shall be billed separately. ¶
(c) A written order by the treating practitioner identifying the specific type of manual wheelchair needed. If the order does not specify the type requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific manual wheelchair that is being ordered and any options and accessories requested. The DMEPOS provider may enter the items on this order. This order must be signed and dated by the treating practitioner received by the DMEPOS provider, and submitted to the authorizing authority with a copy of the face-to-face examination required by OAR 410-122-0090; ¶
(d) For purchase of K0001, K0002 or K0003 (without modifications), send documentation listed in (3) (b)(A-E); ¶
(e) When code K0009 is requested, send all information from a PT, OT, or treating practitioner that justifies the medical appropriateness for the item. The only products which may be billed using HCPCS K0009 are those published on the Pricing, Data Analysis, and Coding (PDAC) contractor's Product Classification List (PCL); ¶
(f) Any additional documentation that supports indications of coverage are met as specified in this policy; ¶
(g) For a manual wheelchair rental, submit all of the following: ¶
(A) A written order from the treating practitioner identifying the specific type of manual wheelchair needed: ¶
(i) If the order does not specify the type of wheelchair requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific manual wheelchair that is being ordered and any options and accessories requested; ¶
(ii) The DMEPOS provider may enter the items on this order; ¶
(iii) This order must be signed and dated by the treating practitioner, received by the DMEPOS provider, and submitted to the authorizing authority. ¶
(B) HCPCS codes; ¶
(C) Documentation from the DMEPOS provider that supports the client's home can accommodate and allow for the effective use of the requested wheelchair. ¶
(i) All documentation listed in section (3) of this rule must be kept on file by the DMEPOS provider; ¶
(j) Documentation that coverage criteria have been met must be present in the client's medical records, and this documentation must be made available to the Division upon request. ¶
(4) Table 122-0320 - Manual Wheelchair Base.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 410-122-0320 Manual Wheelchair Base

For the code legend see OAR 410-122-0182.

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

AMEND: 410-122-0325

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Power Wheelchair Base rule. These updates included removing references to rules which are no longer present in OARs, removing obsolete coverage requirements per CMS updates; restructuring the content to match Div 122 formatting for consistency, amending language to plain language for clarity, updating HCPCS codes and corresponding criteria, and adding reference to PDAC for coding verification guidance and clarity.

CHANGES TO RULE:

410-122-0325
Power Wheelchair Base ¶

(1) Indications and limitations of coverage and medical appropriateness: ¶
(a) The Division may cover a power wheelchair (PWC) when conditions of coverage in OAR 410-122-0080~~(1)~~ and all ~~of~~ the following criteria are met: ¶
(A) The client has a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living (MRADLs) in or out of the home. MRADLs include but are not limited to tasks such as toileting, feeding, dressing, grooming, and bathing. A mobility limitation is one that: ¶
(i) Prevents the client from accomplishing an MRADL entirely; or ¶
(ii) Places the client at reasonably determined heightened risk of morbidity or mortality secondary to attempts to perform an MRADL; or ¶
(iii) Prevents the client from completing an MRADL within a reasonable time frame. ¶
(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation; ¶
(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair to perform MRADLs during a typical day: ¶
(i) Assessment of upper extremity function shall consider limitations of strength, endurance, range of motion or coordination, presence of pain, and deformity or absence of one or both upper extremities; ¶
(ii) An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories. ¶
(D) If the client shall be using the PWC in the home, the home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the PWC that is being requested; ¶
(E) Use of a PWC shall significantly improve the client's ability to participate in MRADLs. For clients with severe cognitive and physical impairments, participation in MRADLs may require the assistance of a caregiver; ¶
(F) The presence of a caregiver does not preclude coverage of a PWC if the client is willing and able to safely operate the PWC; ¶
(G) The client is willing to use the requested PWC on a regular basis; ¶
(H) There is objective evidence that demonstrates that the client cannot use a power-operated vehicle (POV); ¶
(I) The client has sufficient mental and physical capabilities to safely operate the PWC; ¶
(J) If the client is unable to safely operate the PWC and has a caregiver, the Division may cover the PWC if the caregiver is unable to adequately propel an optimally-configured manual wheelchair and is available, willing, and able to safely operate the PWC being requested. The caregiver's need to use a PWC to assist the client with their MRADLs shall be considered in determining coverage; ¶
(K) The client's weight is less than or equal to the weight capacity of the PWC requested. ¶
(b) Only when conditions of coverage as specified in section (1) (a) of this rule are met may the Division authorize a PWC for any of the following situations: ¶
(A) When the PWC can be reasonably expected to improve the client's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits, and the client is compliant with treatment: ¶
(i) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a PWC will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs, a PWC may be considered for coverage; ¶
(ii) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of PWC coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a PWC. ¶
(B) When a client's current wheelchair is no longer medically appropriate, or repair and modifications to the

wheelchair exceed replacement costs; ¶
(C) When a covered client-owned wheelchair is in need of repair, the Division may pay for one month's rental of a wheelchair. ¶
(c) For a PWC to be covered, the treating practitioner must conduct a face-to-face examination of the client within six (6) months prior to writing the order~~, and the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the~~at visit with the treating practitioner starts the six (6) month timeline; ¶
(A) The treating practitioner's face-to-face examination ~~and prior to delivery of the device: ¶~~
~~(A) When this examination is~~of the client can be performed during a hospital or nursing facility stay~~, the DMEPOS provider must receive the report of the examination~~; however, the visit must be conducted within six (6) months prior to wr~~ithin ~~45 days after date of discharge~~g the order; ¶
(B) The practitioner may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to provide the assessment for the wheelchair. This individual m~~ay~~ust not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement, or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination: ¶
(i) If the client was referred to the PT/OT before being seen by the practitioner, then once the practitioner has received and reviewed the written report of this examination, the practitioner must see the client and perform any additional examination that is needed. The practitioner's report of the visit shall state concurrence or any disagreement with the PT/OT examination~~. In this situation, the practitioner must provide the DMEPOS provider with a copy of both examinations within 45 days of the face-to-face examination with the practitioner~~ and must occur within the six (6) month timeframe; ¶
(ii) If the practitioner examined the client before referring the client to a PT/OT, then again in person after receiving the report of the PT/OT examination, ~~the 45-day period begins on the date of that second practitioner visit. However,~~ it is also acceptable for the practitioner to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the practitioner must send a copy of the note from his initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider~~. The 45-day period begins when the practitioner signs and dates the PT/OT examination~~; ¶
(iii) If the PWC is a replacement of a similar item that was previously covered by the Division or when only PWC accessories are being ordered and all other coverage criteria in this rule are met, a face-to-face examination is not required. ¶
(d) The Division does not reimburse for another chair if a client has a medically appropriate wheelchair, regardless of payer; ¶
(e) If the client will be using the PWC in the home, the home must be able to accommodate and allow for the effective use of the requested PWC. The Division does not reimburse for adapting the living quarters; ¶
(f) The equipment must be supplied by a DMEPOS provider that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the client; ¶
(g) The ATP must be employed by the provider in a full-time, part-time, or contracted capacity as is acceptable by state law. The ATP, if part-time or contracted, must be under the direct control of the provider; ¶
(h) Documentation must be complete and detailed enough so a third party ~~would~~shall be able to understand the nature of the provider's ATP involvement, if any, in the licensed/certified medical professional (LCMP) specialty evaluation; ¶
(i) The ATP may not conduct the provider evaluation at the time of delivery of the power mobility device to the client's residence; ¶
(j) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement also includes support services such as ~~emergency services,~~ delivery, set-up, pick-up and delivery for repairs/modifications, education, ~~and~~ ongoing assistance with use of the wheelchair, and if provided, also includes support services such as emergency services; ¶
(k) The delivery of the PWC must be within 120 days following approval of the PA request by the Division; ¶
(~~L~~l) A PWC may not be ordered by a podiatrist; ¶
(~~m~~2) The ~~following services are not considered~~ Division does not consider the following services medically necessary or medically appropriate: ¶
(~~A~~a) A PWC for ~~functionally ambulatory clients; ¶~~
~~(B) A PWC used to replace private or public transportation such as automobile, bus, or taxi~~clients who are able to independently self-propel an optimally configured manual wheelchair; ¶
(~~C~~b) A PWC with a captain's chair for a client who needs a separate wheelchair seat and/or back cushion; ¶
(~~D~~c) Items or upgrades that primarily allow performance of leisure or recreational activities including but not

limited to backup wheelchairs, backpacks, accessory bags, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves~~, head lights, and tail lights;~~; ¶
(3) Coding Guidelines: ¶
(~~E~~a) ~~Power mobility devices, not coded by the Pricing, Data Analysis and Coding (PDAC) contractor or does not meet criteria; ¶~~
~~(F) Power wheelchairs not otherwise classified (K0898). ¶~~
~~(2) Coding Guidelines: ¶~~
~~(a) Specific types of PWCs:~~Specific types of PWCs: ¶
(A) A Group 1 PWC (K0813-K0816) or a Group 2 PWC (K0820-K0829) may be covered when all of the coverage criteria for a PWC are met and the wheelchair is appropriate for the client's weight and physical dimensions; ¶
(~~A~~B) A Group ~~1~~2 PWC ~~(K0813-K0816) or a Group 2 PWC~~with a seat elevation system (K08~~2~~30-K08~~29~~31) may be covered when all of the coverage criteria for a PWC are met, and ~~the wheelchair is appropriate for the client's weight and physical dimensions;~~criteria for a power seat elevation system are met in accordance with OAR 410-122-0340; ¶
(i) When billing a heavy duty or very heavy-duty power wheelchair described by HCPCS codes K0824, K0825, K0826, K0827, K0828, and K0829 that could include a seat elevation system, that system, if included, shall be billed separately under HCPCS code K0108 by using HCPCS codes K0824 - K0829 plus K0108; ¶
(ii) K0108 may also be applied to Group 2 noncomplex heavy-duty bases (K0824, K0825, K0826, K0827, K0828, and K0829) and Group 5 power driven wheelchair bases. For example, a K0825 wheelchair with an accessory seat elevation system shall be billed using K0108. ¶
(~~B~~C) A Group 2 Single Power Option PWC (K0835 - K0840) may be covered when the coverage criteria for a PWC are met; and~~:~~ if ¶
(i) ~~C~~One of the following criteria I or II is met, and ~~criteria III and IV~~the following criteria in (ii) are met~~; and~~: ¶
(I) The client requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); or ¶
(II) The client meets the coverage criteria for a power tilt or recline seating system and the system is being used on the wheelchair; ~~and~~¶
~~(II~~ ¶
(ii) All of the following criteria I and II are met: ¶
(I) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, nurse practitioner, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical appropriateness for the wheelchair and its special features (see Documentation Requirements in section (3) of this rule). The PT, OT, nurse practitioner, or practitioner ~~may~~billing or rendering services must have no financial relationship with the DMEPOS provider; and ¶
(I~~V~~I) The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the client~~;~~. ¶
(~~C~~D) A Group 2 Multiple Power Option PWC (K0841, K0842, K0843) may be covered when the coverage criteria for a PWC are met, and if: ¶
(i) ~~C~~One of the following criteria I or II is met, and ~~criteria III and IV~~the following criteria in (ii) are met~~;~~: / ¶
(I) The client meets the coverage criteria for a power tilt or recline seating system and the system is being used on the wheelchair; or ¶
(II) The client uses a ventilator that is mounted on the wheelchair; ~~and~~¶
~~(II~~ ¶
(ii) All of the following criteria I and II are met: ¶
(I) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT, OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical appropriateness for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or practitioner ~~may~~billing or rendering services must have no financial relationship with the DMEPOS provider; and ¶
(I~~V~~I) The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the client~~;~~. ¶
(~~D~~E) A Group 3 PWC with no power options (K0848-K0855) may be covered when: ¶
(i) The coverage criteria for a PWC are met; and ¶
(ii) The client's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and ¶
(iii) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such

as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or practitioner ~~may~~billing or rendering services must have no financial relationship with the DMEPOS provider; ~~¶~~
~~(~~E~~~~and ¶
(iv) The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the client; ¶
(F) A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) may be covered when: ¶
(i) The Group 3 criteria in section (2)(a)(D) (i-ii) are met; and ¶
(ii) The Group 2 Single Power Option in section (2)(a)(B) or Multiple Power Options section (2)(a)(C) (respectively) are met. ¶
(~~F~~G) Requests for Group 4 PWCs shall be reviewed on a case-by-case basis. Client specific clinical documentation must be submitted that supports the medical need for this level of PWC and demonstrates that there is no equally effective, less costly PWC that meets the client's medical needs. ¶
(~~G~~H) ~~A push-rim activated~~Requests for power wheelchairs not otherwise classified (K0898) shall be reviewed on a case-by-case basis. Client specific clinical documentation must be submitted that supports the individual's medical need and demonstrates that there is no equally effective, less costly PWC that meets the client's medical needs. ¶
(I) A power assist ~~device~~system (E0986) may be covered if all of the following criteria are met: ¶
(i) The client meets criteria for a power wheelchair but does not require a fully-powered wheelchair; and ¶
(ii) The client has demonstrated ability to self-propel~~ling~~ in a manual wheelchair or a history of self-propelling for at least one year; and ¶
(iii) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical need for the device; and ¶
(iv) The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the client; ¶
(v) E0986 is all-inclusive. All components, e.g., drive wheels, batteries, chargers, controls, mounting hardware, etc, for a manual wheelchair conversion are included in this code. ¶
(b) PWC Basic Equipment Package: Each PWC code is required to include the following items on initial issue (i.e., no separate billing/payment at the time of initial issue, unless otherwise noted): ¶
(A) Lap belt or safety belt; ¶
(B) Battery charger, single mode; ¶
(C) Complete set of tires and casters, any type; ¶
(D) Legrests~~.~~: There is no separate billing or payment if fixed, swing away, or detachable non-elevating leg rests with or without calf pad are provided. Elevating legrests may be billed separately; ¶
(E) Footrests/foot platform~~.~~: There is no separate billing or payment if fixed, swingaway or detachable footrests or a foot platform without angle adjustment are provided. There is no separate billing for angle adjustable footplates with Group 1 or 2 power wheelchairs. Angle adjustable footplates may be billed separately with Group 3, 4 or 5 power wheelchairs; ¶
(F) K0040 may be billed separately with K0848 through K0864; ¶
(G) Armrests~~.~~: There is no separate billing or payment if fixed, swingaway, or detachable non-adjustable armrests with arm pad are provided. Adjustable height armrests may be billed separately; ¶
(H) Upholstery for seat and back of proper strength and type for patient weight capacity of the power wheelchair; ¶
(I) Weight specific components (braces, bars, upholstery, brackets, motors, gears) as required by patient weight capacity; ¶
(J) Controller and Input Device~~.~~: There is no separate billing or payment if a non-expandable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a non-standard joystick (i.e., non-proportional or mini, compact or short throw proportional), or other alternative control device may be billed separately. ¶
(c) If a client needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it may be appropriate to request a captain's chair seat rather than a sling/solid seat/back and a separate general use seat and/or back cushion; ¶
(d) A PWC with a seat width or depth of 14" or less is considered a pediatric PWC base and is coded E1239, PWC, pediatric size, not otherwise specified (see OAR 410-122-0720 Pediatric Wheelchairs); ¶

(e4) ~~Contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor regarding correct coding. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information. ¶ (3) Documentation Requirements:~~Prior Authorization (PA): All codes in this rule require PA and may be purchased, rented, and repaired. Submit all of the following documentation with the ~~prior authorization (~~PA~~)~~ request: ¶
(a) A copy of the written report of the face-to-face examination of the client by the practitioner: ¶
(A) This report must include information related to the following: ¶
(i) This client's mobility limitation and how it interferes with the performance of activities of daily living; ¶
(ii) Why a cane or walker cannot sufficiently resolve the client's mobility limitation; ¶
(iii) Why a manual wheelchair cannot sufficiently resolve the client's mobility limitation; ¶
(iv) Why a POV/scooter cannot sufficiently resolve the client's mobility limitation; ¶
(v) The client's physical and mental abilities to operate a PWC safely: ¶
(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in activities of daily living (ADLs), how these conditions shall be ameliorated or compensated by use of the wheelchair; ¶
(II) How these other conditions shall be ameliorated or compensated sufficiently such that the provision of a PWC shall be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs. ¶
(B) The face-to-face examination shall provide pertinent information about the following elements. Only relevant elements need to be addressed: ¶
(i) Symptoms; ¶
(ii) Related diagnoses; ¶
(iii) History: ¶
(I) How long the condition has been present; ¶
(II) Clinical progression; ¶
(III) Interventions that have been tried and the results; ¶
(IV) Past use of walker, manual wheelchair, POV, or PWC and the results. ¶
(iv) Physical exam: ¶
(I) Weight; ¶
(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs; ¶
(III) Presence of abnormal tone or deformity of arms, legs, or trunk; ¶
(IV) Neck, trunk, and pelvic posture and flexibility; ¶
(V) Sitting and standing balance. ¶
(v) Functional assessment indicating any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person: ¶
(I) Transferring between a bed, chair, and power mobility device; ¶
(II) Walking around their home or community including information on distance walked, speed, and balance. ¶
(C) The examination must clearly distinguish the client's abilities and needs within the home and community. ¶
(b) The practitioner's written order received by the DMEPOS provider within 45 days (date stamp or equivalent must be used to document receipt date) after the practitioner's face-to-face examination. The order must include all of the following elements: ¶
(A) Client's name; ¶
(B) Description of the item that is ordered. This may be general (e.g., "power wheelchair" or "power mobility device") or may be more specific: ¶
(i) If this order does not identify the specific type of PWC that is being requested, the DMEPOS provider must clarify this by obtaining another written order that lists the specific PWC that is being ordered and any options and accessories requested; ¶
(ii) The items on this clarifying order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating practitioner, received by the DMEPOS provider, and submitted to the authorizing authority, but does not have to be received within 45 days following the face-to-face examination. ¶
(C) Date of the face-to-face examination; ¶
(D) Pertinent diagnoses/conditions and diagnosis codes that relate specifically to the need for the PWC; ¶
(E) Length of need; ¶
(F) Practitioner's signature; ¶
(G) Date of practitioner's signature. ¶
(c) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions, and options; ¶
(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including how long it has been used by the client and why it cannot be grown (expanded) or modified, if applicable; ¶

(e) If the client shall be using the PWC in the home, the DMEPOS provider or practitioner must perform an on-site, written evaluation of the client's living quarters, prior to delivery of the PWC. This assessment must support that the client's home can accommodate and allow for the effective use of a PWC. Assessment must include but is not limited to evaluation of physical layout, doorway widths, doorway thresholds, surfaces, counter or table height, accessibility (e.g., ramps), electrical service, etc.; ¶
(f) A written document (termed a detailed product description) prepared by the DMEPOS provider and signed and dated by the practitioner that includes: ¶
(i) The specific base (HCPCS code and manufacturer name/model) and all options and accessories (including HCPCS codes), whether PA is required or not, that shall be billed separately; ¶
(ii) The DMEPOS provider's charge and the Division fee schedule allowance for each separately billed item; ¶
(iii) If there is no Division fee schedule allowance, the DMEPOS provider must enter "not applicable"; ¶
(iv)The DMEPOS provider must receive the signed and dated detailed product description from the practitioner prior to delivery of the PWC; ¶
(v) A date stamp or equivalent must be used to document receipt date of the detailed product description. ¶
(g) Any additional documentation that supports indications of coverage are met as specified in this rule; ¶
(h) The DMEPOS provider must keep the above documentation on file; ¶
(i) Documentation that the coverage criteria have been met must be present in the client's medical records and made available to the Division upon request. ¶
(45) ~~Prior Authorization: ¶~~
~~(a) All codes in this rule require PA and may be purchased, rented, and repaired;~~Reimbursement: ¶
(~~b~~a) Codes specified in this rule ~~are not cover~~shall not be reimbursed for clients residing in nursing facilities; ¶
(~~c~~b) Reimbursement on standard Group 1 and Group 2 wheelchairs without power option (K0813-K0816, K0820-K0829) shall only be made on a monthly rental basis; ¶
(~~d~~c) Rented equipment is considered purchased ~~when the Division fee schedule allowable for purchase is met or the actual charge~~after thirteen (13) continuous months of rent or the Division fee schedule purchase price or the actual charge from the provider is met, whichever is less. ¶
(6) Documentation: ¶
(a) For services requiring prior authorization, submit documentation that supports coverage criteria in this rule are met; ¶
(b) Documentation that the coverage criteria have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider ~~is met, whichever is the lowest. ¶~~
~~(5)~~must be made available to the Division upon request. ¶
(7) Procedure codes: ¶
(a) The Medicare Pricing, Data Analysis and Coding (PDAC) contractor assists DMEPOS providers and manufacturers in determining which codes shall be used to describe DMEPOS items. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information; ¶
(b) Refer to the product classification list on the PDAC contractor website for appropriate HCPCS codes. ¶
(c) Refer to Table 122-0325.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 410-122-0325

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0816	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0824	Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA		RT	13	RP	
K0825	Power wheelchair, group 2 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds	PA		RT	13	RP	
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA		RT	13	RP	
K0827	Power wheelchair, group 2 very heavy duty, captain's chair, patient weight capacity 451 to 600 pounds	PA		RT	13	RP	
K0828	Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	PA		RT	13	RP	

Table 410-122-0325

For the code legend see OAR 410-122-0182

K0829	Power wheelchair, group 2 extra heavy duty, captain's chair, patient weight 601 pounds or more	PA		RT	13	RP	
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0831	Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds	PA		RT	13	RP	
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0836	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0837	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0838	Power wheelchair, group 2 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0839	Power wheelchair, group 2 very heavy duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0840	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more	PA	PC	RT	13	RP	
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0842	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	

Table 410-122-0325

For the code legend see OAR 410-122-0182

K0843	Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0850	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0851	Power wheelchair, group 3 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0852	Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0853	Power wheelchair, group 3 very heavy duty, captain's chair, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0854	Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	PA	PC	RT	13	RP	
K0855	Power wheelchair, group 3 extra heavy duty, captain's chair, patient weight capacity 601 pounds or more	PA	PC	RT	13	RP	
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0857	Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0858	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds	PA	PC	RT	13	RP	
K0859	Power wheelchair, group 3 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	

Table 410-122-0325

For the code legend see OAR 410-122-0182

K0860	Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0862	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0863	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0864	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more	PA	PC	RT	13	RP	
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0869	Power wheelchair, group 4 standard, captain’s chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0870	Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0871	Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PA	PC	RT	13	RP	
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0878	Power wheelchair, group 4 standard, single power option, captain’s chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0879	Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	

Table 410-122-0325

For the code legend see OAR 410-122-0182

K0880	Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds	PA	PC	RT	13	RP	
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0885	Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds	PA	PC	RT	13	RP	
K0886	Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PA	PC	RT	13	RP	
K0898	Power wheelchair, not otherwise classified	PA	PC	RT	13	RP	
K0899	Power mobility device, not coded by DME PDAC or does not meet criteria	PA	PC	RT	13	RP	

AMEND: 410-122-0330

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Power-Operated Vehicle rule. These updates included removing references to rules which are no longer present in OARs, removing obsolete coverage requirements per CMS updates; restructuring the OAR to match Div 122 formatting for consistency, amending language to plain language for clarity, updating HCPCS codes and corresponding criteria, and adding reference to PDAC for coding verification guidance and clarity.

