Oregon Health Authority

Health Systems Division: Medical Assistance Programs - Chapter 410

Division 122
DURABLE MEDICAL EQUIPMENT, PROSTHETIC ORTHOTICS AND SUPPLIES (DMEPOS)

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) "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~~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.

(4) “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, and can be reusable or removable. ~~equipment furnished by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or a home health agency that is primarily and customarily used to serve a medical purpose; generally is not useful to a client in the absence of a medical 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. ~~Durable medical equipment extends to supplies and accessories that are necessary for the effective use of covered durable medical equipment.~~

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(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.

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(6) 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.

(~~5~~7) “Home” ~~means,~~ for purposes of purchase, rental, and repair of durable medical equipment (DME) ~~that is used primarily as a supportive measure to support a client's basic daily living activities,~~ means a place of permanent residence such as an assisted living facility ~~(includes the common dining area)~~, ~~a~~ 24-hour residential care facility, ~~an~~ adult foster home, ~~a~~ 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.

(~~6~~8) “Lifetime Need” means 99 months or more.

(~~7~~9) “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.

(~~8~~10) “Medical Records” means the ~~physician’s~~ 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.

(~~9~~11) “Medical Supplies” means health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, ~~and~~ that are required to address an individual~~’s~~ medical disability, illness, or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing. ~~Some medical supplies may also be used on a repeated, limited duration basis.~~

(~~10~~12) “Medically Appropriate” and “Medically Necessary” has the meaning given ~~that~~ these terms in OAR 410-120-0000 for clients age 21 and older and OAR 410-151-0001 for clients under age 21.

Commented [JK1]: Separate definition

(~~11~~13) “Mobility-related Activities of Daily Living (MRADL's)” means personal care activities including, but not limited to, tasks such as toileting, eating, dressing, grooming, and bathing. MRADL is a term used to describe movement from point A to point B to perform these personal care activities through the day. It is demonstrated when the individual is not able to move to or from a location of an activity independently, safely or in a timely manner.

(~~12~~14) “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.

(~~13~~15) “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.

(~~14~~16) “The Division Maximum Allowable Rate” means the maximum amount paid by the Division for a service.

(~~15~~17) “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 assistant, nurse practitioners, and certified nurse specialists) as defined in section 1861 of the Social Security Act).

Commented [JK2]: Based on 42 CFR 440.70

(~~16~~18) “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.

(~~17~~18) “Purchase price” means:

(a) Delivery;

(b) Assembly;

(c) Adjustments, if needed; and

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

(~~18~~20) “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.

(~~19~~21) “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.

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 12-2018, amend filed 03/07/2018, effective 03/08/2018
DMAP 36-2017(Temp), f. 9-14-17, cert. ef. 9-15-17 thru 3-13-18
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 54-2004, f. 9-10-04, cert. ef. 10-1-04
OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0020
Orders

(1) The purchase, rental, or modifications of durable medical equipment and the purchase of supplies must have an order from the treating practitioner prior to dispensing items to a client.

(2) For any durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), a provider must have a written order signed and dated by the prescribing practitioner prior to submitting a claim to the Division.

(3) A provider may dispense some items based on a verbal order from the prescribing practitioner, except those items requiring a written order prior to delivery or as specified in a particular rule:

(a) A provider must maintain documentation of the verbal order~~,~~ and this documentation must be available to the Division upon request;

(b) The verbal order must include all of the following elements:

(A) Client’s name;

(B) Practitioner’s name;

(C) Description of the item;

(D) Start date of the order;

(E) Primary ICD-10 diagnosis code for the equipment/supplies requested.

(c) For items that are dispensed based on a verbal order, the provider must obtain a written order that meets the requirements outlined below for written orders.

(4) When specified in rule, a nurse practitioner or clinical nurse specialist may provide the dispensing order and sign the detailed written order only when the following are met:

(a) They are treating the client for the condition for which the item is needed; and

(b) They are practicing independently of a physician; and.

(c) All of the above are permitted when within their scope of practice and licensure with the State of Oregon.

