Fee-for-Service Requirements for OmniPod Insulin Delivery System Coverage

This document answers frequently asked questions from providers who prescribe OmniPod insulin delivery systems to treat Oregon Health Plan fee-for-service members who have diabetes mellitus.

Overview

OmniPod products are not preferred because there are less costly insulin pump alternatives available to treat diabetes mellitus. Because of this, Oregon Health Authority (OHA) requires prior authorization (PA) for purchase of OmniPod products. PA offers providers an opportunity to illustrate why less costly alternatives cannot meet their patient's needs.

Providers must request PA for OmniPod products and supplies using the following codes:

- **OmniPod 5 G6 Intro Kit (Gen 5):** National Drug Code (NDC) 08508-3000-01
- **OmniPod 5 G6 Pods (Gen 5) Refill 5-Pack:** NDC 08508-3000-21
- **OmniPod DASH Pods (Gen 4) Refill 5-pack:** NDC 08508-2000-05

In the MMIS Provider Portal, use the "DMAP-Medical Unit" division code to submit OmniPod PA requests. OHA will complete a clinical review to evaluate individual circumstances and verify the medical necessity and appropriateness of the request.

If OHA approves the request, the dispensing provider can bill for the device and supplies using the pharmacy claim format.

Coverage rules and guidelines

Eligible benefit packages

For members with the BMH, BMM or BMD benefit packages, OHP may cover OmniPod devices and related supplies with prior authorization.

For members with the MED benefit package, OHA only covers the Medicare Part B coinsurance or deductible for the device or related supplies as described in OAR 410-120-1210(4)(c)(A-E).

Prioritized List coverage

Verify that the NDC for the device and/or related supplies is covered for the specific ICD-10 code for the client's diabetes mellitus. You can do this two ways:

- Use the Oregon Medicaid Provider Portal at https://www.or-medicaid.gov, OR
- Call the OHA FFS PA Requirement and Code Pairing Hotline at 800-336-6016 (option 4).

For members under age 21, request prior authorization. Line placement on the Prioritized List does not apply for these members.

Oregon Administrative Rules

Guidance for initial coverage

Oregon Administrative Rule (OAR) 410-122-0520(1)(i)(H) does not specify OmniPod external insulin pump product(s) as a covered insulin delivery device or related supply. This is why PA is required for benefit coverage.

Follow these OARs as guidance for initial coverage:

- 410-122-0525 - External Insulin Infusion Pump
- 410-122-0080(21)(a)(b)(c) - Conditions of Coverage, Limitations, and Restrictions
- 410-122-0020 – Orders
- 410-122-0090 – Face to Face Encounter Requirements

Guidance for continued coverage

OAR 410-122-0525(1)(b) lists criteria for continued coverage.

Prior authorization requirements

How to submit requests

You can submit PA requests in two ways.

- Use the Provider Portal at https://www.or-medicaid.gov. This is the preferred, most interactive, most effective, and most efficient submission pathway. If you need help using the Provider Portal, please contact the Provider Services hotline at (800) 336-6016, Option #5.
- Fax the completed Prior Authorization Request Form (MSC 3971) with supporting documentation to 503-378-5814. Please include the EDMS Coversheet (MSC 3970) as the first page of your submission packet. https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/me3971.pdf

Required documents

- Supporting health records: diagnostic testing reports, chart notes, and other objective data. See Oregon Administrative Rule 410-122-0525 for the coverage criteria.
- Signed letter of medical necessity from the treating practitioner.
- Documentation that illustrates that less costly, equally effective alternatives have been considered or trialed and are not appropriate.
- For members using a continuous glucose monitor (CGM), also specify which CGM system the client uses.

Continuing PA

If the member is expected to continue using the device beyond the approved service dates, submit a new PA request at least two weeks before the end date of the previous approval.

Relevant OARs:

- 410-120-0000 (192)(a)(A-D)(b-c): Medically Appropriate
- 410-120-0000 (193)(a-c): Medically Necessary
- 410-151-0001 (3): EPSDT Medically Appropriate
- 410-151-0001 (4): EPSDT Medically Necessary
- 410-200-0455: YSHCN Specific Requirements
- 410-122-0080 (2)(j): Conditions of Coverage, Limitations, and Restrictions
- 410-120-1320 (1)(2)(3): Authorization of Payment
- 410-122-0525 (1)(a)(A)(B)(C)(i-iii)(I-IV)(D)(i-ii)(b-f)(2)(3)(a-c) (4) Table 122-0525 External Insulin Infusion Pump

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