CHANGES TO RULE:

410-122-0330
Power-Operated Vehicle ¶

(1) Indications and limitations of coverage and medical appropriateness: ¶
(a) The Division may cover a power-operated vehicle (POV) when conditions of coverage in OAR 410-122-0080~~(1)~~ and all of the following criteria are met: ¶
(A) The client has a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living (MRADLs) in or out of the home. MRADLs include but are not limited to tasks such as toileting, feeding, dressing, grooming, and bathing. A mobility limitation is one that: ¶
(i) Prevents the client from accomplishing an MRADL entirely; or ¶
(ii) Places the client at reasonably determined heightened risk of morbidity or mortality secondary to attempts to perform an MRADL; or ¶
(iii) Prevents the client from completing an MRADL within a reasonable time frame. ¶
(B) An appropriately fitted cane or walker cannot resolve the client's mobility limitation; ¶
(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair to perform MRADLs during a typical day: ¶
(i) Assessment of upper extremity function shall consider limitations of strength, endurance, range of motion, or coordination, presence of pain, and deformity or absence of one or both upper extremities; ¶
(ii) An optimally-configured manual wheelchair features an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories. ¶
(D) The client has sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV; ¶
(E) If the client shall be using the POV in the home, the client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the POV being requested. The Division does not reimburse for adapting living quarters; ¶
(F) The client is able to: ¶
(i) Safely transfer to and from the POV; ¶
(ii) Operate the tiller steering system, and ¶
(iii) Maintain postural stability and position while operating the POV. ¶
(G) Use of a POV shall significantly improve the client's ability to participate in their MRADLs; ¶
(H) The client is willing to use the requested POV on a regular basis; ¶
(I) The Division does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup POVs, backpacks, accessory bags, awnings, additional positioning equipment if the POV meets the same need, custom colors, and wheelchair gloves. ¶
(b) For a POV to be covered, the treating practitioner or nurse practitioner must conduct a face-to-face examination of the client within six (6) months before writing the order~~: ¶~~
~~(A) The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provid~~, and that visit with the treating practitioner ~~must receive a written report of this examination within 45 days after the~~starts the six (6) month timeline; ¶
(A) The treating practitioner's face-to-face examination can~~d prior to delivery of the device; ¶~~
~~(B) When this examination is~~ be performed during a hospital or nursing facility stay~~, the DMEPOS provider must receive the report of the examination~~; however, the visit must be conducted within six (6) months prior to writ~~h~~in ~~45 days after date of discharge~~g the order; ¶
(~~C~~B) The practitioner may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement, or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient

or outpatient hospital setting may perform part of the face-to-face examination: ¶
(i) If the client was referred to the PT/OT before being seen by the practitioner, then once the practitioner has received and reviewed the written report of this examination, the practitioner must see the client and perform any additional examination that is needed. The practitioner's report of the visit shall state concurrence or any disagreement with the PT/OT examination~~. In this situation, the practitioner must provide the DMEPOS provider with a copy of both examinations within 45 days of the face-to-face examination with the practitioner;~~ and must occur within the six (6) month timeframe;¶
(ii) If the practitioner examined the client before referring the client to a PT/OT, then again in person after receiving the report of the PT/OT examination, ~~the 45-day period begins on the date of that second practitioner visit. However,~~ it is also acceptable for the practitioner to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the practitioner must send a copy of the note from his initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider~~. The 45-day period begins when the practitioner signs and dates the PT/OT examination~~; ¶
(iii) If the POV is a replacement of a similar item that was previously covered by the Division or when only POV accessories are being ordered and all other coverage criteria in this rule are met, a face-to-face examination is not required. ¶
(~~c~~2) The Division ~~may authorize a new POV when a client's existing POV is no longer medically appropriate or repair and modifications to the POV exceed replacement costs; ¶~~
~~(d) If a client has a~~does not consider the following services medically necessary or medically appropriate ~~POV regardless of payer, the Division may not reimburse for another POV; ¶~~
~~(e) The cost of the POV includes all options and accessories that are provided at the time of initial purchase, including but not limited to batteries, battery chargers, weight appropriate upholstery and seating system, tiller steering, non-expandable controller with proportional response to input, complete set of tires, and all accessories needed for safe operation;~~ ¶
(a) POV for clients who are able to ambulate with the help of assistive equipment or independently able to self-propel an optimally-configured manual wheelchair; ¶
(~~f~~b) ~~Reimbursement for the POV includes all labor charges involved in the assembly of the POV and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education, and on-going assistance with use of the POV; ¶~~
~~(g) If a client-owned POV meets coverage criteria, medically appropriate replacement items including but not limited to batteries may be covered~~A POV used to replace private or public transportation such as an automobile, bus, or taxi; ¶
(~~h~~c) If a POV is covered, a manual or power wheelchair provided at the same time or subsequently shall be ~~denied as not medically appropriate; ¶~~
~~(i) The Division shall cover one month's rental of a POV if a client-owned POV is being repaired; ¶~~
~~(j) The following services are not covered:¶~~
~~(A) POV for functionally ambulatory clients; ¶~~
~~(B) A POV used to replace private or public transportation such as an automobile, bus, or taxi;¶~~
~~(C) A POV for a client residing in a nursing facility.~~considered for denial as not medically appropriate; ¶
(~~2~~3) Coding guidelines: ¶
(a) Group 1 POVs (K0800 - K0802) are typically used only inside the home; ¶
(b) Group 2 POVs (K0806 -K0808) have added capabilities not needed for in home use. Client specific clinical documentation must be submitted that supports the medical need for this level of POV and demonstrates that there is no equally effective, less costly alternative that meets the client's medical needs; ¶
(c) A replacement item including but not limited to replacement batteries shall be requested using the specific wheelchair option or accessory code if one exists (see 410-122-0340, Wheelchairs Options/Accessories). If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified); ¶
(d) For guidance on correct coding, DMEPOS providers shall contact the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare and Medicaid Services. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information. ¶
(34) ~~Documentation requirements~~Prior Authorization (PA): Submit all of the following documentation with the ~~prior authorization (~~PA~~)~~ request: ¶
(a) A copy of the written report of the face-to-face examination of the client by the practitioner:~~-~~¶
(A) The report must include information related to the following: ¶
(i) The client's mobility limitation and how it interferes with the performance of activities of daily living; ¶
(ii) Why a cane or walker cannot sufficiently resolve the client's mobility limitations; ¶
(iii) Why a manual wheelchair cannot sufficiently resolve the client's mobility limitations; ¶
(iv) The client's physical and mental abilities to operate a POV (scooter): ¶

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in MRADLs, how these conditions shall be ameliorated or compensated; ¶
(II) How these other conditions shall be ameliorated or compensated sufficiently such that the additional provision of //POV shall be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs. ¶
(B) The face-to-face examination shall provide pertinent information about the following elements but may include other details. Only relevant elements need to be addressed: ¶
(i) Symptoms; ¶
(ii) Related diagnoses; ¶
(iii) History: ¶
(I) How long the condition has been present; ¶
(II) Clinical progression; ¶
(III) Interventions that have been tried and the results; ¶
(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results; ¶
(iv) Physical exam: ¶
(I) Weight; ¶
(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs; ¶
(III) Presence of abnormal tone or deformity of arms, legs, or trunk; ¶
(IV) Neck, trunk, and pelvic posture and flexibility; ¶
(V) Sitting and standing balance. ¶
(v) Functional assessment indicating any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person: ¶
(I) Transferring between a bed, chair, and power mobility device; ¶
(II) Walking around their home or community including information on distance walked, speed, and balance. ¶
(b) The practitioner's written order, received by the DMEPOS provider within thirty (30) days after the practitioner's face-to-face examination that includes all of the following elements: ¶
(A) Client's name; ¶
(B) Description of the item that is ordered. This may be general (e.g., "POV" or "power mobility device") or may be more specific: ¶
(i) If this order does not identify the specific type of POV that is being requested, the DMEPOS provider must clarify this by obtaining another written order that lists the specific POV that is being ordered and any options and accessories requested; ¶
(ii) The items on this order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating practitioner, received by the DMEPOS provider, and submitted to the authorizing authority, but does not have to be received within 45 days following the face-to-face examination. ¶
(C) Most significant ICD-10 diagnosis code that relates specifically to the need for the POV; ¶
(D) Length of need; ¶
(E) Practitioner's signature; ¶
(F) Date of practitioner's signature. ¶
(c) For all requested equipment and accessories, include the manufacturer's name, product name, model number, standard features, specifications, dimensions, and options; ¶
(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it cannot be grown (expanded) or modified, if applicable; ¶
(e) A written evaluation of the client's living quarters performed by the DMEPOS provider. This assessment must support that the client's home can accommodate and allow for the effective use of a POV, including but is not limited to evaluation of door widths, counter/table height, accessibility (e.g., ramps), electrical service, etc.; ¶
(f) All HCPCS to be billed on this claim (both codes that require authorization and those that do not require authorization); ¶
(g) Any additional documentation that supports indications of coverage are met as specified in this rule; ¶
(h) The above documentation must be kept on file by the DMEPOS provider; ¶
(~~i~~5) Reimbursement: ¶
(a) Codes specified in this rule shall not be reimbursed for clients residing in nursing facilities; ¶
(b) If a client has a medically appropriate POV regardless of payer, the Division shall not reimburse for another POV; ¶
(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, weight appropriate upholstery and seating system, tiller steering, non-expandable controller with proportional response to input, complete set of tires, and all accessories needed for safe operation; ¶

(d) Reimbursement for the POV includes all labor charges involved in the assembly of the POV and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education, and on-going assistance with use of the POV; ¶
(e) If a client-owned POV meets coverage criteria, medically appropriate replacement items including but not limited to batteries may be covered; ¶
(f) The Division may cover a new POV when a client's existing POV is no longer medically appropriate or repair and modifications to the POV exceed replacement costs; ¶
(g) The Division shall cover one month's rental of a POV if a client-owned POV is being repaired; ¶
(h) The Division shall purchase, rent, and repair; ¶
(A) Rental charges apply toward purchase; ¶
(B) Item is considered purchased when the Division fee schedule purchase price or the actual charge from the provider is met, whichever is less. ¶
(6) Documentation: ¶
(a) For services requiring prior authorization, submit documentation that supports coverage criteria in this rule are met; ¶
(b) Documentation that the coverage criteria have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to the Division upon request. ¶
~~(4) Billing: ¶~~
~~(a~~7) Procedure Codes: ¶
(~~A~~a) K0800 Power operated vehicle, Group 1 standard, patient weight capacity up to and including 300 pounds - PA; ¶
(~~B~~b) K0801 Power operated vehicle, Group 1 heavy duty, patient weight capacity, 301 to 450 pounds - PA; ¶
(~~C~~c) K0802 Power operated vehicle, Group 1 very heavy duty, patient weight capacity, 451 to 600 pounds - PA. ¶
(~~D~~d) K0806 Power operated vehicle, Group 2 standard, patient weight capacity up to and including 300 pounds - PA ¶
(~~E~~e) K0807 Power operated vehicle, Group 2 heavy-duty, patient weight capacity 301 to 450 pounds - PA ¶
(~~F~~f) K0808 Power operated vehicle, Group 2 very heavy-duty, patient weight capacity 451 to 600 pounds - PA¶
~~(b) The Division shall purchase, rent, and repair; ¶~~
~~(c) Item considered purchased after thirteen (13) months of rent or the Division fee schedule purchase price is met, whichever is less.~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0340

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Wheelchair Options/Accessories rule. These updates included the addition of new HCPCS codes added by CMS and defining corresponding criteria for clarity; and amending the numbering/lettering convention to correct errors in the ordering of this administrative rule and comply with SOS rule writing standards.

CHANGES TO RULE:

410-122-0340
Wheelchair Options/Accessories ¶

(1) Indications and limitations of coverage and medical appropriateness: ¶
(a) The Division may cover options and accessories for covered wheelchairs when the following criteria are met: ¶
(A) The client has a wheelchair that meets Division coverage criteria; and ¶
(B) The client requires the options/accessories to participate in one or more mobility-related activities of daily living (MRADLs) in the home, community or any non-institutional setting in which normal life activities take place. See OAR 410-122-0010, Definitions for definition of MRADLs. ¶
(b) The Division does not co~~v~~nsider options/accessories whose primary benefit is allowing the client to perform leisure or recreational activities medically necessary and/or medically appropriate; ¶
(c) Armrests: ¶
(A) Adjustable arm height option (E0973, K0017, K0018, and K0020) may be covered when the client: ¶
(i) Requires an arm height that is different than what is available using nonadjustable arms; and ¶
(ii) Spends at least two (2) hours per day in the wheelchair. ¶
(B) An arm trough (E2209) is covered if the client has quadriplegia, hemiplegia, or uncontrolled arm movements. ¶
(d) Footrest/Legrest: ¶
(A) Elevating legrests (E0990, K0046, K0047, K0053, and K0195) may be covered when: ¶
(i) The client has a musculoskeletal condition or the presence of a cast or brace that prevents 90-degree flexion at the knee; ¶
(ii) The client has ~~significant~~ edema of the lower extremities that requires having an elevating legrest; or ¶
(iii) The client meets the criteria for and has a reclining back on the wheelchair. ¶
(B) Elevating legrests that are used with a wheelchair that is purchased or owned by the patient are coded E0990. This code is per legrest; ¶
(C) Elevating legrests that are used with a capped rental wheelchair base shall be coded K0195. This code is per pair of legrests. ¶
(D) A footbox (E0954) is a padded box designed to position a client's foot. This item comes in multiple configurations and may be for a single foot or for both feet. Regardless of configuration, the unit of service is per foot./ E0954 includes both prefabricated and custom fabricated products. The code also includes all mounting hardware so E1028 is not separately payable with this code. ¶
(e) Nonstandard Seat Frame Dimensions: ¶
(A) For all adult wheelchairs, payment for seat widths or seat depths of 15-19 inches is included in the payment for the base code. These seat dimensions shall not be billed separately; ¶
(B) Codes E2201-E2204 and E2340-E2343 describe seat widths or depths of 20 inches or more for manual or power wheelchairs; ¶
(C) A nonstandard seat width or depth (E2201-E2204 and E2340-E2343) is covered only if the patient's dimensions justify the need. ¶
(f) Rear Wheels for Manual Wheelchairs. Code E2213 (flat free insert) is used to describe either: ¶
(A) A removable ring of firm material that is placed inside of a pneumatic tire to allow the wheelchair to continue to move if the pneumatic tire is punctured; or ¶
(B) Non-removable foam material in a foam filled rubber tire; ¶
(C) E2213 is not used for a solid self-skinning polyurethane tire. ¶
(g) Batteries/Chargers: ¶
(A) Up to two batteries (E2359-E2365, E2371, K0733) at any one time are allowed if required for a power wheelchair; ¶
(B) Batteries/chargers (E2366) for power wheelchairs are payable separately from the purchased wheelchair base. ¶
(h) Seating: ¶