(5) When specified in rule, a physician assistant may provide the dispensing order and sign the detailed written order only when the following are met:

(a) They are treating the client for the condition for which the item is needed; and

(b) They are practicing under the supervision of a Doctor of Medicine or Doctor of Osteopathy; and

(c) All of the above are permitted when within their scope of practice and licensure with the State of Oregon.

(~~5~~6) The DMEPOS provider must have on file a written order, information from the prescribing practitioner concerning the client's diagnosis and medical condition, and any additional information required in a specific rule.

(~~6~~7) The Division accepts any of the following forms of orders ~~and Certificates of Medical Necessity (CMN)~~: a photocopy, facsimile image, electronically maintained or original "pen and ink" document:

(a) An electronically maintained document is one that has been created, modified, and stored via electronic means such as commercially available software packages and servers;

(b) The provider shall ensure the authenticity and validity of a facsimile image, electronically maintained or photocopied order;

(c) A provider must also ensure the security and integrity of all electronically maintained orders ~~and certificates of medical necessity~~;

(d) The written order may serve as the order to dispense the item if the written order is obtained before the item is dispensed.

(~~7~~8) A written order must be legible and contain the following elements:

(a) Client's name; and

Commented [JK3]: Clinical Nurse specialist added to federal Medicaid regulations as allowable provider type to order DME 42 CFR 440.70

Commented [JK4]: CMNs no longer required by CMS for Medicare as clinical documentation with written order should be adequate to support the medical appr/med nec of the requested/billed item. We will still accept CMNs but there is no need to require them. https://www.cms.gov/newsroom/news-alert/cms-discontinuing-use-certificates-medical-necessity-and-durable-medical-equipment-information-forms#:~:text=As%20part%20of%20its%20ongoing,Information%20Forms%20(DIFs)%20for%20claims

Commented [JK5]: Medicare requires the following elements. See https://med.noridianmedicare.com/documents/2230703/16619307/Clinician%20Checklist%20Standard%20Written%20Order for requirements in SWO

(b) Detailed description of the item that can either be a ~~narrative~~ general description (e.g., lightweight wheelchair base) or a brand name/model number including medically appropriate options or additional features; and

(c) The detailed description of the item may be completed by someone other than the practitioner. However, the prescribing practitioner must review the detailed description and personally indicate agreement by his signature and the date that the order is signed:

(A) Practitioners shall sign for services they order;

(B) This signature must be handwritten or electronic, and it must be in the client's medical record;

(C) The ordering practitioner shall ensure the authenticity of the signature;

(d) Primary ICD-10 diagnosis code for the equipment and supplies requested;~~.~~ and

(e) Quantity to be dispensed, if applicable; and

(~~e~~f) Order date; and

(~~f~~g) Treating practitioner's name; and

(~~g~~h) Treating practitioner's signature:

(A) This signature must be handwritten or electronic, and it must be in the client's medical record;

(B) The ordering/treating practitioner shall ensure the authenticity of the signature; and

(~~8~~C) Use of signature stamps may not be used on any medical record.

~~(9) When a DMEPOS provider submits a Centers for Medicare & Medicaid Services (CMS) CMN form to the Division as documentation, it must include the following:~~

~~(a) The corresponding instructions for completing the specific CMN form must be followed; and~~

~~(b) Section B on the CMN may not be completed by the DMEPOS provider.~~

(~~10~~9) The DMEPOS provider shall obtain as much documentation from the client's medical record as necessary for assurance that the Division coverage criteria for an item is met.

(~~11~~10) Certain items require one or more of the following additional elements in the written order:

(a) For accessories or supplies that will be provided on a periodic basis:

Commented [JK6]: HCPCS code alone, without description or item, is not adequate as the nurse reviewer needs the description to review and the physician needs to review the detailed description to personally attest to the equipment being provided.

Commented [JK7]: We need this to determine coverage based on the Prioritized List of Health Services.