(A) The Division may cover a general use seat cushion and a general-use wheelchair back-cushion for a client whose wheelchair meets Division coverage criteria; ¶
(B) A skin protection seat cushion may be covered for a client who meets both of the following criteria: ¶
(i) The client has a wheelchair that meets Division coverage criteria; and ¶
(ii) The client has either of the following: ¶
(I) Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or ¶
(II) Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift. ¶
(C) A positioning seat cushion (E2605, E2606), positioning back cushion (E2613-E2616, E2620, E2621), and positioning accessory (E0953, E0955-E0957, E0960) may be covered for a client who meets both of the following criteria: ¶
(i) The client has a wheelchair with a sling/solid seat/back and client meets Division coverage criteria; and ¶
(ii) The client has any significant postural asymmetries. ¶
(D) A combination skin protection and positioning seat cushion (E2607, E2608, E2624, E2625) may be covered when a client meets the criteria for both a skin protection seat cushion and a positioning seat cushion; ¶
(E) Separate payment is allowed for a seat cushion solid support base (E2231) with mounting hardware when it is used on an adult manual wheelchair (K0001-K0009, E1161).~~/~~ Separate payment is not allowed for the solid support base and mounting hardware when it is used on a power wheelchair;¸ ¶
(F) There is no separate payment for a solid insert (E0992) that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion; ¶
(G) There is no separate payment for mounting hardware for a seat or back cushion; ¶
(H) There is no separate payment for a headrest (E0955, E0966) on a captain's seat on a power wheelchair; ¶
(I) A custom fabricated seat cushion (E2609) and a custom fabricated back cushion (E2617) are cushions that are individually made for a specific patient: ¶
(i) Basic materials include liquid foam or a block of foam and sheets of fabric or liquid coating material: ¶
(I) A custom fabricated cushion may include certain prefabricated components (e.g., gel or multi-cellular air inserts). These components may not be billed separately; ¶
(II) The cushion must have a removable vapor permeable or waterproof cover¸ or it must have a waterproof surface. ¶
(ii) The cushion must be fabricated using molded-to-patient-model technique, direct molded-to-patient technique, computer-aided design and computer-aided manufacturing (CAD-CAM) technology, or detailed measurements of the patient used to create a configured cushion: ¶
(I) If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual client, the cushion must be billed as a prefabricated cushion, not custom fabricated; ¶
(II) The cushion must have structural features that significantly exceed the minimum requirements for a seat or back positioning cushion. ¶
(iii) If a custom fabricated seat and back are integrated into a one-piece cushion, code as E2609 plus E2617. ¶
(J) A custom fabricated seat cushion may be covered if criteria in subparagraph (i) and (iii) are met. A custom fabricated back cushion may be covered if criteria subparagraph (ii) and (iii) are met: ¶
(i) Client meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion; ¶
(ii) Client meets all of the criteria for a prefabricated positioning back cushion; ¶
(iii) There is a comprehensive written evaluation by a licensed/certified medical professional-, such as a physical therapist (PT) or occupational therapist (OT), who is not an employee of or otherwise paid by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider, which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs. ¶
(K) A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion that has not received ~~a written~~ coding verification as published by the Pricing, Data Analysis and Coding (PDAC) contractor by the Centers for Medicare and Medicaid Services; or that does not meet the criteria stated in this rule is not covered; ¶
(L) A headrest extension (E0966) is a sling support for the head. Code E0955 describes any type of cushioned headrest; ¶
(M) The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, that is an integral part of the cushion; ¶
(N) A solid insert (E0992) is a separate rigid piece of wood or plastic that is inserted in the cover of a cushion to provide additional support and is included in the allowance for a seat cushion; ¶
(O) A solid support base for a seat cushion is a rigid piece of plastic or other material that is attached with hardware to the seat frame of a wheelchair in place of a sling seat. A cushion is placed on top of the support base. Use code E2231 for this solid support base that is used with a manual wheelchair. A solid support base is included in the allowance for power wheelchair codes. Separate payment is not allowed for a solid support base and

mounting hardware when it is used on a power wheelchair; ¶
(i) The Division shall only cover accessories billed under the following codes when PDAC ~~makes written confirmation of~~lists the use of the code for the specific product being billed: E2601-E2608, E2610-E2616, E2620-E2625, E2609 and E2617 (brand-name products); K0108 (for wheelchair cushions): ¶
(A) ~~Information concerning the documentation that must be submitted to PDAC for a Coding Verification Request can be foun~~PDAC coding is available and can be verified on the PDAC website or by contacting PDAC; ¶
(B) A product classification list with products that have received a coding verification can be found on the PDAC website. ¶
(j) Code E1028 ~~(swingaway or removable mounting hardware upgrade)~~shall be used to bill manual swingaway, retractable, or removable mounting hardware for wheelchair accessories that include mounting hardware such as (not all-inclusive): swingaway or flip-down hardware for head control interfaces E2327, E2328, E2329, E2330, and swingaway hardware for an indicator display box that is related to the multi-motor electronic connection E2310 or E2311. E1028 may be billed in addition to codes E095~~5-~~3 andE0957. ~~It~~E1028 shall not be billed in addition to codes E0950, E0954, E0960, or E1020 ~~or E2325 as mounting hardware is included in the allowance for these codes. It shall not be used for mounting hardware related to a wheelchair seat cushion or back cushion code;~~ ¶
~~(k) Power seating systems:~~as mounting hardware is included in the allowance for these codes. E1028 shall not be used for mounting hardware related to a wheelchair seat cushion or back cushion code. Code E1032 shall be used to bill manual swingaway, retractable or removable mounting hardware for wheelchair accessories described by joysticks or other drive control interfaces. E1032 shall not be billed in addition to code E2325 as mounting hardware is included in the allowance for this code. Code E1033 shall be used to bill manual swingaway, retractable or removable mounting hardware for headrest and may be billed with code E0955. E1034 shall be used to bill manual swingaway, retractable or removable mounting hardware for lateral trunk or hip support and may be billed with code E0956. Powered swingaway or retractable mounting hardware shall be billed using HCPCS code K0108; ¶
(k) Power seating systems - tilt only, recline only, or combination tilt and recline, with or without elevating leg rests may be covered when A-D are met and to treat conditions such as, but not limited to E-I: ¶
(A) The client has met criteria for a power wheelchair; and ¶
(B) A specialty evaluation was performed by a licensed/certified physical therapist (PT) or occupational therapist (OT) or practitioner who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs and ¶
(C) The PT, OT, or/practitioner may have no financial relationship with the supplier; and ¶
(D) The wheelchair is or was provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary; ¶
(E) The client is at risk for developing a pressure ulcer and is unable to change positioning or perform a functional weight shift; or ¶
(F) The client utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed; or ¶
(G) The power seating system is needed to manage increased tone or spasticity; or ¶
(H) For clients with absent or impaired sensation and at risk for developing a pressure injury; or ¶
(I) The power seating system is needed to manage chronic edema; ¶
(~~A~~i) A power-tilt seating system (E1002)~~:~~ ¶
~~(i) I~~ includes all the following: ¶
(I) A solid seat platform and a solid back; any frame width and depth; ¶
(II) Detachable or flip-up fixed height or adjustable height armrests; ¶
(III) Fixed or swingaway detachable legrests; ¶
(IV) Fixed or flip-up footplates; ¶
(V) Motor and related electronics with or without variable speed programmability; ¶
(VI) Switch control that is independent of the power wheelchair drive control interface; ¶
(VII) Any hardware that is needed to attach the seating system to the wheelchair base. ¶
(ii) It does not include a headrest; ¶
(iii) It must have the following features: ¶
(I) Ability to tilt to greater than or equal to 20 degrees from horizontal; ¶
(II) Ability for the supplier to adjust the seat to back angle; ¶
(III) Ability to support patient weight of at least 250 pounds. ¶
(~~B~~iv) A power recline seating system (E1003-E1005)~~:~~ ¶
~~(i) I~~ includes ~~all~~ the following: ¶
(I) A solid seat platform and a solid back; ¶

(II) Any frame width and depth; ¶
(III) Detachable or flip-up fixed height or adjustable height arm rests; ¶
(IV) Fixed or swingaway detachable legrests; ¶
(V) Fixed or flip-up footplates; ¶
(VI) A motor and related electronics with or without variable speed programmability; ¶
(VII) A switch control that is independent of the power wheelchair drive control interface; ¶
(VIII) Any hardware that is needed to attach the seating system to the wheelchair base. ¶
(~~ii~~v) It does not include a headrest; ¶
(~~ii~~vi) It must have the following features: ¶
(I) Ability to recline to greater than or equal to 150 degrees from horizontal; ¶
(II) Back height of at least 20 inches; ¶
(III) Ability to support patient weight of at least 250 pounds. ¶
(~~C~~vii) A power tilt and recline seating system (E1006-E1008)~~: ¶~~
~~(i) I~~ includes the following: ¶
(I) A solid seat platform and a solid back; ¶
(II) Any frame width and depth; detachable or flip-up fixed height or adjustable height armrests; ¶
(III) Fixed or swing-away detachable legrests; fixed or flip-up footplates; ¶
(IV) Two motors and related electronics with or without variable speed programmability; ¶
(V) Switch control that is independent of the power wheelchair drive control interface; ¶
(VI) Any hardware that is needed to attach the seating system to the wheelchair base. ¶
(viii) It does not include a headrest; ¶
(~~ii~~ix) It must have the following features: ¶
(I) Ability to tilt to greater than or equal to 20 degrees from horizontal; ¶
(II) Ability to recline to greater than or equal to 150 degrees from horizontal; ¶
(III) Back height of at least 20 inches; ability to support patient weight of at least 250 pounds. ¶
(~~D~~J) Coding for a power tilt system (E1002), power recline system (E1003-E1005), and tilt/recline system (E1006-E1008) are all inclusive. Billing K0108 for additional heavy duty or bariatric features is considered unbundling and not allowed; ¶
(~~E~~K) A mechanical shear reduction feature (E1004 and E1007) consists of two separate back panels. As the posterior back panel reclines or raises, a mechanical linkage between the two panels allows the client's back to stay in contact with the anterior panel without sliding along that panel; ¶
(~~F~~L) A power shear reduction feature (E1005 and E1008) consists of two separate back panels. As the posterior back panel reclines or raises, a separate motor controls the linkage between the two panels and allows the client's back to stay in contact with the anterior panel without sliding along that panel; ¶
(~~G~~M) A power leg elevation feature (E1010, E1012) involves a dedicated motor and related electronics with or without variable speed programmability that allows the legrest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control that may or may not be integrated with the power tilt and recline controls; ¶
(~~L~~N) A center mount power elevating leg rest/platform includes all components of the leg rest, including fixed angle footplates and foot platforms. Adjustable angle footplates coded K0040 are separately payable when provided with leg rests coded as E1012. ¶
(I) Codes E2~~300~~298, E2310 and E2311 (Power Wheelchair Accessory): ¶
(A) Describe the electronic components that allow the client to control two or more of the following motors from a single interface (e.g., proportional joystick, touchpad, or non-proportional interface): Power wheelchair drive, power tilt, power recline, power shear reduction, power leg elevation, power seat elevation, power standing; ¶
(B) Include a function selection switch that allows the client to select the motor that is being controlled and an indicator feature to visually show which function has been selected; ¶
(C) When the wheelchair drive function is selected the indicator feature may also show the direction that is selected (forward, reverse, left, right). This indicator feature may be in a separate display box or may be integrated into the wheelchair interface; ¶
(D) Payment for the code includes an allowance for fixed mounting hardware for the control box and for the display box (if present); ¶
(E) When a switch is medically appropriate and a client has adequate hand motor skills, a switch shall be considered the least costly alternative; ¶
(F) E2~~300~~298, power seat elevation system, may be covered for clients using complex power wheelchairs, when one of the following criteria (i) or (ii) are met and (iii)-(iv) are met: ¶
(i) The client must routinely transfer between uneven surfaces and the seat elevation feature allows them to accomplish transfers independently or with caregiver assistance; or ¶
(ii) The client cannot be safely transferred using a patient lift or standing transfer and can safely transfer with the

seat elevation feature; ~~or~~and ¶
(iii) The seat elevation feature has been demonstrated to allow the client to access areas in the home or community necessary to perform their MRADLs; and ¶
(iv) The client has had a specialty evaluation that documents the medical need and client's ability to safely operate the seat elevation equipment. This evaluation must be performed by a licensed/certified medical professional, such as physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation wheelchair evaluations~~; and.~~ ¶
(~~v~~G) Power seat elevation systems added to complex rehabilitative power wheelchairs (K0835-K0864) and Group 5 power wheelchairs (K0890, K0891) must use code E2~~300.~~298./ ¶
(~~vi~~H) Code E2~~300~~298 cannot be added to any non-complex power wheelchair base (K0813-K0829). HCPCS codes K0830 and K0831 for Group 2 standard base wheelchairs (non-complex) include the seat elevation feature and may be used if client meets criteria for the power wheelchair and the seat elevation criteria are met.~~-~~/ // ¶
(~~G~~I) E2310 or E2311 may be covered when a client does not have hand motor skills or presents with cognitive deficits, contractures, or limitation of movement patterns that prevents operation of a switch; ¶
(~~H~~J) In addition, an alternate switching system must be medically appropriate and not hand controlled (not running through a joystick). ¶
(m) Power Wheelchair Drive Control Systems: ¶
(A) The term interface in the code narrative and definitions describes the mechanism for controlling the movement of a power wheelchair. Examples of interfaces include but are not limited to joystick, sip and puff, chin control, head control, etc.; ¶
(B) A proportional interface is one in which the direction and amount of movement by the client controls the direction and speed of the wheelchair. One example of a proportional interface is a standard joystick; ¶
(C) A non-proportional interface is one that involves a number of switches. Selecting a particular switch determines the direction of the wheelchair, but the speed is pre-programmed. One example of a non-proportional interface is a sip-and-puff mechanism; ¶
(D) The term controller describes the microprocessor and other related electronics that receive and interpret input from the joystick (or other drive control interface) and convert that input into power output to the motor and gears in the power wheelchair base; ¶
(E) A non-expandable controller has the following features: ¶
(i) May have the ability to control up to ~~2~~two (2) power seating actuators through switches or the drive control (for example, seat elevator and single actuator power elevating leg rests). Control of these items through the Control Input Device would require the use of an additional component, E2310 or E2311); and ¶
(ii) Can accommodate only an integral joystick or a standard proportional remote joystick; and ¶
(iii) May allow for the incorporation of an attendant control; ¶
(F) An expandable controller is capable of accommodating or operating one or more of the following additional functions or devices: ¶
(i) Other types of proportional input devices (e.g., mini-proportional or compact joysticks, touchpads, chin control, head control, etc); / ¶
(ii) Non-proportional input devices (e.g., sip and puff, head array, etc); / ¶
(iii) Operate ~~3~~three (3) or more powered seating actuators through switches or the drive control. Control of these items through the Control Input Device shall require the use of an additional component, E2310 or E2311; ¶
(iv) A separate display; ¶
(v) Other electronic devices (e.g., augmentative communication device) ¶
(vi) An attendant control; ¶
(G) For power wheelchairs capable of being upgraded to an expandable controller, E2377 is used if an expandable controller is provided at the time of initial issue.~~-~~/ Code E2376 is used with complete replacement of an expandable controller; ¶
(H) A harness (E2313) describes all of the wires, fuse boxes, fuses, circuits, switches, etc. that are required for the operation of an expandable controller. It includes all necessary fasteners, connectors, and mounting hardware. Code E2313 is separately billable in addition to an expandable controller both at initial issue and with complete replacement. ¶
(I) A switch is an electronic device that turns power to a particular function either "on" or "off." The external component of a switch may be either mechanical or non-mechanical. Mechanical switches involve physical contact in order to be activated. Examples of the external components of mechanical switches include but are not limited to toggle, button, ribbon, etc. Examples of the external components of non-mechanical switches include but are not limited to proximity, infrared, Bluetooth, fiber optic, etc. Some of the codes include multiple switches. In those situations, each functional switch may have its own external component, or multiple functional switches may be integrated into a single external switch component, or multiple functional switches may be integrated into the wheelchair control interface without having a distinct external switch component; ¶

(J) A stop switch allows for an emergency stop when a wheelchair with a non-proportional interface is operating in the latched mode. (Latched mode is when the wheelchair continues to move without the patient having to continually activate the interface.) This switch is sometimes referred to as a kill switch; ¶
(K) A direction change switch allows the client to change the direction that is controlled by another separate switch or by a mechanical proportional head control interface. For example, it allows a switch to initiate forward movement one time and backward movement another time; ¶
(L) A function selection switch allows the client to determine what operation is being controlled by the interface at any particular time. Operations may include but are not limited to drive forward, drive backward, tilt forward, recline backward, etc.; ¶
(M) An integrated proportional joystick and controller is an electronics package in which a joystick and controller electronics are in a single box that is mounted on the arm of the wheelchair; ¶
(N) The interfaces described by codes E2312, E2321, E2322, E2325, and E2327-E2330, E2373-E2377 must have programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking; ¶
(O) A mini-proportional (short-throw) remote joystick (E2312) can only be used with an expandable controller. There is no separate billing for control buttons, displays, switches, etc. There is no separate billing for fixed mounting hardware, regardless of the body part used to activate the joystick; ¶
(P) A remote joystick (E2321) is one in which the joystick is in one box that is mounted on the arm of the wheelchair and the controller electronics are located in a different box that is typically located under the seat of the wheelchair; ¶
(Q) When code E2321 is used for a chin control interface, the chin cup is billed separately with code E2324; ¶
(R) Code E2322 describes a system of 3-5 mechanical switches that are activated by the client touching the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch, and a mechanical direction change switch, if provided, are included in the allowance for the code; ¶
(S) Code E2323 includes prefabricated joystick handles that have shapes other than a straight stick, e.g., U shape or T shape or that have some other nonstandard feature, e.g., flexible shaft; ¶
(T) A sip and puff interface (E2325) is a non-proportional interface in which the client holds a tube in their mouth and controls the wheelchair by either sucking in (sip) or blowing out (puff). A mechanical stop switch is included in the allowance for the code. E2325 does not include the breath tube kit that is described by code E2326; ¶
(U) A proportional, mechanical head control interface (E2327) is one in which a headrest is attached to a joystick-like device. The direction and amount of movement of the client's head pressing on the headrest control the direction and speed of the wheelchair. A mechanical direction control switch is included in the code; ¶
(V) A proportional, electronic head control interface (E2328) is one in which a client's head movements are sensed by a box placed behind the client's head. The direction and amount of movement of the client's head (which does not come in contact with the box) control the direction and speed of the wheelchair. A proportional, electronic extremity control interface (E2328) is one in which the direction and amount of movement of the client's arm or leg control the direction and speed of the wheelchair; ¶
(W) A non-proportional, contact switch head control interface (E2329) is one in which a client activates one of three mechanical switches placed around the back and sides of their head. These switches are activated by pressure of the head against the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code; ¶
(X) A non-proportional, proximity switch head control interface (E2330) is one in which a client activates one of three switches placed around the back and sides of their head. These switches are activated by movement of the head toward the switch, though the head does not touch the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code; ¶
(Y) Code K0108 may not be used for additional features of a joystick.-K0108 is appropriately used at the time of replacement in the following situations: ¶
(i) An integrated proportional joystick and controller box are being replaced due to damage; or ¶
(ii) An interface other than a remote joystick (e.g., sip and puff, head control) is being replaced but the controller is not being replaced; or ¶
(iii) There is no specific E code which describes the type of drive control interface system which is provided; ¶
(Z) The KC modifier (replacement of special power wheelchair interface) shall not be used at the time of initial issue of a wheelchair but may be used in the following situations: ¶
(i) Due to a change in the client's condition an integrated joystick and controller is being replaced by another drive control interface, e.g., remote joystick, head control, sip and puff, etc.; or ¶
(ii) The client has a drive control interface described by codes E2320-E2322, E2325, or E2327-E2330 and both the interface (e.g., joystick, head control, sip and puff), and the controller electronics are being replaced due to irreparable damage. ¶
(n) Other power wheelchair accessories. An electronic interface (E2351) to allow a speech generating device to be

operated by the power wheelchair control interface may be covered if the client has a covered speech generating device (See chapter 410, division 129, Speech-Language Pathology, Audiology and Hearing Aid Services.); ¶
(o) Miscellaneous accessories: ¶
(A) Anti-rollback device (E0974) is covered if the client propels himself and needs the device because of ramps; ¶
(B) A safety belt/pelvic strap (E0978) is covered if the client has weak upper body muscles, upper body instability, or muscle spasticity that requires use of this item for proper positioning; ¶
(C) A shoulder harness/straps or chest strap (E0960) and a safety belt/pelvic strap (E0978) are covered only to treat a client's medical symptoms: ¶
(i) A medical symptom is defined as an indication or characteristic of a physical or psychological condition; ¶
(ii) E0960 and E0978 are not covered when intended for use as a physical restraint or for purposes intended for discipline or convenience of others. ¶
(D) One example (not all-inclusive) of a covered indication for swingaway, retractable, or removable hardware (E1028~~) would~~, E1032, E1033, or E1034) may be to move the component out of the way so that a client could perform a slide transfer to a chair or bed; ¶
(E) A manual fully reclining back option (E1226) is covered if the client spends at least two (2) hours per day in the wheelchair and has one or more of the following conditions: ¶
(i) The client is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or ¶
(ii) The client utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed; ¶
(iii) Trunk or lower extremity casts/braces that require the reclining back feature for positioning; ¶
(iv) Excess extensor tone of the trunk muscles; or ¶
(v) The need to rest in a recumbent position two or more times during the day, and transfer between wheelchair and bed is very difficult. ¶
(F) A power standing system (E2301) is covered if the client spends at least two (2) hours per day in the wheelchair, requires supported standing to address one or more the following areas (i - viii) and criteria (ix - xiii) are met: ¶
(i) Maintain or improve bladder function; or ¶
(ii) Maintain or promote bone/joint health; or ¶
(iii) Maintain or improve bowel and/or bladder function; or ¶
(iv) Maintain or improve digestive process; or ¶
(v) Maintain or promote cardiac function; or ¶
(vi) Management of contractures and range of motion in the lower extremities; or ¶
(vii) Management of pain associated with spasticity or tone; or ¶
(viii) Reduced respiratory function secondary to inability to independently achieve an upright posture; and ¶
(ix) Effective weight bearing cannot be achieved by any other means; and ¶
(x) Unable to stand without external support; and ¶
(xi) Able to move to/from a seated and standing position by mechanical means; and ¶
(xii) Demonstrated tolerance for standing and at least partial weight bearing; and ¶
(xiii) Moving in a standing position is required to perform or participate in MRADLs. ¶
(2) Documentation Requirements. Submit documentation that supports coverage criteria in this rule are met and the specified information as follows with the prior authorization (PA) request: ¶
(a) When code K0108 is billed, a narrative description of the item, the manufacturer, the model's name or number (if applicable), and information justifying the medical appropriateness for the item; ¶
(b) Options/accessories for individual consideration might include documentation on the client's diagnosis, the client's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the client performs, etc.), the duration of the condition, the expected prognosis, past experience using similar equipment; ¶
(c) For a custom-fabricated seat cushion: ¶
(A) A comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a DMEPOS provider) that clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs; ¶
(B) Diagnostic reports that support the medical condition; ¶
(C) Dated and clear photographs; ¶
(D) Body contour measurements. ¶
(d) Documentation that the coverage criteria in this rule have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to the Division upon request. ¶
(3) Table 122-0340 - 1. ¶

(4) Table 122-0340 - 2.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 410-122-0340-1

For the code legend see OAR 410-122-0182.

Column II code is included in the allowance for the corresponding Column I code when provided at the same time. When multiple codes are listed in column I, all the codes in column II relate to each code in column I.

Column I	Column II
Power Operated Vehicle (K0800-K0802, K0806-K0808, K0812)	All options and accessories
Rollabout Chair (E1031)	All options and accessories
Transport Chair (E1037, E1038, E1039)	All options and accessories except E0990, K0195
Manual Wheelchair Base (E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009)	E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2224, E2225, E2226, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072, K0077
Power Wheelchair Base Groups 1 and 2 (K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843)	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0077, K0098
Power Wheelchair Base Groups 3, 4, and 5 (K0848- K0864, K0868-K0871, K0877- K0880, K0884-K0886, K0890, K0891)	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0077, K0098
E0973	K0017, K0018, K0019
E0950	E1028
E0954	E1028
E0990	E0995, K0042, K0043, K0044, K0045, K0046, K0047
Power tilt and/or recline seating systems (E1002, E1003, E1004, E1005, E1006, E1007, E1008)	E0973, K0015, K0017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1009, E1010, E1012	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
E2325	E1028
E1020	E1028
K0039	K0038
K0045	K0043, K0044
K0046	K0043
K0047	K0044
K0053	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047

Column II code is included in the allowance for the corresponding Column I code when provided at the same time. When multiple codes are listed in column I, all the codes in column II relate to each code in column I.

Column I	Column II
K0069	E2220, E2224
K0070	E2211, E2212, E2224
K0071	E2214, E2215, E2225, E2226
K0072	E2219, E2225, E2226
K0077	E2221, E2222, E2225, E2226
K0195	E0995, K0042, K0043, K0044, K0045, K0046, K0047

Arm of Chair

Code	Description	PA	PC	RT	MR	RP	NF
E0973	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each		PC	RT	13	RP	
E2209	Wheelchair accessory, arm trough, with or without hand support, each		PC	RT	13	RP	
K0015	Detachable, non-adjustable height armrest, replacement only, each		PC	RT	13	RP	
K0017	Detachable, adjustable height armrest, base, replacement only, each		PC	RT	13	RP	
K0018	Detachable, adjustable height armrest, upper portion, replacement only, each		PC	RT	13	RP	
K0019	Arm pad, replacement only, each		PC	RT	13	RP	
K0020	Fixed, adjustable height armrest, pair		PC	RT	13	RP	
E2626	Shoulder elbow orthosis, mobile arm support attached to w/c, balanced, adjustable, prefabricated, includes fitting and adjustment	PA	PC				
E2627	Shoulder elbow orthosis, mobile arm support attached to w/c, balanced, adjustable rancho type, prefabricated, includes fitting and adjustment	PA	PC				
E2628	Shoulder elbow orthosis, mobile arm support attached to w/c, balanced, reclining, prefabricated, includes fitting and adjustment	PA	PC				
E2629	Shoulder elbow orthosis, mobile arm support attached to w/c, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment	PA	PC				
E2630	Shoulder elbow orthosis, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support, prefabricated, includes fitting and adjustment	PA	PC				
E2631	SEO, addition to mobile arm support, elevating proximal arm	PA	PC				
E2632	SEO, addition to mobile arm support, elevating proximal arm	PA	PC				
E2633	SEO, addition to mobile arm support, supinator	PA	PC				

Foot Rest/Leg Rest

Code	Description	PA	PC	RT	MR	RP	NF
E0951	Heel loop/holder, any type, with or without ankle strap, each		PC	RT	13	RP	*
E0952	Toe loop/holder, any type, each		PC	RT	13	RP	*
E0954	Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot		PC	RT	13	RP	*
E0990	Wheelchair accessory, elevating leg rest, complete assembly, each		PC	RT	13	RP	*
E0995	Wheelchair accessory, calf rest/pad, replacement only, each		PC	RT	13	RP	*
E1020	Residual limb support system for wheelchair, any type		PC	RT	13	RP	*
K0037	High mount flip-up footrest, each		PC	RT	13	RP	*
K0038	Leg strap, each		PC	RT	13	RP	*
K0039	Leg strap, H style, each		PC	RT	13	RP	*
K0040	Adjustable angle footplate, each		PC	RT	13	RP	*
K0041	Large size footplate, each		PC	RT	13	RP	*
K0042	Standard size footplate, replacement only, each		PC	RT	13	RP	*
K0043	Footrest, lower extension tube, replacement only, each		PC	RT	13	RP	*
K0044	Footrest, upper hanger bracket, replacement only, each		PC	RT	13	RP	*
K0045	Footrest, complete assembly, replacement only, each		PC	RT	13	RP	*
K0046	Elevating leg rest, lower extension tube, replacement only, each		PC	RT	13	RP	*
K0047	Elevating leg rest, upper hanger bracket, replacement only, each		PC	RT	13	RP	*
K0050	Ratchet assembly, replacement only		PC	RT	13	RP	*
K0051	Cam release assembly, footrest or leg rest, replacement only, each		PC	RT	13	RP	*
K0052	Swing-away, detachable footrests, replacement only, each		PC	RT	13	RP	*
K0053	Elevating footrests, articulating (telescoping), each		PC	RT	13	RP	*
K0195	Elevating leg rests, pair (for use with capped rental wheelchair base)			RT	13		*

Non-Standard Seat Frame Dimension

Code	Description	PA	PC	RT	MR	RP	NF
E2201	Manual wheelchair accessory, non-standard seat frame, width greater than or equal to 20 inches and less than 24 inches		PC	RT	13	RP	
E2202	Manual wheelchair accessory, non- standard seat frame width, 24-27 inches		PC	RT	13	RP	
E2203	Manual wheelchair accessory, non- standard seat frame depth, 20 to less than 22 inches		PC	RT	13	RP	
E2204	Manual wheelchair accessory, non-standard seat frame depth, 22 to 25 inches		PC	RT	13	RP	
E2340	Power wheelchair accessory, non-standard seat frame width, 20-23 inches		PC	RT	13	RP	*
E2341	Power wheelchair accessory, non-standard seat frame width, 24-27 inches		PC	RT	13	RP	*

E2342	Power wheelchair accessory, non- standard seat frame depth, 20 or 21 inches		PC	RT	13	RP	*
E2343	Power wheelchair accessory, non- standard seat frame depth, 22-25 inches		PC	RT	13	RP	*
K0056	Seat height less than 17 inches or equal to or greater than 21 inches for high strength, lightweight, or ultra-lightweight wheelchair		PC	RT	13	RP	

Rear Wheels for Manual Wheelchairs

Code	Description	PA	PC	RT	MR	RP	NF
E0961	Manual wheelchair accessory, wheellock brake extension (handle), each		PC	RT	13	RP	*
E0967	Manual wheelchair accessory, hand rim with projections, any type, replacement only, each		PC	RT	13		
E0988	Manual wheelchair accessory, lever- activated, wheel drive, pair		PC	RT	13	RP	*
E2205	Manual wheelchair accessory, hand rim without projections (includes ergonomic or contoured), any type, replacement only, each		PC	RT	13	RP	*
E2206	Manual wheelchair accessory, wheel lock assembly, complete, replacement only, each		PC	RT	13	RP	*
E2211	Manual wheelchair accessory, pneumatic propulsion tire, any size, each		PC	RT	13	RP	*
E2212	Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each		PC	RT	13	RP	*
E2213	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each		PC	RT	13	RP	*
E2216	Manual wheelchair accessory, foam filled propulsion tire, any size, each		PC	RT	13	RP	*
E2218	Foam propulsion tire, any size, each		PC	RT	13	RP	*
E2220	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, replacement only, each		PC	RT	13	RP	*
E2224	Manual wheelchair accessory, propulsion wheel excludes tire, any size, replacement only, each		PC	RT	13	RP	*
E2227	Manual wheelchair accessory, gear reduction drive wheel, each		PC	RT	13	RP	*
E2228	Manual wheelchair accessory, wheel braking system and lock, complete, each		PC	RT	13	RP	*
K0065	Spoke protectors, each		PC	RT	13	RP	*
K0069	Rear wheel assembly, complete, with solid tire, spokes or molded, replacement only, each		PC	RT	13	RP	*
K0070	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, replacement only, each		PC	RT	13	RP	*

Front Casters for Manual Wheelchairs

Code	Description	PA	PC	RT	MR	RP	NF
E2214	Pneumatic caster tire, any size, each		PC	RT	13	RP	*
E2215	Tube for pneumatic caster tire, any size, each		PC	RT	13	RP	*
E2217	Foam filled caster tire, any size, each		PC	RT	13	RP	*
E2219	Foam caster tire, any size, each		PC	RT	13	RP	*

E2221	Solid caster tire (removable), any size, replacement only, each		PC	RT	13	RP	*
E2222	Manual wheelchair accessory, solid (rubber/plastic) caster tire with		PC	RT	13	RP	*
E2225	Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each		PC	RT	13	RP	*
E2226	Manual wheelchair accessory, caster fork, any size, replacement only, each		PC	RT	13	RP	*
K0071	Front caster assembly, complete, with pneumatic tire, replacement only, each		PC	RT	13	RP	*
K0072	Front caster assembly, complete, with semi-pneumatic tire, replacement only, each		PC	RT	13	RP	*
K0073	Caster pin lock, each		PC	RT	13	RP	*
K0077	Front caster assembly, complete, with solid tire, each		PC	RT	13	RP	*

Batteries/Chargers

Code	Description	PA	PC	RT	MR	RP	NF
E2358	Power wheelchair accessory, group 34 non-sealed lead acid battery, each		PC				*
E2359	Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)		PC				*
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	13	RP	*
E2367	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each		PC	RT	13	RP	*
E2371	Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glassmat), each		PC	RT			*
E2372	Power wheelchair accessory, group 27 non-sealed lead acid battery, each		PC	RT			*
E2397	Power wheelchair accessory, lithium-based battery, each		PC	RT			*
K0733	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)		PC	RT			*

Power Seating Systems

Code	Description	PA	PC	RT	NR	RP	NF
E1002	Wheelchair accessory, power seating system, tilt only	PA	PC	RT	13	RP	*
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction	PA	PC	RT	13	RP	*
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	PA	PC	RT	13	RP	*
E1005	Wheelchair accessory, power seating system, recline only, with power shear reduction	PA	PC	RT	13	RP	*
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	PA	PC	RT	13	RP	*
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	PA	PC	RT	13	RP	*
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	PA	PC	RT	13	RP	*
E1009	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each	PA	PC	RT	13	RP	*
E1010	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair	PA	PC	RT	13	RP	*
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each	PA	PC	RT	13	RP	*
E2298	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type	PA	PC	RT	13	RP	*
E2301	Wheelchair accessory, power standing system, any type	PA	PC	RT	13	RP	*
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch and fixed mounting hardware	PA	PC	RT	13	RP	*
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	PA	PC	RT	13	RP	*

Power Wheelchair Drive Control Systems

Code	Description	PA	PC	RT	MR	RP	NF
E2312	Power wheelchair accessory, hand or chin control interface, mini- proportional remote joystick, proportional, including fixed mounting hardware	PA	PC	RT	13	RP	*
E2313	Power wheelchair accessory, harness for upgrade for expandable controller, including all fasteners, connectors and mounting hardware, each	PA	PC	RT	13		
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	13	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	13	RP	*
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, pre-fabricated		PC	RT	13	RP	*
E2324	Power wheelchair accessory, chin cup for chin control interface		PC	RT	13	RP	*
E2325	Power wheelchair accessory, sip and puff interface, non-proportional, including all related electronics, mechanical stop switch, and manual swing away mounting hardware	PA	PC	RT	13	RP	*
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	PA	PC	RT	13	RP	*
E2327	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	PA	PC	RT	13	RP	*
E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	PA	PC	RT	13	RP	*
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, non-proportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	PA	PC	RT	13	RP	*
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, non-proportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	PA	PC	RT	13	RP	*
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware	PA	PC	RT	13	RP	*
E2373	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	PA	PC	RT	13	RP	*

E2374	Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only	PA	PC	RT	13		
E2375	Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only	PA	PC	RT	13		
E2376	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	PA	PC	RT	13		
E2377	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	PA	PC	RT	13		

Other Power Wheelchair Accessories

Code	Description	PA	PC	RT	MR	RP	NF
E1016	Shock absorber for power wheelchair, each	PA	PC	RT	13	RP	*
E1018	Heavy-duty shock absorber for heavy-duty or extra heavy-duty power wheelchair	PA	PC	RT	13	RP	*
E2351	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface	PA	PC	RT	13	RP	*
E2368	Power wheelchair component, driver wheel motor, replacement only	PA	PC	RT	13	RP	*
E2369	Power wheelchair component, drive wheel gear box, replacement only	PA	PC	RT	13	RP	*
E2370	Power wheelchair component, integrated drive wheel motor and gear box combination, replacement only	PA	PC	RT	13	RP	*
E2378	Power wheelchair component, actuator, replacement only		PC	RT	13	RP	
E2381	Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each		PC	RT	13		
E2382	Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each		PC	RT	13		
E2383	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each		PC	RT	13		
E2384	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each		PC	RT	13		
E2385	Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each		PC	RT	13		
E2386	Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each		PC	RT	13		
E2387	Power wheelchair accessory, foam filled caster tire, any size, replacement only, each		PC	RT	13		
E2388	Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each		PC	RT	13		
E2389	Power wheelchair accessory, foam caster tire, any size, replacement only, each		PC	RT	13		
E2390	Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, anysize, replacement only, each		PC	RT	13		

E2391	Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each		PC	RT	13		
E2392	Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each		PC	RT	13	RP	*
E2394	Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each		PC	RT	13	RP	*
E2395	Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each		PC	RT	13	RP	*
E2396	Power wheelchair accessory, caster fork, any size, replacement only, each		PC	RT	13	RP	*
K0098	Drive belt for power wheelchair, replacement only		PC	RT	13	RP	*

Seat Cushion

Code	Description	PA	PC	RT	MR	RP	NF
E2601	General use wheelchair seat cushion, width less than 22 inches, any depth	PA	PC	RT	13		
E2602	General use wheelchair seat cushion, width 22 inches or greater, any depth	PA	PC	RT	13		
E2603	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	PA	PC	RT	13		
E2604	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	PA	PC	RT	13		
E2605	Positioning wheelchair seat cushion, width less than 22 inches, any depth	PA	PC	RT	13		
E2606	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	PA	PC	RT	13		
E2607	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	PA	PC	RT	13		
E2608	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	PA	PC	RT	13		
E2609	Custom fabricated wheelchair seat cushion, any size	PA	PC				NF
E2610	Wheelchair seat cushion, powered	PA	PC	RT	13		
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth		PC	RT	13		
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth		PC	RT	13		
E2624	Skin protection and positioning wheelchair seat cushion, adjustable width less than 22 inches, any depth		PC	RT	13		
E2625	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth		PC	RT	13		

Back Cushion

Code	Description	PA	PC	RT	MR	RP	NF
E2611	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	PA	PC	RT	13		
E2612	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	PA	PC	RT	13		

E2613	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	PA	PC	RT	13		
E2614	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	PA	PC	RT	13		
E2615	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	PA	PC	RT	13		
E2616	Positioning wheelchair back cushion, posterior-lateral width 22 inches or greater, any height, including any type of mounting hardware	PA	PC	RT	13		
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware	PA	PC				
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware	PA	PC	RT	13		
E2621	Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware	PA	PC	RT	13		

Miscellaneous & Positioning Accessories

Code	Description	PA	PC	RT	MR	RP	NF
E0950	Wheelchair accessory, tray, each		PC	RT	13	RP	
E0953	Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each		PC	RT	13	RP	
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each		PC	RT	13	RP	
E0956	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each		PC	RT	13	RP	
E0957	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each		PC	RT	13	RP	*
E0958	Manual wheelchair accessory, one-arm drive attachment, each Covered if the client propels the chair himself/herself with only one hand and the need is expected to last at least six months		PC	RT	13	RP	*
E0959	Manual wheelchair accessory, each, adapter for amputee, each		PC	RT	13	RP	*
E0960	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware		PC	RT	13	RP	*
E0966	Manual wheelchair accessory, headrest extension, each	PA	PC	RT	13	RP	
E0971	Anti-tipping device, wheelchair		PC	RT	13	RP	
E0705	Wheelchair accessory, transfer board or device, each		PC	RT	13	RP	*
E0974	Manual wheelchair accessory, anti-rollback device, each		PC	RT	13	RP	*
E0978	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each		PC	RT	13	RP	*
E0981	Wheelchair accessory, seat upholstery, replacement only, each		PC	RT	13	RP	*

E0982	Wheelchair accessory, back upholstery, replacement only, each		PC	RT	13	RP	*
E0985	Wheelchair accessory, seat lift mechanism	PA	PC	RT	13	RP	*
E0992	Manual wheelchair accessory, solid seat insert		PC	RT	13	RP	*
E1015	Shock absorber for manual wheelchair, each	PA	PC	RT	13	RP	*
E1017	Heavy-duty shock absorber for heavy-duty or extra heavy-duty manual wheelchair, each	PA	PC	RT	13	RP	*
E1028	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other		PC	RT	13	RP	*
E1029	Wheelchair accessory, ventilator tray, fixed		PC	RT	13	RP	*
E1030	Wheelchair accessory, ventilator tray, gimbaled	PA	PC	RT	13	RP	*
E1225	Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each	PA		RT	13		*
E1226	Wheelchair accessory, manual, fully reclining back (recline greater than 80 degrees), each	PA	PC	RT	13	RP	NF
E2207	Wheelchair accessory, crutch and cane holder, each	PA	PC	RT	13	RP	*
E2208	Wheelchair accessory, cylinder tank carrier, each		PC	RT	13	RP	*
E2210	Wheelchair accessory, bearings, any type, replacement only, each		PC	RT	13	RP	*
E2230	Manual wheelchair accessory, manual standing system	PA	PC	RT	13	RP	
E2231	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	PA	PC	RT	13	RP	*
E2619	Replacement cover for wheelchair seat cushion or back cushion, each	PA	PC	RT	13		*
K0105	IV hanger, each		PC	RT	13	RP	*
K0108	Wheelchair component or accessory, not otherwise specified	PA	PC	RT	13	RP	*
K0669	Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from DME PDAC	PA	PC	RT	13	RP	*

AMEND: 410-122-0365

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Standing and Positioning Aids rule. These updates included clarifying PA requirements and restructuring content to match Division 122 formatting for consistency and clarity.