Commented [JK8]: Medicare has discontinued use of CMNs

(A) Quantity used;

(B) Specific frequency of change or use. “As needed” or “prn” orders are not acceptable;

(C) Number of units;

(D) Length of need. For example, an order for surgical dressings might specify one “4 x 4” hydrocolloid dressing that is changed one to two times per week for one month or until the ulcer heals.

(b) For orthoses, if a custom-fabricated orthosis is ordered by the practitioner, this must be clearly indicated on the written order;

(c) Length of need:

(A) If the coverage criteria in a rule specifies length of need; or

(B) If the order is for a rule item.

(d) Any other medical documentation required by rule.

(~~12~~11) Repairs, labor for repairs, parts for durable medical equipment (DME) repairs, and replacement parts for DME (e.g., batteries) do not require a written order.

(~~13~~12) A new order is required:

(a) When required by Medicare for a Medicare covered service;

(b) When there is a change in the original order for an item (e.g., quantity);

(c) When an item is permanently replaced;

(d) When indicated by the prescribing practitioner:

(A) A new order is required when an item is being replaced because the item is worn, or the client’s condition has changed;

(B) The provider’s records ~~should also~~shall include client-specific information regarding the need for the replacement item;

(C) This information ~~should~~ shall be maintained in the provider’s files and be available to the Division upon request;

(D) A new order is required before replacing lost, stolen, or irreparably damaged items to reaffirm the medical appropriateness of the item. Proof of loss or damage through documentation

Commented [JK9]: No longer required by Medicare but we need this information to monitor appropriate utilization and billing. For example, Incontinence supplies not covered by Medicare require more info to manage

Commented [JK10]: No longer required by Medicare however length of need is necessary and required for Medicaid to monitor appropriate utilization and billing.

such as police report, pictures, and corroborating statement shall be maintained by the DME supplier and made available upon request by the Division;

(e) When there is a change in a DMEPOS provider or in cases where two or more providers merge, the recipient provider ~~should~~ shall make all reasonable attempts to secure copies of all ~~active CMN's and~~ written orders from the transferring provider. This document ~~should~~ shall be kept on file by the recipient provider and made available upon request by the Division;

(f) On a regular ~~or specific~~ basis (even if there is no change in the order) ~~only if~~ when it is so specified in the documentation section of a particular rule.

Commented [JK11]:

(~~14~~13) A provider shall maintain and provide legible copies of facsimile images and electronic transmissions of orders.

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 12-2018, amend filed 03/07/2018, effective 03/08/2018
DMAP 36-2017(Temp), f. 9-14-17, cert. ef. 9-15-17 thru 3-13-18
DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 36-2003, f. & cert. ef. 5-1-03
OMAP 72-2002(Temp), f. & cert. ef. 12-24-02 thru 5-15-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
HR 17-1996, f. & cert. ef. 8-1-96
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 32-1992, f. & cert. ef. 10-1-92
HR 13-1991, f. & cert. ef. 3-1-91, Renumbered from 461-024-0004
AFS 48-1989, f. & cert. ef. 8-24-89
AFS 49-1987, f. 10-16-87, ef. 11-1-87
AFS 20-1983, f. 5-5-83, ef. 6-1-83
AFS 52-1982, f. & ef. 5-1-82
AFS 41-1982, f. & ef. 4-29-82

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

(1) For clients under the age of 21: 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 cannot 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 ~~the~~ criteria in ~~this~~ these rules, including all of the following conditions. The item:

(a) Is approved for marketing and registered or listed as a medical device by the Food and Drug Administration (FDA), when FDA approval is required, and is otherwise generally considered to be safe and effective for the intended purpose. In the event of delay in FDA approval and registration, the Division shall review purchase options on a case-by-case basis;

(b) Is ~~reasonable and~~ medically appropriate and medically necessary for the client, as defined in OAR 410-120-0000;

(c) Meets definition of durable medical equipment, prosthetics, orthotics and medical supplies as defined in OAR 410-120-0000 and 410-122-0010; ~~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 can withstand repeated use and can be reusable or removable;~~

(~~g~~d) Meets the coverage criteria as specified in this division and subject to service limitations of the Division rules;

(~~h~~e) 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) ~~found in OAR 410-141-0520 and not otherwise excluded under OAR 410-141-0500~~;

(~~i~~f) Is included in the Oregon Health Plan (OHP) client's benefit package of covered services; ~~and~~

(~~j~~g) Is the least costly, medically appropriate item that meets the medical needs of the client.~~;~~

Commented [JK12]: This is required for class II devices for safety reasons. It is necessary and required by federal regs to protect clients and to ensure the equipment has met all safety standards.
Do we need additional language to support that items such as car seats, that are not FDA approved, may be covered for children under age 21? Must meet EPSDT criteria so must have a billable code.

Commented [JK13]: Not necessary to state def of DME again here. This is the definition of DME and so reviewers should be using the definition in OAR 410-122-0010

(~~i~~h) ~~A client's~~Must be reviewed by a practitioner annually to ensure continued need;

(i) Coverage is not restricted to items covered by the Medicare program.

(2) 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, standing frames). Prior authorization criteria for these services/items must still be met.

(3) 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 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~~third-party resource.

(4) 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.

Commented [JK14]: This is required by 42 CFR 440.70

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Commented [JK15]: Need leadership and DOJ input on this

(5) DMEPOS providers shall have documentation on file that supports coverage criteria are met.

(6) 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.

(7) Documentation described in sections (4), (5), and (6) above shall be made available to the Division upon request.

~~(8) To identify non-covered items at a code level, providers can refer to the Division fee schedule, subject to the limitation that fee schedules and codes do not determine coverage and are solely provided as a mechanism to facilitate payment for covered services and supplies consistent with OAR 410-122-0186. If an item or supply is not covered for an OHP client in accordance with these rules, there is no basis for payment regardless of whether there is a code for the item or supply on the fee schedule.~~ 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.

(9) Some benefit packages do not cover equipment and supplies (see OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System).

(10) 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.

(11) Equipment purchased by the Division for a client becomes the property of the client.

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

(13) A provider who supplies rented equipment shall continue furnishing the same item throughout the entire rental period, except under documented reasonable circumstances.

(14) Before renting, providers must consider purchase for long-term requirements.

(15) 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.

(16) 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.

(17) 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.

(18) 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.

(19) 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.

(20) ~~A request may be made~~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:

Commented [JK16]: To ensure the fee schedule is not used to deny coverage

(a) The DME supplier ~~client's physician~~ must submit clinical documentation from the prescribing practitioner that is ~~sufficient~~ client-specific ~~information~~ and ~~clinical documentation to the Division that~~ demonstrates there is no equally effective, less costly covered item or service that meets the client's medical needs;

(b) The client's ~~physician~~ 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) In no case may a requested service or item for a client age 21 and older be approved unless it is medically appropriate and medically necessary as defined in OAR 410-120-0000 ~~and 410-141-0000~~ and meets all requirements of this rule;

(d) In no case may a requested service or item for a client under the age of 21 be approved unless it is medically appropriate and medically necessary as defined in EPSDT rules found at OAR 410-xxx-xxxx.

(~~d~~e) 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).

(21) 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
History:
DMAP 12-2018, amend filed 03/07/2018, effective 03/08/2018
DMAP 36-2017(Temp), f. 9-14-17, cert. ef. 9-15-17 thru 3-13-18
DMAP 87-2014, f. 12-31-14, cert. ef. 1-1-15
DMAP 3-2011, f. 3-23-11, cert. ef. 3-25-11
DMAP 29-2010(Temp), f. & cert. ef. 10-13-10 thru 3-25-11
DMAP 28-2010(Temp), f. & cert. ef. 10-7-10 thru 3-25-11
DMAP 26-2010(Temp), f. 9-24-10, cert. ef. 10-1-10 thru 3-25-11
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 46-2004, f. 7-22-04, cert. ef. 8-1-04
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 26-1994, f. & cert. ef. 7-1-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 10-1992, f. & cert. ef. 4-1-92
HR 6-1991, f. & cert. ef. 1-18-91, Renumbered from 461-024-0020
HR 24-1990(Temp), f. & cert. ef. 7-27-90
AFS 48-1989, f. & cert. ef. 8-24-89
AFS 6-1989(Temp), f. 2-9-89, cert. ef. 3-1-89
AFS 3-1982, f. 1-20-82, ef. 2-1-82