CHANGES TO RULE:

410-122-0365
Standing and Positioning Aids ¶

(1) Indications and ~~coverage~~limitations of coverage and medical appropriateness: Standing frame systems, prone standers, supine standers or boards, and accessories ~~ar~~may be covered ~~when:~~by the Division when conditions of coverage in OAR 410-122-0080 and the following criteria are met: ¶
(a) The client is unable to stand or ambulate independently due to conditions such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities; ¶
(b) The client is at high risk for lower extremity contractures that cannot be appropriately managed by other treatment modalities (i.e., stretching, active therapy, home programs, etc) ¶
(c) The client has been sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate a standing or upright position and obtain medical benefit; and, ¶
(d) The client is following a home therapy program for the stander established by a physical or occupational therapist; and ¶
(e) The home is able to accommodate the equipment; and ¶
(f) The weight of the client does not exceed manufacturer's weight capacity; and ¶
(g) The client has demonstrated an ability to utilize the standing aid independently or with assistance from a caregiver; and ¶
(h) The client has demonstrated compliance with other programs; and ¶
(i) The client has demonstrated a successful clinical evaluation or trial period in a monitored setting; and ¶
(j) The client does not have access to equipment from another source. ¶
(2) Sidelyers and custom positioners shall meet the following criteria in addition to the criteria in Table 122-0365: ¶
(a) The client shall be sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit; and ¶
(b) The client shall be following a therapy program initially established by a physical or occupational therapist; and, ¶
(c) The home shall be able to accommodate the equipment; and ¶
(d) The caregiver or family are capable of using the equipment appropriately. ¶
(3) Criteria for Specific Accessories: ¶
(a) A back support may be covered when a client: ¶
(A) Needs balance, stability, or positioning assistance; or ¶
(B) Has extensor tone of the trunk muscles; or ¶
(C) Needs support while being raised or while completely standing; ¶
(b) A tall back may be covered when: ¶
(A) The client is over 5'11" tall; and ¶
(B) The client has no trunk control and needs additional support; or ¶
(C) The client has more involved need for assistance with balance, stability, or positioning; ¶
(c) Hip guides may be covered when a client: ¶
(A) Lacks motor control or strength to center hips; or ¶
(B) Has asymmetrical tone that causes hips to pull to one side; or ¶
(C) Has spasticity; or ¶
(D) Has low tone or high tone; or ¶
(E) Needs balance, stability, or positioning assistance; ¶
(d) A shoulder retractor or harness may be covered when: ¶
(A) Erect posture cannot be maintained without support due to lack of motor control or strength; or ¶
(B) Has kyphosis; or ¶
(C) Presents strong flexor tone; ¶
(e) Lateral supports may be covered when a client: ¶
(A) Lacks trunk control to maintain lateral stability; or ¶

(B) Has scoliosis that requires support; or ¶
(C) Needs a guide to find midline; ¶
(f) A headrest may be covered when a client: ¶
(A) Lacks head control and cannot hold head up without support; or ¶
(B) Has strong extensor thrust pattern that requires inhibition; ¶
(g) Independent adjustable knee pads may be covered when a client: ¶
(A) Has severe leg length discrepancy; or ¶
(B) Has contractures in one leg greater than the other; ¶
(h) An actuator handle extension may be covered when a client: ¶
(A) Has no caregiver; and ¶
(B) Is able to transfer independently into standing frame; and ¶
(C) Has limited range of motion in arm or shoulder and cannot reach actuator in some positions; ¶
(i) Arm troughs may be covered when a client: ¶
(A) Has increased tone that pulls arms backward so hands cannot come to midline; or ¶
(B) Has poor tone, strength, or control that causes arms to hang out to side and backward causing pain and risking injury; or ¶
(C) Has needs for posture; ¶
(j) A tray may be covered when proper positioning cannot be accomplished with other accessories; ¶
(k) Abductors may be covered to reduce tone for proper alignment and weight bearing; ¶
(~~L~~l) Sandals (shoe holders) may be covered when a client: ¶
(A) Has dorsiflexion of the foot or feet; or ¶
(B) Has planar flexion of the foot or feet; or ¶
(C) Has eversion of the foot or feet; or ¶
(D) Has need for safety. ¶
(4) If a client has one aid that meets medical needs, regardless of who obtained it, the Division may not provide another aid of same or similar function. ¶
(5) Gait Belts (E0700) shall be 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: ¶
(A) A minor correction of ambulation; or ¶
(B) Minimal or standby assistance to walk alone; or ¶
(C) Requires assistance with transfer; ¶
(6) ~~Documentation that shall be kept on file by the Durable Medical Equipment (DME) provider includes:~~For services requiring prior authorization (PA), submit the following documentation to support coverage criteria in this rule are met: ¶
(a) Documentation of medical appropriateness, which has been reviewed and signed by the prescribing practitioner; ¶
(b) The care plan outlining positioning and treatment regimen and all DME currently available for use by the client; ¶
(c) The practitioner's order; ¶
(d) Each item requested shall be itemized with description of product, make, model number, and manufacturers' suggested retail price (MSRP); ¶
(e) The Positioner Justification form (DMAP 3155) or reasonable facsimile with recommendation for most appropriate equipment completed by the prescribing practitioner or the evaluating PT or OT; ¶
(7) Providers shall use the appropriate HCPCS code assigned to the standing system base (e.g., E0637, E0638, E0641, and E0642). ¶
(8) Providers shall use E1399 for standing frame accessories when billing separately from the base. PA is required when the billed charge for the accessory is greater than $150. ¶
(9) PDAC coding verification is not required on standing frame equipment and accessories as this is statutorily excluded from Medicare coverage and as such does not have an assigned HCPCS code. ¶
~~(9) Table 122-0365.¶~~
~~[ED. NOTE: Tables referenced ar~~10) Documentation and medical records to support the client meets all criteria and conditions of coverage in this rule must be kept on file with the DMEPOS provider and shall be made available ~~from~~to the ~~agency.]~~Division upon request. ¶
(11) Table 122-0365.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0365 Standing and Positioning Aids

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0637	Combination sit-to-stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels	PA	PC	RT		RP	
E0638	Standing frame/table system, one position (e.g., upright, supine, or prone stander) any size including pediatric, with or without wheels Must meet the criteria listed in section (1) of this rule Electric, motorized, or powered option is covered by exception only	PA	PC	RT		RP	
E0641	Standing frame/table system, multi-position (e.g., 3-way stander), any size including pediatric, with or without wheels Must meet the criteria listed in section (1) of this rule Electric, motorized, or powered option is covered by exception only	PA	PC	RT		RP	
E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric Must meet the criteria listed in section (1) of this rule Electric, motorized, or powered option is covered by exception only	PA	PC	RT		RP	
E0700	Safety equipment (for gait belt only) Must meet the criteria listed in section (5) of this rule		PC				

E1399 - DME, miscellaneous

For the code legend see OAR 410-122-0182.

Code	Description	PA	PC	RT	MR	RP	NF
E1399	Sidelyer includes accessories Covered if the client: Must meet the criteria in section (2) 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 Positioning is needed to prevent reflux during feeding.	PA	PC			RP	
E1399	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 (2) of this rule is met.	PA	PC			RP	
E1399	Standing Frame/Table Accessories Covered if the client: Must meet the criteria listed in section (3) of this rule, and Cannot be successfully positioned in equipment without specified accessories	PA	PC			RP	

AMEND: 410-122-0380

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Hospital Beds rule. These updates included amending non-covered language to comply with federal guidelines, adding language to clarify intent; adding a link to the enclosed safety bed policy, and restructuring the content to match Division 122 formatting for consistency and clarity;

CHANGES TO RULE:

410-122-0380
Hospital Beds ¶

(1) Indications and limitations of coverage and medical appropriateness: The Division may cover ~~some~~a hospital bed~~s for a covered condition including:~~ when conditions of coverage in OAR 410-122-0080 and the following criteria are met: ¶
(a) A fixed height hospital bed (E0250, E0251, E0290, E0291, E0328) when the client meets at least one (1) of the following criteria: ¶
(A) Has a medical condition that requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed; ¶
(B) Requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain; ¶
(C) 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 shall have been considered and ruled out; ¶
(D) Requires traction equipment that can only be attached to a hospital bed; ¶
(b) A variable height hospital bed (E0255, E0256, E0292 and E0293) when all of the following criteria are met: ¶
(A) Criteria for a fixed height hospital bed are met; ¶
(B) A bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position is required; ¶
(c) A semi-electric hospital bed (E0260, E0261, E0294, E0295, and E0329) when all of the following criteria are met: ¶
(A) Criteria for a fixed height hospital bed are met; ¶
(B) Frequent changes or an immediate need for a change in body position are required; ¶
(C) The client or caregiver is capable of safely and effectively operating the bed controls; ¶
(d) A heavy duty extra wide hospital bed (E0301, E0303) when all of the following criteria are met: ¶
(A) Criteria for a fixed height hospital bed are met; ¶
(B) The client weighs more than 350 pounds but less than 600 pounds; ¶
(C) The client or caregiver is capable of safely and effectively operating the bed controls; ¶
(e) An extra heavy duty hospital bed (E0302, E0304) when all of the following are met: ¶
(A) Criteria for one of the hospital beds described in (1)(a)-(d) are met; ¶
(B) The client weighs more than 600 pounds; ¶
(C) The client or caregiver is capable of safely and effectively operating the bed controls; ¶
(D) When provided for a nursing facility client, the bed shall be rated for institutional use; ¶
(f) Total electric hospital beds (E0265, E0266, E0296, E0297, and E03297) are ~~not covered since the height adjustment feature is considered a convenience feature;¶~~
~~(g) Payment Autho~~reviewed on a case-by-case basis to determine if the client's documentation supports the height adjustment feature is medically necessary and medically appropriz~~ation: Subject to service limitations of Division rules, a hospital bed rental may be dispensed without PA only from the initial date of service through the second date of service. The durable medical equipment, prosthetics, orthotics, and supplies (~~e for the treatment of the client's condition; ¶
(g) No prior authorization (PA) is required for the initial two (2) months rental of a hospital bed unless otherwise specified in this rule (2)(b) and (d). The DMEPOS~~)~~ provider is ~~still~~ responsible to ensure all ~~rule~~ requirements ~~are met. Payment authorization is~~in this rule are met. ¶
(2) PA Required: PA is obtained from the same authorizing authority as specified in OAR 410-122-0040 and required ~~pri~~for t~~o submitting any claims to the Division regardless of the date of service, including the initial and second~~he following services: ¶
(a) Initial purchase or subsequent rentals of a hospital bed starting with the third (3rd) month date~~s~~ of service~~, and will be given once all required documentation has been received and any other applic~~; ¶

(b) Total electric hospital beds starting with the first (1st) month rental or upon initial purchase; ¶
(c) Replacement of a hospital bed during the five (5) year reasonable ~~rule requirements have been met. Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040. Required documentation shall be received by the authorizing authority prior to the third date of service.~~useful lifetime due to loss, theft, or irreparable damage; ¶
(d) Enclosed safety beds starting with the first (1st) month rental or upon initial purchase. Refer to the Division's policy for criteria and coverage guidelines: https://www.oregon.gov/oha/HSD/OHP/Announcements/Safety-Bed-Policy1124.pdf. ¶
(~~2~~3) Documentation requirements: ~~Submit documentation that has been reviewed, signed, and dated by the prescribing practitioner and that supports conditions of coverage as~~ ¶
(a) For services requiring prior authorization, submit documentation that supports coverage criteria specified in this rule are met, including: ¶
(~~a~~A) For all hospital beds: ¶
(~~A~~i) Primary diagnosis code for the condition necessitating the need for a hospital bed; ¶
(~~B~~ii) The type of bed currently used by the client and why it doesn't meet the medical needs of the client; ¶
(~~b~~B) For semi-electric beds: Why a variable height bed cannot meet the medical needs of the client; ¶
(~~c~~C) For heavy duty and extra heavy-~~-~~duty beds: The client's height and weight. ¶
(~~3~~b) ~~Table 122-0380 - Hospital Beds.~~¶
~~[ED. NOTE: Tables referenced ar~~Documentation and medical records to support the client meets all criteria and conditions of coverage in this rule must be kept on file with the DMEPOS provider and shall be made available ~~from~~to the ~~agency.]~~Division upon request. ¶
(4) Table 122-0380 - Hospital Beds.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0380 Hospital Beds

For the code legend see OAR 410-122-0182.

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

Code	Description	PA	PC	RT	MR	RP	NF
Fixed Height							
E0250	Hospital Bed, fixed height, with any type side rails, with mattress	*	PC	RT	13	RP	
E0251	Hospital Bed, fixed height, with any type side rails, without mattress	*	PC	RT	13	RP	
E0290	Hospital Bed, fixed height, without side rails, with mattress	*	PC	RT	13	RP	
E0291	Hospital Bed, fixed height, without side rails, without mattress	*	PC	RT	13	RP	
E0328	Hospital bed, pediatric, manual, 360-degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes 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	
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	
E0329	Hospital bed, pediatric, electric or semi-electric, 360-degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress	*	PC	RT	13	RP	

Heavy-Duty and Extra Heavy-Duty

E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	*	PC	RT	13	RP	
E0302	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	*	PC	RT	13	RP	NF
E0303	Hospital bed, heavy duty, extra-wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	*	PC	RT	13	RP	
E0304	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	*	PC	RT	13	RP	NF

AMEND: 410-122-0515

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Neuromuscular Electrical Stimulator (NMES) rule. These updates included restructuring content to match Div 122 formatting for consistency, revising coverage language to meet current federal coverage determination guidelines, clarifying eligible types of NMES devices for coverage, and revising non-covered language to comply with federal guidelines.

CHANGES TO RULE:

410-122-0515
Neuromuscular Electrical Stimulator (NMES) ¶

Indications and limitations of coverage and medical appropriateness:~~¶~~
~~(1) A~~ The Division may cover a neuromuscular electrical stimulator (NMES) that uses electrodes to transmit an electrical impulse to the skin over selected muscle groups. There are two (2) broad categories of NMES~~.~~: ¶
(~~2~~1) One type of NMES is for treatment of muscle atrophy~~.~~: ¶
(~~3~~a) ~~NMES devices i~~In this category, the NMES device stimulates the muscle when the client is in a resting state to treat muscle atrophy~~.~~: ¶
(~~4~~b) The Division shall cover this type of NMES to treat muscle atrophy specific to disuse atrophy where nerve supply to the muscle is intact (including brain, spinal cord and peripheral nerves) and to treat other non-neurological reasons for disuse atrophy. Some examples would be casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins). ¶
(~~5~~2) ~~NMES to enhance functional activity of neurologically impaired clients: Specifically, the Division shall cover NMES used to improve the ability to walk in clients with Spinal Cord Injury (SCI).¶~~
~~(6) This~~The second type of NMES is commonly referred to as functional electrical stimulation (FES). FES devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence. ¶
(~~7~~a) In this category, the FES device is used to enhance functional activity of neurologically impaired clients. FES devices used to improve the ability to walk in clients with spinal cord injury (SCI) shall be covered; ¶
(b) The Division shall ~~/~~only cover ~~NMES/~~FES for SCI clients for walking, who meet the following criteria: ¶
(~~a~~A) Client has completed at least thirty-two (32) physical therapy sessions, directly performed one-on-one with the physical therapist with the ~~NMES/FES~~ device over a trial period of three (3) months, with the specific goal of using the ~~NMES/~~FES device to achieve walking, not to reverse or retard muscle atrophy; ¶
(~~b~~B) Therapists with the sufficient skills to provide these services are only employed at inpatient hospitals; outpatient hospitals; comprehensive outpatient rehabilitation facilities; and outpatient rehabilitation facilities; ¶
(~~c~~C) The practitioner treating the client for SCI will use this trial period to properly evaluate the person's ability to use the ~~NMES/~~FES frequently and for the long term; and ¶
(~~d~~D) The client meets all of the following characteristics: ¶
(~~e~~i) Intact lower motor units (L1 and below) (both muscle and peripheral nerve); ¶
(~~f~~ii) Muscle and joint stability for weight bearing at upper and lower extremities that demonstrates balance and control to maintain an upright support posture independently; ¶
(~~g~~iii) Demonstrated brisk muscle contraction to NMES and sensory perception of electrical stimulation sufficient for muscle contraction; ¶
(~~h~~iv) High motivation, commitment and cognitive ability to use ~~NMES/~~FES devices for walking; ¶
(~~i~~v) Can transfer independently and demonstrates independent standing tolerance for at least three (3) minutes; ¶
(~~j~~vi) Demonstrated hand and finger function to manipulate controls; ¶
(~~k~~vii) At least six~~-~~ (6) month post recovery spinal cord injury and restorative surgery; ¶
(~~l~~viii) Hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and ¶
(~~m~~ix) Demonstrated willingness to use the device long-term~~;~~. ¶
(~~n~~3) ~~NMES/~~FES for walking is ~~not covered in~~contraindicated for ~~an~~ SCI client with any of the following: ¶
(~~A~~a) Cardiac pacemaker; ¶
(~~B~~b) Severe scoliosis or severe osteoporosis; ¶
(~~C~~c) Skin disease or cancer at area of stimulation; ¶
(~~D~~d) Irreversible contracture; or ¶
(~~E~~e) Autonomic dysflexia; ~~or~~ ¶
(~~F~~4) T~~reatment of muscle weakness due to the following condi~~he requested system or device shall either be approved, registered, or listed as a medical device with the Food and Drug Administration~~s~~ (~~not all-inclusive):~~FDA)

and otherwise generally considered to be safe and effective for the intended purpose. ¶
(5) Documentation requirements: ¶
(i~~a~~) ~~Stroke; spinal cord injury;~~ubmit the following documentation for per~~ipheral nerve injury; other central nervous system, spinal or peripheral nerve disease/condition affecting motor and/or sensory pathways to/from~~or authorization (PA) review: ¶
(A) An order from the treating practitioner; ¶
(B) Documentation of signs/symptoms/medical condition exhibited by the client that clearly specifies the medical appropriateness and medical necessity for the device; ¶
(C) Medical records that corroborate conditions for coverage are met as specified in this rule. ¶
(b) Documentation and medical records to support the ~~muscles being stimulated;¶~~
~~(ii) Documentation requirements: Submit documentation that supports coverage criteria as specified in this rule are met.~~client meets all criteria and conditions of coverage in this rule must be kept on file with the DMEPOS provider and shall be made available to the Division upon request. ¶
(6) Procedure codes: ¶
(a) The Medicare Pricing, Data Analysis and Coding contractor is responsible for assisting DMEPOS providers and manufacturers in determining which HCPCS code shall be used to describe DMEPOS items; ¶
(b) Refer to the product classification list on the Medicare Pricing, Data Analysis and Coding (PDAC) contractor website for appropriate Healthcare Common Procedure Coding System (HCPCS) codes. ¶
(~~8~~c) ~~Procedure codes:~~NMES: ¶
(A) E0745, Neuromuscular stimulator, electronic shock unit - Division shall rent - Purchased after no more than 10 months of rental - PA required. ¶
(~~a~~B) A4595, Electrical stimulator supplies, ~~2~~two (2) lead, per month, (e.g. TENS, NMES) - Includes all supplies necessary for the effective use of the device - Division shall ~~-~~/purchase~~ - Prior authorization (~~; ¶
(d) FES: ¶
(A) E0764, Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program; - Division shall rent - Purchased after no more than 10 months of rental - PA~~) required~~;~~. ¶
(~~b~~B) E074~~5, Neuromuscular stimulator, electronic shock unit - Division shall rent - Purchased after no more than 10 months of rental - PA requir~~70 - Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified - Division shall rent - Purchased after no more than 10 months of rental - PA required. ¶
(C) A4595, Electrical stimulator supplies, two (2) lead, per month/one (1) unit (e.g. FES, NMES) - Includes all supplies necessary for the effective use of the device. Not reimbursable with initial purchase. If medically necessary, a maximum of two (2) units per month (4 leads) is allowed.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0525

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) External Insulin Infusion Pump rule. These updates included removing non-covered language to comply with federal guidelines and adding language to align with OAR 410-122-0520 guidance for consistency and clarity.

CHANGES TO RULE:

410-122-0525
External Insulin Infusion Pump ¶

(1) Indications and limitations of coverage and medical appropriateness: ¶
(a) The Division may cover an external insulin infusion pump for the administration of continuous subcutaneous insulin for the treatment of diabetes mellitus when criterion (A) or (B) is met and criterion (C) or (D) is met: ¶
(A) C-peptide testing requirement: ¶
(i) The C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method; or ¶
(ii) For a client with renal insufficiency and a creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, a fasting C-peptide level is less than or equal to 200 percent of the lower limit of normal of the laboratory's measurement method; and ¶
(iii) A fasting blood sugar obtained at the same time as the C-peptide level is less than or equal to 225 mg/dl. ¶
(B) Beta cell autoantibody test is positive; ¶
(C) The client has: ¶
(i) Completed a comprehensive diabetes education program; and ¶
(ii) Been on a program of multiple daily injections of insulin (i.e., at least three injections per day) with frequent self-adjustments of insulin dose for at least six (6) months prior to initiation of the insulin pump; and ¶
(iii) Documented frequency of glucose self-testing an average of at least four (4) times per day during the two (2) months prior to initiation of the insulin pump and meets one (1) or more of the following criteria while on the multiple injection regimen: ¶
(I) Glycosylated hemoglobin level (HbA1C) greater than ~~7~~seven (7) percent; ¶
(II) History of recurring hypoglycemia; ¶
(III) Wide fluctuations in blood glucose before mealtime; ¶
(IV) Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL; ¶
(V) History of severe glycemic excursions; ¶
(D) The client has: ¶
(i) Been on an external insulin infusion pump prior to enrollment in the medical assistance program, and; ¶
(ii) Documented frequency of glucose self-testing an average of at least four times per day during the month prior to medical assistance program enrollment; ¶
(b) For continued coverage of an external insulin pump and supplies, the client shall be seen and evaluated by the treating practitioner at least every three (3) months; ¶
(c) The external insulin infusion pump shall 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; ¶
(d) The Division may cover supplies (including dressings) used with an external insulin infusion pump during the period of covered use of an infusion pump. These supplies are billed with codes A4224 or A4225; ¶
(e) Code A4224 includes catheter insertion devices for use with external insulin infusion pump infusion cannulas and are not separately payable; ¶
(f) A4224 is limited to one (1) unit of service per week. ¶
(2) Coding guidelines: ¶
(a) Code A4224 includes all cannulas, needles, dressings, and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784); ¶
(b) Refer to the product classification list on the Medicare Pricing, Data Analysis and Coding (PDAC) contractor website for appropriate Healthcare Common Procedure Coding System (HCPCS) codes; ¶
(c) Insulin delivery devices and related supplies other than those identified in this rule and coverage table 122-0525 are not considered to be medically necessary or medically appropriate. ¶
(3) Documentation requirements: ¶
(a) With the request for PA, the DMEPOS provider shall submit medical justification that supports the criteria in

this rule are met; ¶
(b) When billing and dispensing for an item in Table 122-0525, the DMEPOS provider shall ensure that medical records corroborate all criteria in this rule are met; ¶
(c) The DMEPOS provider shall keep medical records on file and make them available to the Division upon request. ¶
(4) Table 122-0525.¶
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0525 External Insulin Infusion Pump

For the code legend see OAR 410-122-0182.