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

(1) For initial ordering of DME items identified in section (5) of this rule, 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 months prior to the start of services.~~:~~

(~~a~~2) Telehealth encounters used to satisfy the face-to-face encounter requirement for a DMEPOS item must meet the requirements of 42 CFR 410.78 and 414.65.

(~~a~~3) The face-to-face encounter shall be conducted and documented by ~~the treating physician (MD or DO) or an authorized non-physician practitioner (NPP)~~one of the following practitioners:~~;~~

(~~b~~a) ~~Authorized non-physician practitioners (NPP) for medical equipment and supplies are nurse practitioners, clinical nurse specialists working in collaboration with a physician, or physician assistants under the supervision of a physician~~A physician;

(~~c~~b) ~~The physician or NPP conducting the face-to-face encounter shall document that the client was evaluated or treated for a condition that supports the need for the DME item ordered within six months prior to completing the written order for the equipment;~~A nurse practitioner or clinical nurse specialist, as authorized by State law;

(~~d~~c) ~~If the NPP performing the face-to-face encounter does not have prescribing authority, the NPP shall communicate the clinical findings to the ordering physician~~A physician assistant, 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;

(e2) The ~~ordering physician~~ practitioner responsible for ordering the services must document the face-to-face encounter ~~shall~~ 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~~incorporate the clinical findings into a written or electronic document included in the client's medical record;~~.

(~~2~~3) 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.

(3) The DME supplier shall maintain and provide documentation of the qualifying face-to-face encounter, written order/prescription, and ~~provide~~ the supporting ~~the~~ documentation when the item requires prior authorization or at the Division's request.

(4) 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.

(~~4~~5) The DME supplier shall have documentation on file that supports all coverage criteria in the DMEPOS rules are met.

(~~5~~6) The table at ~~https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/DME_List_of_Specified_Covered_Items_updated_March_26_2015.pdf~~ 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.

Formatted: Font: (Default) Times New Roman, 12 pt

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 12-2018, adopt filed 03/07/2018, effective 03/08/2018
DMAP 36-2017(Temp), f. 9-14-17, cert. ef. 9-15-17 thru 3-13-18

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 HCPCS code will be reviewed by the ~~Division of Medical Assistance Programs~~ Division~~(Division)~~ on a ~~case~~ case-~~by~~ by-case basis to ensure rule 410-122-0080 is appropriately applied to item billed.

(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 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 lists ~~all of~~ 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 www.oregon.gov/OHA/HSD/OHP/Pages/Fee-Schedule.aspx.

(9) CMS updates permanent national codes annually on January 1st.

(10) CMS may add, change, or delete temporary national codes on a quarterly basis.

(11) The Medicare Pricing, Data Analysis and Coding (PDAC) contractor is responsible for assisting DMEPOS providers and manufacturers in determining which HCPCS code ~~should~~ shall be used to describe DMEPOS items.

[Publications: Publications referenced are available from the agency.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 413.042 & 414.065
History:
DMAP 39-2018, minor correction filed 05/25/2018, effective 05/25/2018
DMAP 3-2011, f. 3-23-11, cert. ef. 3-25-11
DMAP 26-2010(Temp), f. 9-24-10, cert. ef. 10-1-10 thru 3-25-11

Commented [JK17]: Check with leadership – how often is the fee schedule updated? Should this say MMIS reference rather than fee schedule?

Commented [JK18]: Add language here as well about not all codes have to be on fee schedule to be considered for coverage?

DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 63-2001, f. 12-28-01, cert. ef. 1-1-02
OMAP 54-2001(Temp), f. 10-31-01, cert. ef. 11-1-01 thru 4-15-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 26-1999, f. & cert. ef. 6-4-99
OMAP 12-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 26-1994, f. & cert. ef. 7-1-94
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91, Renumbered from 410-122-0100
HR 7-1990, f. 3-30-89, cert. ef. 4-1-89, Renumbered from 461-024-0200
AFS 48-1989, f. & cert. ef. 8-24-89
AFS 6-1989(Temp), f. 2-9-89, cert. ef. 3-1-89

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) 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) Payment for repairs is not covered when:

(i) The skill of a technician is not required;

(ii) The equipment has been previously denied;

Commented [JK19]: Recommendation to change this to allow non-skilled individuals to do the work and be reimbursed for it, to assist with needed repairs. See comment below

(iii) Equipment is being rented, including separately itemized charges for repair;

(iv) Equipment, parts ~~Parts~~ and labor are covered under a manufacturer's or supplier's warranty.

(D) 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 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.

(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 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 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;

Commented [JK20]: These services differ depending on the equipment – so, for example, routine servicing and maintenance of a CPAP will include cleaning the mask and machine with warm water. Maintenance that must be performed by authorized technicians is covered as a repair. This is to ensure safety of the individual.
Note: Repairs done by individuals not authorized and trained to do so will void manufacturer's warranty.
In addition, most equipment that requires frequent and substantial servicing (i.e., oxygen concentrators) is paid as a rental only and then maintained by the DME supplier. There is no current mechanism to pay unskilled, untrained individuals. Only enrolled DME suppliers can bill the K0739 code for repairs. There are no HCPCS codes that can be billed for routine servicing and maintenance as these are included in the rate paid for the device.

Commented [JK21]: Ask RAC for recommended language. Add language regarding growing out of wc

(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.

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 years;

(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 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.

(~~D~~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.

(~~C~~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 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;

(~~D~~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 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;

(~~E~~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.

Commented [JK22]: Per PDAC – when a manufacturer applies for a HCPCS code for their product, they must attest that the product will meet the 5-year reasonable useful lifetime. If the manufacturer answers no to this question, then their product is not given a HCPCS code.
Under federal Medicare regulations, DME suppliers must replace the equipment at no charge to Medicare or the beneficiary if the equipment doesn't last the entire 5-year reasonable useful lifetime. They will cover repairs.

By definition, durable medical equipment is intended to be durable.

(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 may only take place no sooner than approximately ~~seven~~ fourteen calendar days prior to the delivery/shipping date;

(C) For subsequent deliveries of refills, the provider ~~may~~ shall deliver the DMEPOS product no sooner than ~~approximately fifteen~~ ten 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-month quantity of supplies at a time. This three-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:

(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 ~~CMN or physician's~~ practitioner's order is not required;

(b) Submit the following documentation with the prior authorization 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 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 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 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 may 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 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:

(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;

(d) K0462 – Temporary replacement for client-owned equipment being repaired, any type~~– Prior authorization (PA) required – PA~~.

Commented [JK23]: Recommend removing PA to make provision of loaners during repairs more accessible and prevent delays in repairs.

Statutory/Other Authority: ORS 413.042~~, &~~ ORS 414.065, ORS 646A.460 to 646A.476
Statutes/Other Implemented: ORS 414.065
History:
DMAP 12-2018, amend filed 03/07/2018, effective 03/08/2018
DMAP 36-2017(Temp), f. 9-14-17, cert. ef. 9-15-17 thru 3-13-18
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0186
Payment Methodology

(1) The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ utilizes a payment methodology for covered durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) that is generally based on the 2012 Medicare fee schedule:

(a) The Division fee schedule amount is 82.6 percent of 2012 Medicare Fee Schedule for items covered by Medicare and the Division, except for:

(A) Ostomy supplies fee schedule amounts are 93.3 percent of 2012 Medicare Fee Schedule (See Table 122-0186-1 for list of Ostomy codes subject to this pricing); and

(B) Prosthetic and Orthotic fee schedule amounts (L-codes) are 82.6 percent of 2012 Medicare Fee Schedule; and