Equipment and Supplies

Code	Description	PA	PC	RT	MR	RP	NF
E0776	IV Pole		PC	RT	13		NF
E0784	External ambulatory infusion pump, insulin Supplies	PA	PC	RT	13	RP	NF
A4224	Supplies for maintenance of insulin infusion catheter, per week	PA	PC				NF
A4225	Supplies for external insulin infusion pump, syringe type cartridge, sterile, each	PA	PC				NF
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each		PC				NF
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each		PC				NF
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each		PC				NF
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each		PC				NF
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each		PC				NF

AMEND: 410-122-0560

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Urological Supplies rule. These updates included adding utilization guidance for clarity, adding criteria to support CMS coding updates & reference to Prioritized List GN 116 for coverage guidance.

CHANGES TO RULE:

410-122-0560
Urological and Bowel Supplies ¶

(1) Indications and Limitations of Coverage and Medical Appropriateness: ¶
(a) The Division may cover the following urinary catheters, external urinary collection devices, and medically appropriate related supplies when used to drain or collect urine for a client who has permanent urinary incontinence or permanent urinary retention; ¶
(b) Indwelling Catheters (A4311-A4316, A4338-A4346): ¶
(A) No more than one (1) catheter per month for routine catheter maintenance; ¶
(B) Non-routine catheter changes when documentation substantiates medical appropriateness, such as for the following indications: ¶
(i) Catheter is accidentally removed (e.g., pulled out by client); ¶
(ii) Catheter malfunctions (e.g., balloon does not stay inflated, hole in catheter); ¶
(iii) Catheter is obstructed by encrustation, mucous plug, or blood clot; ¶
(iv) History of recurrent obstruction or urinary tract infection for which it has been established that an acute event is prevented by a scheduled change frequency of more than once (1) per month; ¶
(C) A specialty indwelling catheter (A4340) or an all-silicone catheter (A4344, A4312, or A4315) when documentation in the client's medical record supports the medical appropriateness for that catheter rather than a straight Foley type catheter with coating (such as recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex); ¶
(D) A three-way indwelling catheter either alone (A4346) or with other components (A4313 or A4316) only if continuous catheter irrigation is medically appropriate; ¶
(c) Catheter Insertion Tray (A4310-A4316, A4353, and A4354): ¶
(A) Only one (1) insertion tray per episode of indwelling catheter insertion; ¶
(B) One (1) intermittent catheter with insertion supplies (A4353) per episode of medically appropriate sterile intermittent catheterization; ¶
(d) Urinary Drainage Collection System (A4314-A4316, A4354, A4357, A4358, A5102, and A5112): ¶
(A) For routine changes of the urinary drainage collection system as noted in Table 122-0560-1; ¶
(B) Additional charges for medically appropriate non-routine changes when the documentation substantiates the medical appropriateness (e.g., obstruction, sludging, clotting of blood, or chronic, recurrent urinary tract infection); ¶
(C) A vinyl leg bag (A4358) or a latex leg bag (A5112) only for clients who are ambulatory or are chair or wheelchair bound; ¶
(e) Intermittent Irrigation of Indwelling Catheters: ¶
(A) Supplies for the intermittent irrigation of an indwelling catheter when they are used on an as needed (non-routine) basis in the presence of acute obstruction of the catheter; ¶
(B) Routine intermittent irrigations of a catheter are not covered; ¶
(C) Routine irrigations are defined as those performed at predetermined intervals; ¶
(D) Covered supplies for medically appropriate non-routine irrigation of a catheter include either an irrigation tray (A4320) or an irrigation syringe (A4322), and sterile water/saline (A4217); ¶
(f) Continuous Irrigation of Indwelling Catheters: ¶
(A) Supplies for continuous irrigation of a catheter when there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically appropriate catheter changes; ¶
(B) Continuous irrigation as a primary preventative measure (i.e., no history of obstruction) is not covered; ¶
(C) Documentation must substantiate the medical appropriateness of catheter irrigation and in particular continuous irrigation as opposed to intermittent irrigation; ¶
(D) The records must also indicate the rate of solution administration and the duration of need; ¶
(E) Covered supplies for medically appropriate continuous bladder irrigation include a three-way Foley catheter (A4313, A4316, and A4346), irrigation tubing set (A4355), and sterile water/saline (A4217): ¶

(i) The Division may cover one (1) irrigation tubing set per day for continuous catheter irrigation; ¶
(ii) Continuous irrigation is considered a temporary measure and may only be covered for up to 14 days; ¶
(g) Intermittent Catheterization: Intermittent catheter supplies when basic coverage criteria are met and the client or caregiver can perform the procedure: ¶
(A) For each episode of covered catheterization, one (1) catheter (A4351, A4352) and an individual packet of lubricant (A4332); or ¶
(B) One (1) sterile intermittent catheter kit (A4353) when the client requires catheterization and meets one of the following criteria (i-iv): ¶
(i) The client is immunosuppressed. Examples of immunosuppressed clients include (but are not limited) clients who are: ¶
(I) On a regimen of immunosuppressive drugs post-transplant; ¶
(II) On cancer chemotherapy; ¶
(III) Has AIDS; ¶
(IV) Has a drug-induced state such as chronic oral corticosteroid use; ¶
(ii) The client has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization; ¶
(iii) The client is a pregnant, spinal cord-injured female with neurogenic bladder (for duration of pregnancy only); ¶
(iv) The client has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization with A4351/A4352 and sterile lubricant (A4332), twice within the 12-month period prior to the initiation of sterile intermittent catheter kits. A urinary tract infection means a urine culture with greater than 10,000 colony forming units of a urinary pathogen; and documentation in the client's medical records of concurrent presence of one or more of the following signs, symptoms or laboratory findings: ¶
(I) Fever (oral temperature greater than 38 C [100.4 F]); ¶
(II) Systemic leukocytosis; ¶
(III) Change in urinary urgency, frequency, or incontinence; ¶
(IV) Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation); ¶
(V) Physical signs of prostatitis, epididymitis, orchitis; ¶
(VI) Increased muscle spasms; ¶
(VII) Pyuria (greater than five white blood cells [WBCs] per high-powered field); ¶
(C) The kit code (A4353) must be used for billing even if the components are packaged separately rather than together as a kit; ¶
(h) Coude (Curved) Tip Catheters: ¶
(A) Use of a Coude (curved) tip catheter (A4352) in female clients is rarely medically appropriate; ¶
(B) For any client, when a Coude tip catheter is dispensed and billed, there must be specific documentation in the client's medical record why a Coude tip catheter is required rather than a straight tip catheter; ¶
(i) External Catheters/Urinary Collection Devices: ¶
(A) Male external catheters (condom-type) or female external urinary collection devices for clients who have permanent urinary incontinence when used as an alternative to an indwelling catheter; ¶
(B) Coverage for male external catheters (A4349) is limited to 35 per month; ¶
(C) Greater utilization of these devices must be accompanied by documentation of medical appropriateness; ¶
(D) Male external catheters (condom-type) or female external urinary collection devices are not covered for clients who also use an indwelling catheter; ¶
(E) The Division may cover specialty type male external catheters such as those that inflate or that include a faceplate (A4326) or extended wear catheter systems (A4348) only when documentation substantiates the medical appropriateness for such a catheter; ¶
(F) Coverage of female external urinary collection devices is limited to one metal cup (A4327) per week or one (1) pouch (A4328) per day; ¶
(j) Anal Irrigation System and Catheter: ¶
(A) Refer to the Prioritized List of Health Services Anal Irrigation Systems Guideline Note for coverage guidelines; ¶
(B) Utilization and frequency are determined by the treating practitioner. The following represents the usual maximum number of kits and catheters expected to be medically appropriate: ¶
(i) A4459 - 1 unit (one unit = one kit) every threee (3) months; ¶
(ii) A4453 - 31 units (one unit = one catheter) per month; ¶
(k) Miscellaneous Supplies: ¶
(A) Appliance cleaner (A5131): One (1) unit of service (16 oz) per month when used to clean the inside of certain urinary collecting appliances (A5102, A5105, A5112); ¶
(B) One (1) external urethral clamp or compression device (A4356) every three (3) months or sooner if the rubber/foam casing deteriorates; ¶

(C) Adhesive catheter anchoring devices (A4333, three per week) and catheter leg straps (A4334, one (1) per month) for indwelling urethral catheters; ¶
(D) A catheter/tube anchoring device (A5200) separately payable when it is used to anchor a covered suprapubic tube or nephrostomy tube; ¶
(E) Non-Sterile Gloves ~~- The Division will not pay for more than 200 pairs of non-sterile gloves (A4927) per month;~~(A4927): four (4) units are allowed per month, one (1) unit = 100 each (50 pairs); ¶
(~~k~~l) The following services are not covered: ¶
(A) Creams, salves, lotions, barriers (liquid, spray, wipes, powder, paste) or other skin care products (A6250); ¶
(B) Catheter care kits (A9270); ¶
(C) Adhesive remover (A4456, A4455); ¶
(D) Catheter clamp or plug (A9270); ¶
(E) Disposable underpads, all sizes, diapers or incontinence garments, any type, disposable or reusable unless authorized under 410-122-0630 Incontinent Supplies; ¶
(F) Drainage bag holder or stand (A9270); ¶
(G) Urinary suspensory without leg bag (A4359); ¶
(H) Measuring container (A9270); ¶
(I) Urinary drainage tray (A9270); ¶
(J) Gauze pads (A6216-A6218) and other dressings; ¶
(K) Other incontinence products not directly related to the use of a covered urinary catheter or external urinary collection device (A9270); ¶
(L) Irrigation supplies that are used for care of the skin or perineum of incontinent clients; ¶
(M) Syringes, trays, sterile saline, or water used for routine irrigation; ¶
(N) Disposable external urethral clamp or compression device, with pad and/or pouch, each. ¶
(2) Guidelines: ¶
(a) Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within three (3) months. A determination that there is no possibility that the client's condition may improve sometime in the future is not required. If the medical records, including the judgment of the attending treating practitioner, indicate the condition is of long and indefinite duration (ordinarily at least three (3) months), the test of permanence is considered met; ¶
(b) A urinary intermittent catheter with insertion supplies (A4353) is a kit, which includes a catheter, lubricant, gloves, antiseptic solution, applicators, drape, and a tray or bag in a sterile package intended for single use; ¶
(c) Adhesive strips or tape used with male external catheters are included in the allowance for the code and are not separately payable; ¶
(d) Catheter insertion trays (A4310-A4316, A4353, and A4354) that contain component parts of the urinary collection system, (e.g., drainage bags and tubing) are inclusive sets and payment for additional component parts may be allowed only per the stated criteria in each section of the policy; ¶
(e) Extension tubing (A4331) may be covered for use with a latex urinary leg bag (A5112) and is included in the allowance for codes A4314, A4315, A4316, A4354, A4357, A4358, and A5105 and A4331 cannot be separately billed with these codes; ¶
(f) Use A4333 when used to anchor an indwelling urethral catheter; ¶
(g) Use code A5105 when billing for a urinary suspensory with leg bag; ¶
(h) Replacement leg straps (A5113, A5114) are used with a urinary leg bag (A4358, A5105, or A5112). These codes are not used for a leg strap for an indwelling catheter; ¶
(i) A4326 is a male external catheter with an integrated collection chamber that does not require the use of an additional leg bag. ¶
(3) Documentation Requirements: ¶
(a) For services requiring prior authorization (PA), submit documentation which supports coverage criteria as specified in this rule are met; ¶
(b) Intermittent Catheterization: ¶
(A) The practitioner's order must indicate the actual number of times intermittent catheterization is performed per day; ¶
(B) The client's medical records must support the number of times per day intermittent catheterization is performed; ¶
(c) When requesting quantities of supplies greater than the maximum units specified in this rule, submit documentation supporting the medical appropriateness for the higher utilization to the appropriate authorization authority for PA; ¶
(d) Documentation, which supports condition of coverage requirements for codes billed in this rule, must be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request; ¶

(e) A client's medical records must support the justification for supplies billed to the Division. ¶
(4) Table 122-0560-1, Maximum Quantity of Supplies. ¶
(5) Table 122-0560-2. ¶
(6) Table 122-0560-3, Procedure Codes.¶
~~[ED. NOTE: Tables referenced rule are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0560-1 Maximum Quantity of Supplies

Code	Units/Month
A4314	1
A4315	1
A4316	1
A4332	200
A4351	200
A4352	200
A4353	200
A4354	1
A4357	2
A4358	2
A4927	4
A5112	1

Code	Units/3 Months
A5102	1

Table 122-0560-2

In the following table, the Column I code includes the items identified by the codes in Column II. The Column I code must be used instead of multiple Column II codes when the items are provided at the same time.

If a code exists that includes multiple products, use that code for billing rather than the individual codes.

Column I	Column II
A4310	A4332
A4311	A4310, A4332, A4338
A4312	A4310, A4332, A4344
A4313	A4310, A4332, A4346
A4314	A4310, A4311, A4331, A4332, A4338, A4354, A4357
A4315	A4310, A4312, A4331, A4332, A4344, A4354, A4357
A4316	A4310, A4313, A4331, A4332, A4346, A4354, A4357
A4354	A4310, A4332, A4357, A4331
A4357	A4331
A4358	A4331, A5113, A5114
A5112	A5113, A5114
A5105	A4331, A4358, A5112, A5113, A5114

Table 122-0560-3 Procedure Codes

For the code legend see OAR 410-122-0182.

Code	Description	PA	PC	RT	MR	RP	NF
A4217	Sterile water/saline, 500 ml.		PC				
A4310	Insertion tray without drainage bag and without catheter (accessories only)		PC				
A4311	Insertion tray without drainage bag, with indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)		PC				
A4312	Insertion tray without drainage bag with indwelling catheter, Foley type, three- way for continuous irrigation		PC				
A4313	Insertion tray without drainage bag with indwelling catheter, Foley type, three- way for continuous irrigation		PC				
A4314	Insertion tray with drainage bag with indwelling catheter, Foley type, two- way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)		PC				
A4315	Insertion tray with drainage bag with indwelling catheter, Foley type, two- way, all silicone		PC				
A4316	Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation		PC				
A4320	Irrigation tray with bulb or piston syringe, any purpose		PC				
A4321	Therapeutic agent for urinary catheter irrigation		PC				
A4322	Irrigation syringe, bulb or piston, each		PC				
A4326	Male external catheter with integral collection chamber, any type, each		PC				
A4327	Female external urinary collection device; metal cup, each		PC				
A4328	Female external urinary collection device; pouch, each		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, each		PC				
A4333	Urinary catheter anchoring device, adhesive skin attachment, each		PC				
A4334	Urinary catheter anchoring device, leg strap, each		PC				
A4335	Incontinence supply; miscellaneous	PA	PC				
A4336	Incontinence supply, urethral insert, any type, each		PC				
A4338	Indwelling catheter; Foley type, two- way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.),each		PC				
A4340	Indwelling catheter; specialty type, e.g., coude, mushroom, wing, etc., each		PC				
A4341	Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each		PC				

A4342	Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each		PC				
A4344	Indwelling catheter Foley type, two-way, all silicone or polyurethane, each		PC				
A4346	Indwelling catheter, Foley type, three-way for continuous irrigation, each		PC				
A4349	Male external catheter, with or without adhesive, disposable, each		PC				
A4351	Intermittent urinary catheter; straight tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each		PC				
A4352	Intermittent urinary catheter; coude (curved) tip, with or without coating (teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each		PC				
A4353	Intermittent urinary catheter, with insertion supplies		PC				
A4354	Insertion tray with drainage bag but without catheter		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 catheter clamp), each		PC				
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each		PC				
A4358	Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each		PC				
A4360	Disposable external urethral clamp or compression device, with pad and/or pouch, each		PC				
A4402	Lubricant, per ounce		PC				
A4450	Tape, non-waterproof, per 18 square inches		PC				
A4452	Tape, waterproof, per 18 square inches		PC				
A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce		PC				
A4456	Adhesive remover, wipes, any type, each		PC				
A5102	Bedside drainage bottle with or without tubing, rigid or expandable, each		PC				
A5105	Urinary suspensory with leg bag, with or without tube, each		PC				
A5112	Urinary drainage bag, leg or abdomen, latex, with or without tube, with straps, each		PC				
A5113	Leg strap; latex, replacement only, per set		PC				
A5114	Leg strap; foam or fabric, replacement only, per set		PC				
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.		PC				
A5200	Percutaneous catheter/tube anchoring device, adhesive skin attachment		PC				

AMEND: 410-122-0580

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Bath Supplies rule. These updates included adding language to clarify coverages and adding reimbursement/billing guidance for clarity.

CHANGES TO RULE:

410-122-0580
Bath Supplies ¶

(1) Indications and limitations of coverage~~:~~¶
~~(a)~~ and medical appropriateness: The Division may cover bath supplies when ~~medically necessary and medically appropriate.~~the client meets the conditions of coverage in OAR 410-122-0080 and when the following guidelines are met: ¶
(a) A rehab shower/commode chair may be covered when all of the following criteria are met: ¶
(A) Client is unable to use a standard shower chair/bench due to a neurological or 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/commode chair; ¶
(D) Less costly alternatives have been considered or tried and ruled out; ¶
(E) The rehab shower/commode chair meets the following specifications and standard features as a minimum: ¶
(i) Constructed specifically for use as a rehab shower/commode chair (corrosive resistant); ¶
(ii) Swing-away or detachable arms; ¶
(iii) Removable commode pan holder and pan; ¶
(iv) Adjustable removable footrests; ¶
(v) Wheel lock system; ¶
(F) The rehab shower/commode chair must be supplied by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the rehab shower/commode chair selection for the client; ¶
(~~b~~G) Verification of the healthcare common procedure coding system (HCPCS) code assignment by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor is not required for a rehab shower/commode chair; ¶
(~~c~~H) Use E1399 for a rehab shower/commode chair and accessories that are not included in the base for the rehab shower/commode chair. PDAC coding verification is not required for these items as they are statutorily excluded from coverage by Medicare and have no assigned HCPCS codes. ¶
(b) Custom/Specialized Pediatric Bath Chair: ¶
(A) Custom/Specialized pediatric bath chair requires fitting and/or adjustment to treat a specific medical need; ¶
(B) Custom/Specialized pediatric bath chairs require prior authorization (PA). Documentation must include the following: ¶
(i) The treating practitioner's records supporting the medical appropriateness of the item ordered and explaining why a standard bath chair will not meet the individual's medical needs; and ¶
(ii) Documentation shall identify less costly alternatives and explain why a less costly alternative will fail to meet the individual's medical needs. ¶
(C) A custom/specialized pediatric bath chair shall be billed using the appropriate HCPCS code (E0240, E0245, or E0247) and modifier 22; ¶
(i) DMEPOS providers shall refer to the product classification list on the PDAC contractor website for coding verification; ¶
(ii) A pediatric custom/specialized bath chair billed using HCPCS code E0240, E0245, or E0247 and modifier 22 shall be reimbursed following the payment methodology outlined in OAR 410-122-0186 for manually priced items. ¶
(2) Documentation requirements: ¶
(a) The practitioner's order and medical justification for the equipment must be kept on file by the DMEPOS provider. The client's medical records must contain information which supports the medical appropriateness of the item and accessories ordered; ¶
(b) For ~~a rehab shower/commode chair~~services requiring prior authorization, submit documentation which supports conditions of coverage in this rule are met. ¶
(3) Table 122-0580 Bath Supplies.¶

~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0580 Bath Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E0160	Sitz type bath or equipment, portable, used with or without commode		PC				
E0161	Sitz type bath or equipment, portable, used with or without commode with faucet attachments		PC				
E0162	Sitz bath chair		PC	RT			
E0240	Bath/shower chair, with or without wheels, any size *__Custom/Specialized Pediatric__ Bath/shower chair, with or without wheels, any size	 PA	PC				
E0241	Bathtub wall rail, each		PC				
E0242	Bathtub rail, floor base		PC				
E0243	Toilet rail, each		PC				
E0245	Tub stool or bench __*Custom/Specialized Pediatric__ Tub stool or bench	 PA	PC				
E0246	Transfer tub rail attachment		PC				
E0247	Transfer bench for tub or toilet with or without commode opening __*Custom/Specialized Pediatric__ Transfer bench for tub or toilet with or without commode opening	 PA	PC				
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening		PC				
E0705	Transfer board or device, any type, each		PC	RT			
E1399	Durable medical equipment, miscellaneous	PA	PC	RT			RP

AMEND: 410-122-0620

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Miscellaneous Supplies Table rule. These updates included updating PA requirements for clarity and updating criteria to support recently published Prioritized List Ancillary Guideline Note A4.