(C) Complex Rehabilitation items and services other than power wheelchairs, fee schedule amounts are 88 percent of 2012 Medicare Fee Schedule (See Table 122-0186-2 for list of Complex Rehabilitation codes subject to this pricing); and

(D) Group 1 power wheelchairs (K0813-K0816) and Group 2 power wheelchairs with no added power option (K0820-K0829) fee schedule amounts are 55 percent of 2012 Medicare Fee Schedule;

(E) Group 3 power wheelchairs (K0835-K0864) fee schedule amounts are 58.7 percent of 2012 Medicare Fee Schedule;

(b) For items that are not covered by Medicare but covered by the Division, the fee schedule amount shall be 99 percent of the Division's published rate effective 7/31/11;

(c) For new codes added by the Center for Medicare and Medicaid Services (CMS), payment shall be based on the most current Medicare fee schedule and shall follow the same payment methodology as stated in section (1)(a)(A-E) of this rule. New codes that do not appear on the current Medicare fee schedule shall be manually priced as indicated in section (4)(a-c) of this rule.

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

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

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

(c) The actual charge submitted.

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

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

(a) Seventy-five percent of manufacturer's suggested retail price (MSRP) verifiable with quote~~, invoice, or bill~~ from the manufacturer that clearly states the amount indicated is MSRP; or

(b) If MSRP is not available, ~~then~~ reimbursement shall be acquisition cost plus ~~20~~ twenty percent, verifiable with quote, invoice, or bill from the manufacturer that clearly states the amount indicated is provider's actual acquisition cost; ~~or~~

~~(c) Actual charge submitted by the provider.~~

Commented [JK24]: MMIS will automatically pay this amount if it is lower than the amount approved.

(5) Reimbursement on miscellaneous codes E1399 and K0108 shall be capped at $3,200.

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

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

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

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

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

Commented [JK25]: Specifically spelled out in rules like standing frames and rehab shower chairs where PDAC verification is not required

Commented [JK26]: The intent is to allow billing misc codes for standing frame accessories and rehab shower chairs and accessories as these do not have assigned HCPCS codes.

(8) The Division may review items that exceed the maximum allowable or cap on a case-by-case basis and may ask the provider to submit the following documentation for reimbursement:

(a) Documentation which supports that the client meets all of the coverage criteria for the less costly alternative; and,

(b) A comprehensive evaluation by a licensed clinician (who is not an employee of or otherwise paid by a provider) that clearly explains why the less costly alternative is not sufficient to meet the client's medical needs, and;

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

(d) The expected outcome or change in the client's condition.

(9) PA is not required for codes A4649, E1399, and K0108 when the cost is $150.00 or less per each unit:

(a) Only items that have received an official product review coding decision from an organization such as PDAC with codes A4649, E1399, or K0108 shall be billed to the Division unless otherwise stated in these rules. These products may be listed in the PDAC Durable Medical Equipment Coding System Guide (DMECS) DMEPOS Product Classification Lists;

Commented [JK27]: Will specify in standing frame and rehab shower chair rules

(b) Subject to service limitations of the Division's rules;

(c) The amount billed to the Division may not exceed 75 percent of MSRP. The provider must retain documentation of the quote, invoice~~,~~ or bill to allow the Division to verify through audit procedures.

(10) For rented equipment, the equipment is considered paid for and owned by the client when the Division fee schedule allowable is met or the actual charge from the provider is met, whichever is lowest. The provider must transfer title of the equipment to the client.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 3-2016, f. & cert. ef. 2-3-16
DMAP 44-2014, f. & cert. ef. 7-11-14
DMAP 2-2014(Temp), f. 1-15-14, cert. ef. 2-1-14 thru 7-31-14
DMAP 57-2012, f. & cert. ef 12-27-12
DMAP 31-2012(Temp), f. 6-29-12, cert. ef. 7-1-12 thru 12-27-12
DMAP 42-2011, f. 12-21-11, cert. ef. 1-1-12
DMAP 22-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-25-12
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04