CHANGES TO RULE:

410-122-0620
Miscellaneous Supplies ¶

Procedure Codes - Table 122-0620.¶
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

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, per pint		PC				
A4247	Betadine or iodine swabs/wipes, per box		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				
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope • refer to the Prioritized List of Health Services Home Blood Pressure Monitors Guideline Note		PC				
A4663	Blood pressure cuff only • refer to the Prioritized List of Health Services Home Blood Pressure Monitors Guideline Note		PC				
A4670	Automatic blood pressure monitor • refer to the Prioritized List of Health Services Home Blood Pressure Monitors Guideline Note		PC				
A8000	Helmet, protective, soft, prefabricated, includes all components and accessories		PC	RT	10		
A8001	Helmet, protective, hard, prefabricated, includes all components and accessories		PC	RT	10		
E0191	Heel or elbow protector, each		PC				
E0370	Air pressure elevator for heel		PC				

S8265	Haberman feeder for cleft lip/palate		PC				
V5266	Battery for use in hearing device • Limited to 60 batteries per calendar year		PC				NF

AMEND: 410-122-0630

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Incontinent Supplies rule. These updates included clarifying utilization limits for guidance, fixing the spacing in guidelines for clarity and readability, and adding reference to the Prioritized List Guideline Note 129 for coverage guidance and clarity.

CHANGES TO RULE:

410-122-0630
Incontinent Supplies ¶

(1) The-/Division may cover incontinent supplies for urinary or fecal incontinence in accordance with Prioritized List of Health Services Fecal Incontinence Guideline Note and as follows: ¶
(a) Category I Incontinent Supplies: For up to 200 units (any code or product combination in this category) per month, unless documentation supports the medical appropriateness for a higher quantity. For quantities over this limit a prior authorization shall be required. When requesting multiple Category I product types (i.e., diapers and liners) that exceed the allowable, prior authorization and documentation as described in (4)(a)(D) of this rule are required; ¶
(b) Category II Underpads: ¶
(A) Disposable underpads: For up to 100 units (any combination of T4541 and T4542) per month, unless documentation supports the medical appropriateness for a higher quantity, up to a maximum of 150 units per month; ¶
(B) Reusable/washable underpads: For up to eight units (any combination of T4537 and T4540) in a 12-month period; ¶
(C) Category II Underpads may be separately payable with Category I Incontinent Supplies with documentation that supports medical appropriateness for the use of this product; ¶
(D) T4541 and T4542 are not separately payable with T4537 and T4540 for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for eight reusable/washable underpads on a given date of service, a client would not be eligible for disposable underpads for the subsequent 12 months; ¶
(c) Category III Washable Protective Underwear: ¶
(A) For up to 12 units in a 12 month period; ¶
(B) Category III Washable Protective Underwear is not separately payable with Category I Incontinent Supplies for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for 12 units of T4536 on a given date of service, a client would not be eligible for Category I Incontinent Supplies for the subsequent 12 months; ¶
(d) The following services require PA: ¶
(A) A4335 (Incontinence supply; miscellaneous); ¶
(B) T4543 (Disposable incontinence product, brief/diaper, bariatric); ¶
(C) T4544 (Disposable incontinence product, protective underwear/pull-on); ¶
(D) Quantity of supplies greater than the amounts listed in this rule as the maximum monthly utilization (e.g., more than 200 units per month of Category I Incontinent Supplies, or ~~100 glove~~two (2) units per month of gloves). ¶
(2) Incontinent supplies are not covered: ¶
(a) For nocturnal enuresis; or ¶
(b) For children under the age of three. (3). ¶
(3) A provider may only submit A4335 when there is no definitive Healthcare Common Procedure Coding System (HCPCS) code that meets the product description. ¶
(4) Documentation requirements: ¶
(a) The client's medical records shall support the medical appropriateness for the services provided or being requested by the medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider, including, but not limited to: ¶
(A) For all categories, the medical reason and condition causing the incontinence; and ¶
(B) When a client is using urological or ostomy supplies at the same time as incontinent products specified in this rule, information that clearly corroborates the overall quantity of supplies needed to meet bladder and bowel management is medically appropriate; ¶
(C) For all clients not residing in their home subsequent PA requests for incontinence product(s), the provider shall submit a log with the PA request. This log shall be the most recent log for the client documenting the number and

frequency of incontinent product changes; ¶
(D) PA requests for multiple Category I incontinence product types for the same client (i.e. doubling up) shall be accompanied by adequate explanation from the client's ordering practitioner to explain why a single, more appropriate, incontinence product cannot be used; ¶
(E) Although PA is not required for Category II incontinence products, the DMEPOS provider shall have documentation on file from the prescribing practitioner supporting medical appropriateness; ¶
(F) When requesting PA for T4543 (Bariatric Brief/Diaper) or T4544 (Protective underwear/pull-on), submit product information showing that the item is size XXL or larger. The request shall also include client weight and measurements that support the use of the bariatric incontinence product (e.g., client weight, waist and hip size). These items are manually priced following payment methodology outlined in OAR 410-122-0186. ¶
(b) For services requiring PA, submit documentation as specified in (4)(a)(A)-(E) and (F); ¶
(c) The DMEPOS provider is required to keep supporting documentation on file and make available to the Division on request. ¶
(5) Quantity specification: ¶
(a) For PA and reimbursement purposes, a unit count for Category I-III codes is considered as a single or individual piece of an item and not as a multiple quantity; ¶
(b) If an item quantity is listed as number of boxes, cases or cartons, the total number of individual pieces of that item contained within that respective measurement (box, case or carton) shall be specified in the unit column on the PA request. See table 122-0630-2; ¶
(c) For gloves (Category IV Miscellaneous), 100 ~~gloves~~each (50 pairs) equal one (1) unit. ¶
(6) Table 122-0630-1, Incontinent Supplies ¶
(7) Table 122-0630-2, Incontinent Supplies - Counting Units and Pieces ¶
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0630-1 Incontinent Supplies

For the code legend see OAR 410-122-0182.

CATEGORY I – Incontinent Supplies

Code	Description	PA	PC	RT	MR	RP	NF
A4335	Incontinence supply; miscellaneous	PA	PC				
T4521	Adult-sized disposable incontinence product, brief/diaper, small, each		PC				
T4522	Adult-sized disposable incontinence product, brief/diaper, medium, each		PC				
T4523	Adult-sized disposable incontinence product brief/diaper, large, each		PC				
T4524	Adult-sized disposable incontinence product, brief/diaper, extra-large, each		PC				
T4525	Adult-sized disposable incontinence product, protective underwear/pull-on, small size, each		PC				
T4526	Adult-sized disposable incontinence product, protective underwear/pull-on, medium size, each		PC				
T4527	Adult-sized disposable incontinence product, protective underwear/pull-on, large size, each		PC				
T4528	Adult-sized disposable incontinence product, protective underwear/pull-on, extra-large size, each		PC				
T4529	Pediatric-sized disposable incontinence product, brief/diaper, small/medium, each		PC				
T4530	Pediatric-sized disposable incontinence product, brief/diaper, large, each		PC				
T4531	Pediatric-sized disposable incontinence product, protective underwear/pull-on, small/medium size, each		PC				
T4532	Pediatric-sized disposable incontinence product, protective underwear/pull-on, large size, each		PC				
T4533	Youth-sized disposable incontinence product, brief/diaper, each		PC				
T4534	Youth-sized disposable incontinence product, protective underwear/pull-on, each		PC				
T4535	Disposable liner/ shield/ guard/ pad/ undergarment, for incontinence, each Including but not limited to: pant liner, insert, insert pad, shield, pad, guard, booster pad, or belt-less undergarment		PC				

T4538	Diaper service, reusable diaper, each diaper		PC				
T4543	Disposable incontinence product, brief/diaper, bariatric, each	PA	PC				
T4544	Disposable incontinence product, protective underwear/pull-on, above extra-large, each	PA	PC				

CATEGORY II – Underpads

T4537	Incontinence product, protective underpad, reusable, bed size, each		PC				
T4540	Incontinence product, protective underpad, reusable, chair size, each		PC				
T4541	Incontinence product, disposable, large, each (more than 394 square inches)		PC				
T4542	Incontinence product, disposable, small, each (less than or equal to 394 square inches)		PC				

CATEGORY III – Washable Protective Underwear

T4536	Incontinence product, protective underwear/pull-on, reusable, any size, each		PC				

CATEGORY IV - Miscellaneous

A4927	Gloves, non-sterile, per 100 (50 pairs) Limited to 2 units (100 pairs) per month Covered only when directly related to usage of incontinent supplies		PC				

Table 122-0630-2 – Incontinent Supplies – Counting Units and Pieces

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

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

AMEND: 410-122-0658

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Gradient Compression Stockings/Sleeves rule. These updates included updating coverage to align with current federal CMS lymphedema benefit; adding all applicable new CMS HCPCS codes for clarity and adding reference to Prioritized List Guideline Note 43 for coverage guidance.

CHANGES TO RULE:

410-122-0658
Gradient Compression Stockings/Sleeves ¶

(1) Indications and Limitations of Coverage and Medical Appropriateness: ¶
(a) The Division may cover gradient compression stockings/sleeves for the following indications: when the client meets the conditions of coverage in OAR 410-122-0080 and when all the following guidelines and criteria are met: ¶
(A) Ulceration due to chronic venous insufficiency; ¶
(B) Varicose veins with ulcer or inflammation; ¶
(C) Phlebitis/thrombophlebitis; ¶
(D) Deep vein thrombosis (DVT) prophylaxis during pregnancy and postpartum or immobilization due to surgery, trauma, or debilitation; ¶
(E) Funded lymphedema conditions even in the absence of ulcers or other complications; and ¶
(F) Edema following a covered surgery, fracture, burns, or other trauma; ¶
(b) A gradient compression stocking may be covered when it is used to secure a primary dressing over an open venous stasis ulcer that is currently being treated by a practitioner and requires medically necessary debridement and when the gradient stocking delivers compression less than 50 mmHg; ¶
(c) Two (2) gradient compression stockings/sleeves per affected limb may be provided at dispensing (the second one is for use while the first one is being laundered); ¶
(d) Replacement stockings/sleeves are limited to two (2) per affected limb every six (6) months. Requests for quantities that exceed this amount require detailed medical documentation (e.g., change in size, unusual drainage, wear that renders them ineffective); ¶
(e) Custom-made gradient compression stockings/sleeves require prior authorization with documentation that supports that the treating practitioner has considered ready-made gradient compression stockings/sleeves and the reason why they will not meet the medical needs of the client. ¶
(f) The following services are not covered: ¶
(A) Antiembolism stockings (A4490-A4510); ¶
(B) Garter belts (A6544); ¶
(C) Stockings/sleeves for the following conditions: ¶
(i) Solely for the purpose of air travel; ¶
(ii) Treatment of non-funded lymphedema conditions; ¶
(iii) Venous insufficiency without stasis ulcers; ¶
(D) Support hose (pantyhose). ¶
(2) Gradient compression garments, related supplies and accessories are covered for the treatment of lymphedema and in accordance with the Prioritized List of Health Services Lymphedema Guideline Note. ¶
(a) A quantity of three (3) daytime garments or wraps per body area are allowed once every six (6) months; ¶
(b) A quantity of two (2) nighttime garments per body area are allowed once every two (2) years; ¶
(c) Replacements needed in cases of loss, theft, or irreparable damage may be covered by the Division in accordance with OAR 410-122-0184; ¶
(d) Lymphedema compression treatment items include the following: ¶
(A) Standard and custom daytime gradient compression garments; ¶
(B) Nighttime gradient compression garments; ¶
(C) Gradient compression wraps with adjustable straps; ¶
(D) Compression bandaging systems; ¶
(E) Accessories such as zippers, liners/linings, padding or fillers that are necessary for the effective use of a gradient compression garment or wrap; ¶
(F) Refer to Table 122-0658 for a complete list of HCPCS codes; ¶
(G) DMEPOS providers shall refer to the product classification list on the Medicare Pricing, Data Analysis and

Coding (PDAC) contractor website for coding verification and HCPCS codes used to identify specific durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). ¶
(3) Documentation Requirements: Medical records that support the conditions of coverage are met, as specified in this rule, shall be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request. ¶
(~~3~~4) Table 122-0658¶
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0658 Gradient Compression Stockings

For the code legend see OAR 410-122-0182.

Code	Description	PA	PC	RT	MR	RP	NF
A6515	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, FULL LEG, EACH, CUSTOM						
A6516	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, FOOT, EACH, CUSTOM						
A6517	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, BELOW KNEE, EACH, CUSTOM						
A6518	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, ARM, EACH, CUSTOM						
A6519	GRADIENT COMPRESSION GARMENT, NOT OTHERWISE SPECIFIED, FOR NIGHTTIME USE, EACH						
A6520	GRADIENT COMPRESSION GARMENT, GLOVE, PADDED, FOR NIGHTTIME USE, EACH						
A6521	GRADIENT COMPRESSION GARMENT, GLOVE, PADDED, FOR NIGHTTIME USE, CUSTOM, EACH						
A6522	GRADIENT COMPRESSION GARMENT, ARM, PADDED, FOR NIGHTTIME USE, EACH						
A6523	GRADIENT COMPRESSION GARMENT, ARM, PADDED, FOR NIGHTTIME USE, CUSTOM, EACH						
A6524	GRADIENT COMPRESSION GARMENT, LOWER LEG AND FOOT, PADDED, FOR NIGHTTIME USE, EACH						
A6525	GRADIENT COMPRESSION GARMENT, LOWER LEG AND FOOT, PADDED, FOR NIGHTTIME USE, CUSTOM, EACH						
A6526	GRADIENT COMPRESSION GARMENT, FULL LEG AND FOOT, PADDED, FOR NIGHTTIME USE, EACH						
A6527	GRADIENT COMPRESSION GARMENT, FULL LEG AND FOOT, PADDED, FOR NIGHTTIME USE, CUSTOM, EACH						
A6528	GRADIENT COMPRESSION GARMENT, BRA, FOR NIGHTTIME USE, EACH						
A6529	GRADIENT COMPRESSION GARMENT, BRA, FOR NIGHTTIME USE, CUSTOM, EACH						
A6530	BELOW KNEE, 18-30 MM HG, EACH		PC				
A6531	BELOW KNEE, 30-40 MMHG, EACH		PC				
A6532	BELOW KNEE, 40-50 MMHG, EACH		PC				
A6533	THIGH LENGTH, 18-30 MMHG, EACH		PC				
A6534	THIGH LENGTH, 30-40 MMHG, EACH		PC				
A6535	THIGH LENGTH, 40-50 MMHG, EACH		PC				
A6536	FULL LENGTH/CHAP STYLE, 18-30 MMHG, EACH		PC				
A6537	FULL LENGTH/CHAP STYLE, 30-40 MMHG, EACH		PC				
A6538	FULL LENGTH/CHAP STYLE, 40-50 MMHG, EACH		PC				
A6539	WAIST LENGTH, 18-30 MMHG, EACH		PC				
A6540	WAIST LENGTH, 30-40 MMHG, EACH		PC				
A6541	WAIST LENGTH, 40-50 MMHG, EACH		PC				
A6549	GRADIENT COMPRESSION STOCKING/SLEEVE, NOT OTHERWISE SPECIFIED	PA	PC				
A6552	BELOW KNEE, 30-40 MMHG, EACH		PC				
A6553	BELOW KNEE, 30-40 MMHG, CUSTOM, EACH		PC				

A6554	BELOW KNEE, 40 MMHG OR GREATER, EACH		PC				
A6555	BELOW KNEE, 40 MMHG OR GREATER, CUSTOM, EACH		PC				
A6556	THIGH LENGTH, 18-30 MMHG, CUSTOM, EACH		PC				
A6557	THIGH LENGTH, 30-40 MMHG, CUSTOM, EACH		PC				
A6558	THIGH LENGTH, 40 MMHG OR GREATER, CUSTOM, EACH		PC				
A6559	FULL LENGTH/CHAP STYLE, 18-30 MMHG, CUSTOM, EACH		PC				
A6560	FULL LENGTH/CHAP STYLE, 30-40 MMHG, CUSTOM, EACH		PC				
A6561	FULL LENGTH/CHAP STYLE, 40 MMHG OR GREATER, CUSTOM, EACH		PC				
A6562	WAIST LENGTH, 18-30 MMHG, CUSTOM, EACH		PC				
A6563	WAIST LENGTH, 30-40 MMHG, CUSTOM, EACH		PC				
A6564	WAIST LENGTH, 40 MMHG OR GREATER, CUSTOM, EACH		PC				
A6565	GRADIENT COMPRESSION GAUNTLET, CUSTOM, EACH						
A6566	GRADIENT COMPRESSION GARMENT, NECK/HEAD, EACH						
A6567	GRADIENT COMPRESSION GARMENT, NECK/HEAD, CUSTOM, EACH						
A6568	GRADIENT COMPRESSION GARMENT, TORSO AND SHOULDER, EACH						
A6569	GRADIENT COMPRESSION GARMENT, TORSO/SHOULDER, CUSTOM, EACH						
A6570	GRADIENT COMPRESSION GARMENT, GENITAL REGION, EACH						
A6571	GRADIENT COMPRESSION GARMENT, GENITAL REGION, CUSTOM, EACH						
A6572	GRADIENT COMPRESSION GARMENT, TOE CAPS, EACH						
A6573	GRADIENT COMPRESSION GARMENT, TOE CAPS, CUSTOM, EACH						
A6574	GRADIENT COMPRESSION ARM SLEEVE AND GLOVE COMBINATION, CUSTOM, EACH						
A6575	GRADIENT COMPRESSION ARM SLEEVE AND GLOVE COMBINATION, EACH						
A6576	GRADIENT COMPRESSION ARM SLEEVE, CUSTOM, MEDIUM WEIGHT, EACH						
A6577	GRADIENT COMPRESSION ARM SLEEVE, CUSTOM, HEAVY WEIGHT, EACH						
A6578	GRADIENT COMPRESSION ARM SLEEVE, EACH						
A6579	GRADIENT COMPRESSION GLOVE, CUSTOM, MEDIUM WEIGHT, EACH						
A6580	GRADIENT COMPRESSION GLOVE, CUSTOM, HEAVY WEIGHT, EACH						
A6581	GRADIENT COMPRESSION GLOVE, EACH						
A6582	GRADIENT COMPRESSION GAUNTLET, EACH						

A6583	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, BELOW KNEE, EACH						
A6584	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, NOT OTHERWISE SPECIFIED						
A6585	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, ABOVE KNEE, EACH						
A6586	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, FULL LEG, EACH						
A6587	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, FOOT, EACH						
A6588	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, ARM, EACH						
A6589	GRADIENT PRESSURE WRAP WITH ADJUSTABLE STRAPS, BRA, EACH						
A6593	ACCESSORY FOR GRADIENT COMPRESSION GARMENT OR WRAP WITH ADJUSTABLE STRAPS, NOT-OTHERWISE SPECIFIED						
A6594	GRADIENT COMPRESSION BANDAGING SUPPLY, BANDAGE LINER, LOWER EXTREMITY, ANY SIZE OR LENGTH, EACH						
A6595	GRADIENT COMPRESSION BANDAGING SUPPLY, BANDAGE LINER, UPPER EXTREMITY, ANY SIZE OR LENGTH, EACH						
A6596	GRADIENT COMPRESSION BANDAGING SUPPLY, CONFORMING GAUZE, PER LINEAR YARD, ANY WIDTH, EACH						
A6597	GRADIENT COMPRESSION BANDAGE ROLL, ELASTIC LONG STRETCH, PER LINEAR YARD, ANY WIDTH, EACH						
A6598	GRADIENT COMPRESSION BANDAGE ROLL, ELASTIC MEDIUM STRETCH, PER LINEAR YARD, ANY WIDTH, EACH						
A6599	GRADIENT COMPRESSION BANDAGE ROLL, INELASTIC SHORT STRETCH, PER LINEAR YARD, ANY WIDTH, EACH						
A6600	GRADIENT COMPRESSION BANDAGING SUPPLY, HIGH DENSITY FOAM SHEET, PER 250 SQUARE CENTIMETERS, EACH						
A6601	GRADIENT COMPRESSION BANDAGING SUPPLY, HIGH DENSITY FOAM PAD, ANY SIZE OR SHAPE, EACH						
A6602	GRADIENT COMPRESSION BANDAGING SUPPLY, HIGH DENSITY FOAM ROLL FOR BANDAGE, PER LINEAR YARD, ANY WIDTH, EACH						
A6603	GRADIENT COMPRESSION BANDAGING SUPPLY, LOW DENSITY CHANNEL FOAM SHEET, PER 250 SQUARE CENTIMETERS, EACH						
A6604	GRADIENT COMPRESSION BANDAGING SUPPLY, LOW DENSITY FLAT FOAM SHEET, PER 250 SQUARE CENTIMETERS, EACH						
A6605	GRADIENT COMPRESSION BANDAGING SUPPLY, PADDED FOAM, PER LINEAR YARD, ANY WIDTH, EACH						

A6606	GRADIENT COMPRESSION BANDAGING SUPPLY, PADDED TEXTILE, PER LINEAR YARD, ANY WIDTH, EACH						
A6607	GRADIENT COMPRESSION BANDAGING SUPPLY, TUBULAR PROTECTIVE ABSORPTION LAYER, PER LINEAR YARD, ANY WIDTH, EACH						
A6608	GRADIENT COMPRESSION BANDAGING SUPPLY, TUBULAR PROTECTIVE ABSORPTION PADDED LAYER, PER LINEAR YARD, ANY WIDTH, EACH						
A6609	GRADIENT COMPRESSION BANDAGING SUPPLY, NOT OTHERWISE SPECIFIED						
A6610	GRADIENT COMPRESSION STOCKING, BELOW KNEE, 18-30 MMHG, CUSTOM, EACH						
A6611	GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, ABOVE KNEE, EACH, CUSTOM						
L8010	MASTECTOMY SLEEVE		PC				
S8420	GRADIENT PRESSURE AID (SLEEVE AND GLOVE COMBINATION), CUSTOM MADE	PA	PC				
S8421	GRADIENT PRESSURE AID (SLEEVE AND GLOVE COMBINATION), READY MADE	PA	PC				
S8422	GRADIENT PRESSURE AID (SLEEVE), CUSTOM-MADE, MEDIUM WEIGHT MANUALLY PRICED	PA	PC				
S8423	GRADIENT PRESSURE AID (SLEEVE) CUSTOM-MADE, HEAVY WEIGHT	PA	PC				
S8424	GRADIENT PRESSURE AID (SLEEVE) READY MADE MANUALLY PRICED	PA	PC				
S8425	GRADIENT PRESSURE AID (GLOVE) CUSTOM MADE, MEDIUM WEIGHT	PA	PC				
S8426	GRADIENT PRESSURE AID (GLOVE) CUSTOM MADE, HEAVY WEIGHT MANUALLY PRICED	PA	PC				
S8427	GRADIENT PRESSURE AID (GLOVE) READY MADE MANUALLY PRICED	PA	PC				
S8428	GRADIENT PRESSURE AID (GAUNTLET) READY MADE	PA	PC				

AMEND: 410-122-0678

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Dynamic Adjustable Extension/Flexion Device rule. These updates included adding recently added CMS HCPCS codes for clarity and adding reference to the OAR coverage table for guidance.

CHANGES TO RULE:

410-122-0678
Dynamic Adjustable Extension/Flexion Device ¶

(1) Indications and limitations of coverage and medical appropriateness: The Division may cover some dynamic adjustable extension/flexion devices for a covered condition when all of the following conditions are met: ¶
(a) As an adjunct to physical therapy for clients with signs and symptoms of persistent joint stiffness in the sub-acute injury or post-operative period (> 3 weeks but < 4 months after injury or surgical procedure) when the device is applied and managed under the direct supervision of a physical therapist; ¶
(b) As an adjunct to physical therapy in the acute post-operative period for clients who are undergoing additional surgery to improve the range of motion of a previously affected joint when the device is managed under the direct supervision of a physical therapist; ¶
(c) For this episode, the device has not been billed to the Division with a current procedure terminology (CPT) code, healthcare common procedure coding system (HCPCS) code, or diagnosis code by any other healthcare provider; ¶
(d) Reimbursement is limited to a maximum of four (4) months per episode; ¶
(e) Reimbursement is on a month-to-month rental basis only. ¶
(2) Documentation requirements: ¶
(a) Submit medical records that support the conditions of coverage, as specified in this rule, have been met, including the treatment plan from the physical therapist; ¶
(b) The treatment plan shall include: ¶
(A) Baseline measurements (pre-intervention measurements) of range of motion (ROM) limitations; ¶
(B) Weekly ROM measurements with documented 10 degree improvement. ¶
(3) Refer to Table 122-0678 - Dynamic Adjustable Extension/Flexion Devices. ~~¶~~
~~[ED. NOTE: Tables referenced are available from the agency.]~~ for HCPCS codes.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

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	PA		RT			NF
E1801	STATIC PROGRESSIVE STRETCH/PATIENT ACTUALIZED SERIAL STRETCH ELBOW DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	PA		RT			NF
E1802	DYNAMIC ADJUSTABLE FOREARM PRONATION/SUPINATION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1803	DYNAMIC ADJUSTABLE ELBOW EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1804	DYNAMIC ADJUSTABLE ELBOW FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			
E1805	DYNAMIC ADJUSTABLE WRIST EXTENSION/FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1806	STATIC PROGRESSIVE STRETCH WRIST DEVICE, FLEXION AND/OR EXTENSION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	PA		RT			NF
E1807	DYNAMIC ADJUSTABLE WRIST EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1808	DYNAMIC ADJUSTABLE WRIST FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			
E1810	DYNAMIC ADJUSTABLE KNEE EXTENSION/FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF

E1811	STATIC PROGRESSIVE STRETCH/PATIENT ACTUALIZED SERIAL STRETCH KNEE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	PA		RT			NF
E1812	DYNAMIC KNEE, EXTENSION/FLEXION DEVICE WITH ACTIVE RESISTANCE CONTROL	PA		RT			NF
E1813	DYNAMIC ADJUSTABLE KNEE EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1814	DYNAMIC ADJUSTABLE KNEE FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1815	DYNAMIC ADJUSTABLE ANKLE EXTENSION/FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1816	STATIC PROGRESSIVE STRETCH/PATIENT ACTUALIZED SERIAL STRETCH ANKLE DEVICE, FLEXION AND/OR EXTENSION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	PA		RT			NF
E1818	STATIC PROGRESSIVE STRETCH/PATIENT ACTUALIZED SERIAL STRETCH FOREARM PRONATION / SUPINATION DEVICE, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	PA		RT			NF
E1822	DYNAMIC ADJUSTABLE ANKLE EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1823	DYNAMIC ADJUSTABLE ANKLE FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1825	DYNAMIC ADJUSTABLE FINGER EXTENSION/FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1826	DYNAMIC ADJUSTABLE FINGER EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1827	DYNAMIC ADJUSTABLE FINGER FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF

E1828	DYNAMIC ADJUSTABLE TOE EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1829	DYNAMIC ADJUSTABLE TOE FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1830	DYNAMIC ADJUSTABLE TOE EXTENSION AND FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1832	STATIC PROGRESSIVE STRETCH FINGER DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	PA		RT			NF
E1840	DYNAMIC ADJUSTABLE SHOULDER FLEXION / ABDUCTION / ROTATION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PA		RT			NF
E1841	STATIC PROGRESSIVE STRETCH/PATIENT ACTUALIZED SERIAL STRETCH SHOULDER DEVICE, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	PA		RT			NF

AMEND: 410-122-0710

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Special Needs Car Seats rule. These updates included amending OAR language to remove obsolete criteria, updating coverage guidelines for clarity, and adding billing codes and billing guidance to rule for clarity.

CHANGES TO RULE:

410-122-0710
~~Special Needs Car Sea~~Adaptive Car Seats and Travel Vests
(1) ~~Special needs car seats are used to~~Indications and limitations of coverage and medical appropriateness: Adaptive car seats and travel vests provide safety during transportation ~~to~~in a vehicle for individuals of all ages with health care needs ~~such as orthopedic or medical needs~~ that cannot be met using conventional car seats ~~for safe travel in a vehicle.~~ ¶
~~(2) A special needs car seat may be covered by the Division when a conventional car seat cannot be used by a client because the client has a significant physical, neurological, or orthopedic condition including.~~ ¶
(2) An adaptive car seat or travel vest that meets Federal Motor Vehicle Safety Standard 213 may be covered by the Division for an individual with a significant health condition for which a conventional car seat harness or its positioning is unsafe or physically incompatible as documented by one or more of the following functional limitations (list not all-inclusive): ¶
(a) Inability to maintain an unsupported sitting position independently; ¶
(b) Significant head and trunk instability; ¶
(c) Significant hypotonicity, hypertonicity, spasticity ~~or,~~ muscle spasm ~~which~~, contractures, seizure activity, or other physiological symptoms or events that result in uncontrollable movement and position changes~~;~~ ¶
~~(d) Orthopedic disease processes resulting in significant bony fragility;¶~~
~~(e) Significant contractures that would result in an inability to perform postural corrections due to vehicle motion;~~ ¶
~~(f) Severe seizure activity that results in uncontrollable movement and position change~~ and/or the inability to make positional correction; ¶
(d) Bony or other fragility for which a conventional car seat harness use or positioning is unsafe; ¶
(e) Fracture casting or post-surgical casting for which positioning in a conventional car seat is unsafe or physically incompatible; ¶
(f) Congenital or acquired condition for which conventional car seat harness use and/or car seat positioning is incompatible (e.g. omphalocele, osteogenesis imperfecta, myelomeningocele, airway anomalies including tracheostomy, scoliosis or kyphosis); or ¶
(g) ~~Orthopedic condition, such as a curvature of the spine, which interferes with proper positioning;~~Neurodevelopmental condition that renders conventional car seat safety features unsafe or ineffective. ¶
(3) Prior Authorization ~~is required. The DMEPOS provider's request for prior authorization~~(PA): The PA request must include the following documentation: ¶
(a) The prescribing practitioner's clinical documentation supporting th~~at the special needs car seat requested is medically appropriate and the least costly alternative that will meet the c~~e individual's diagnosed medical condition(s) for an adaptive car seat or travel vest; ¶
(b) A signed and dated evaluation by a licensed physical therapist, a licen~~t's current medical needs. The prescribing practitioner's documented assessment of the client's medical needs must be within 30 days before the date the PA request is submitted to the Division;¶~~
~~(b) A signed and dated evaluation by a physical therapist or occupational therapist~~sed occupational therapist, or a National Highway Traffic Safety Administration (NHTSA) certified Child Passenger Safety Technician (CPST/CPS Technician) that is co-signed by a licensed practitioner with CPST-I certification in adaptive needs transportation, which includes detailed documentation of all of the following: ¶
(~~i~~A) The individual's medical condition(s) for which the ~~special needs car seat is needed and why a conventional car seat will not meet the current medical needs of the client~~adaptive car seat or travel vest is needed; ¶
(~~ii~~B) Description of what equipment is currently being used to transport the individual in a vehicle and why it no longer meets their medical needs ~~of the client; ¶~~
~~(iii) Other intervention;/~~ ¶
(C) Interventions and less costly alternatives that have been tried and why those interventions were not successful (e.g., conventional car seats, vests, harnesses); ¶
(~~iv) Less costly~~D) Brand name and model number of the adaptive car seats ~~that were considered and why they~~

~~were ruled out; and~~¶
~~(v) A signed, dated, attestation from the prescribing practitioner support~~ or travel vest being requested (including each accessory); ¶
(E) Acknowledgement that the requested adaptive car seat or travel vest is appropriate for use ing the ~~requested special needs car seat;~~vehicle used to transport the client; and ¶
(~~c~~F) Client's current height and weight, and the weight capacity and growth potential of the ~~special needs~~adaptive car seat model or travel vest requested~~;~~. ¶
(~~dc~~) ~~Brand name and model number of the special needs car sea~~An order signed by the prescribing practitioner supporting the adaptive car seat (and accessories) or travel vest requested; and ¶
(~~ed~~) Manufacturer's suggested retail price (MSRP) for the brand and model number of the ~~special needs care seat requested.~~adaptive car seat (including each accessory) or travel vest requested. ¶
(4) The licensed physical therapist, licensed occupational therapist, CPS Technician (CPST), or licensed practitioner performing the evaluation must have no financial relationship with the DMEPOS provider. ¶
(4~~5~~) ~~The prescribing practitioner's order, medical records, and all documentation submitted with the prior authorization request in (3) shall be kept on file by the DMEPOS provider;~~Reimbursement: ¶
(a) HCPCS code E1399 shall be used for billing the adaptive car seats or travel vests and reimbursed in accordance with OAR 410-122-0186; ¶
(b) All accessories shall be billed using HCPCS E1399 and reimbursed in accordance with OAR 410-122-0186; ¶
(c) Certified CPS Technician visits for the initial equipment evaluation, installation and instructional training, and follow up visits to address a change in individual's growth or development, a change in individual's behavior, a change in vehicle/mode of transportation, or a change in medical need may be billed to the Division (Refer to (6) in this rule for coding descriptions and details) only when records of those evaluations and visits are reviewed and co-signed by a licensed practitioner with CPST-I certification in adaptive needs transportation. ¶
(6) Documentation: ¶
(a) For PA, submit documentation that supports coverage criteria and guidelines in this rule are met;/ ¶
(b) Medical records and documentation to support the client meets criteria and conditions of coverage in this rule must be kept on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and shall be made available to the Division upon request./ ¶
(7) Procedure Codes and definitions: ¶
(a) E1399 - Durable medical equipment, miscellaneous (adaptive car seat, accessories, travel vest); - PA Required ¶
(b) 99204 - New patient office or other outpatient visit with moderate level of medical decision making, if using time, 45 minutes or more (Initial assessment and evaluation of client and vehicle performed by certified CPST - provider type specialty 321); ¶
(5~~c~~) ~~Special needs car seats do not require PDAC coding verification;~~99213 - Established patient office or other outpatient visit with low level of decision making, if using time, 20 minutes or more (Follow up visit performed by certified CPST - provider type specialty 321); ¶
(d) 99214 - Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more (Follow up visit performed by certified CPST - provider type specialty 321); ¶
(e) 99215 - Established patient office or other outpatient visit with high level of medical decision making, if using time, 40 minutes or more to address a change in the client's growth or development, a change in client's behavior, a change in vehicle/mode of transportation, or a need to change from a conventional seat to an adaptive car seat or travel vest (Reevaluation/reassessment visit performed by a certified CPST - provider type specialty 321). ¶
(~~6~~f) ~~HCPCS code E1399 shall be used for billing special needs car seats~~A CPST, also known as a CPS Technician, is defined as a professional who is currently NHTSA certified by Safe Kids Worldwide and Safe Travel for all Children (STAC) in Transporting Children with Special Healthcare Needs. A CPST must be trained in adaptive needs transportation and perform services in accordance with the National CPS Board's Child Passenger Safety Technician Code of Conduct.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0730

NOTICE FILED DATE: 09/30/2025

RULE SUMMARY: Oregon Health Plan, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Continuous Glucose Monitoring Equipment and Supplies rule. These updates included adding clarifying language regarding utilization limits and referencing PDAC for coding verification guidance.

CHANGES TO RULE:

410-122-0730
Continuous Glucose Monitoring Equipment and Supplies
(1) Indications and Limitations of Coverage and Medical Appropriateness: ¶
(a) The Division shall cover personal, real-time continuous glucose monitoring (CGM) equipment and supplies for clients with a diagnosis of type 1 diabetes mellitus, type 2 diabetes mellitus, or gestational diabetes when criteria in the Prioritized List of Health Services Continuous Glucose Monitoring Guideline ~~n~~Note ~~108~~ are met; ¶
(b) Continuous glucose monitoring equipment and supplies (E2102, E2103, A4238, A4239, A9276, A9277, A9278) require prior authorization (PA) with clinical documentation to support that all criteria in OAR Ch. 410 Div. 122 DMEPOS rules~~,~~ and Table 122-~~XXXX~~0730 are met; ¶
(c) Initial authorization shall be limited to ~~6~~six (6) months from the date of Division's authorization. Continued use beyond the initial ~~6~~six (6) months authorization requires the provider send to the Division current medical documentation of a client follow up visit with the treating practitioner which supports that there continues to be a medical need, that the requirements of this rule are met, and the client is regularly utilizing the CGM and the data from the CGM to adjust insulin; regularly utilizing means that the client ~~/~~used the device for at least 50~~%~~ percent of the time since the date of the initial authorization; ¶
(d) CGM equipment must be FDA approved for the age of the client; ¶
(e) Insulin pumps with integrated CGM function require prior authorization and must meet criteria in this rule and OAR 410-122-0525; ¶
(f) The Division considers all other applications of real-time CGM to be investigational as the effectiveness of its use has not been established in peer-reviewed professional literature; ¶
(2) Therapeutic/Non-adjunctive CGM devices (E2103 and A4239) are used to make treatment decisions and replaces standard blood glucose monitoring and related supplies. Standard blood glucose monitoring and supplies (E0607, E2100. E2101, A4233, A4234, A4236, A4244. A4245, A4246, A4247, A4250, A4253. A4255. A4257, A4258, A4259) cannot be billed separately to the Division on any day that falls within the CGM authorization time period when the client is using non-adjunctive CGM. This is a duplication of services; ¶
(3) Non-therapeutic/Adjunctive CGM devices (E2102 and A4238) do not replace standard blood glucose monitoring. These supplies may be billed separately; ¶
(4) P~~rior authorization~~A requests for CGM systems that are FDA approved but are not considered DME (i.e., CGM systems that use smart phone exclusively for monitor/receiver) will be reviewed on a case-by-case basis. Clinical documentation from the treating practitioner, specific to the client, must demonstrate that all other covered CGM alternatives have been considered, tried and failed, or reasonably expected to fail; ¶
(5) Providers may not use A9276, A9277, or A9278 to bill supplies for any CGM device coded as an adjunctive CGM (E2102) or non-adjunctive CGM (E2103) device~~;~~¶
~~(~~6. Providers shall refer to the product classification list on the Pricing, Data Analysis and Coding (PDAC) contractor website for coding verification; ¶
(6) Reasonable useful lifetime (RUL) of CGM is no less than three (3) years; ¶
(a) Computation of the useful lifetime is based on when the CGM is delivered to the client, not the age of the device; ¶
(b) If there is a medical need to replace a CGM device within the RUL period, the provider must submit documentation to corroborate the malfunction of the CGM and records to support the individual's medical necessity and appropriateness for the new device and ongoing treatment for a case-by-case review. ¶
(7) Documentation: ¶
(a) For PA, submit documentation that supports coverage criteria and guidelines in this rule are met;/ ¶
(b) Medical records and documentation to support the client meets criteria and conditions of coverage in this rule must be kept on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and shall be made available to the Division upon request./ ¶
(8) See Table 122-0730 ~~/~~for billing codes.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 122-0730 Continuous Glucose Monitoring Equipment and Supplies

For the code legend see OAR 410-122-0182

Code	Description	PA	PC	RT	MR	RP	NF
E2102	Adjunctive, non-implanted continuous glucose monitor or receiver	PA	PC				
A4238	Supply allowance for adjunctive, non-implanted continuous glucose monitor (CGM), includes all supplies and accessories necessary for use of the device (i.e., sensors, transmitter) 1 month supply = 1 unit of service	PA	PC				
E2103	Non-adjunctive, non-implanted continuous glucose monitor or receiver	PA	PC				
A4239	Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (CGM), includes all supplies and accessories necessary for use of the device (i.e., sensors, transmitter) 1 month supply = 1 unit of service	PA	PC				
A9276	Sensor; invasive (e.g., subcutaneous) disposable, for use with non-durable medical equipment interstitial continuous glucose monitoring system 1 unit = 1 day supply	PA	PC				
A9277	Transmitter; external, for use with non-durable medical equipment interstitial continuous glucose monitoring system	PA	PC				

	Limited to 4 per year						
A9278	Receiver (monitor); external, for use with non-durable medical equipment interstitial continuous glucose monitoring system Not separately payable with insulin pump with integrated continuous glucose monitoring function Limited to one per 3 years	PA	PC				
E0784	External ambulatory infusion pump, insulin, (with or without integrated continuous glucose monitoring function) – see OAR 410-122-0525 for coverage criteria	PA	PC	RT			