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 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 ~~physician~~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 periodically re-assess the need for long-term oxygen in the home;

(F) Infants with chronic lung disease (e.g., bronchopulmonary dysplasia);

(G) Premature infants on active therapy for apnea;

(H) When a client exhibits a certain unstable illness and has compromised or potentially compromised respiratory status;

(I) 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 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; and

(ii) A follow-up home visit 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 ~~physician~~practitioner; and

(ii) 24-hour/7 day a week respiratory therapist on-call availability for troubleshooting, exchanging of malfunctioning equipment, etc.;

(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 probes for a client-owned covered oximeter:

(A) The Division will 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).

Commented [JK28]: Talk to MMC about removal of this.

(2) Documentation Requirements:

(a) Submit the following documentation for prior authorization (PA) review:

(A) An order from the treating ~~physician~~ 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 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:

~~(A) PA required;~~

~~(B) The Division will purchase;~~

Commented [JK29]: If Oximeter approved there is no need to PA probes with quantity limits in system

(b) E0445 — Oximeter device for measuring blood oxygen levels non-invasively:

(A) PA 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 months of rent;

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

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09
OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00
OMAP 32-1999, f. & cert. ef. 10-1-99
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98

HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 26-1994, f. & cert. ef. 7-1-94
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 32-1992, f. & cert. ef. 10-1-92
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91

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

(1) The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ may cover a positive airway pressure (PAP) device for treatment of obstructive sleep apnea (OSA) when:

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(a) The client has a face-to-face clinical evaluation by the treating ~~physician~~ practitioner prior to a sleep test to assess the client for obstructive sleep apnea; and

(b) The client has 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 daytime sleepiness as documented by a score of greater than 10 on the Epworth Sleepiness Scale or daytime 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.

(c) 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.

(2) 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-month trial (rental) period for PAP devices is required to determine benefit and ongoing coverage of the device;

(c) Rental charges apply toward purchase.

(3) Respiratory Assist devices:

(a) A respiratory assist device (RAD) without backup rate (E0470) may be covered for clients with OSA when:

(A) Criteria in (1)(a)–(c) of this rule are met, and

(B) A CPAP/APAP device (E0601) has been tried and proven ineffective. 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) If a CPAP/APAP device is tried and found ineffective during the initial facility-based titration or three-month home trial, substitution of a RAD does not require a new face-to-face clinical evaluation or sleep test;

(c) If a CPAP/APAP device has been used for more than three months and the client is switched to a RAD, a clinical re-evaluation must occur, but a new sleep test is not required. A new three-month trial would 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 rate (E0471) is not medically indicated for the treatment of obstructive sleep apnea.

(4) 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 by the appropriate authorizing unit.

(5) Continued Coverage of PAP device:

(a) Ongoing rental of a PAP device (E0470 or E0601) 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 three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating

therapy, the treating practitioner shall conduct a face-to-face clinical re-evaluation and document that the client is benefiting from PAP therapy;

(c) If the clinical re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the client is benefiting from PAP therapy as defined in criteria, continued coverage of the PAP device will commence with the date of that re-evaluation;

(d) If a CPAP/APAP has been used more than three months and the client is switched to a RAD, then the clinical re-evaluation shall occur between the 31st and 91st day following initiation 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. 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;

(b) Accessories are separately reimbursable at the time of initial issue and when 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 ~~amount~~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) Payment Authorization:

(a) From the initial date of service through the second date of service, prior authorization (PA) is not required for PAP device rental and related accessories. The provider is responsible to ensure all rule requirements are met;

(b) Payment authorization (i.e., a payment authorization number for billing) is required prior to submitting claims and will be given once all required documentation has been received and any other applicable 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 starting with the third date of service require PA;

(e) 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;

(f) It is the provider's responsibility to monitor appropriate and effective use of the device as ordered by the treating practitioner. When the equipment is not being used as prescribed, the provider shall stop billing for the equipment and related accessories and supplies.

(8) Guidelines:

(a) Polysomnography is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with ~~physician~~ 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 ~~physician~~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.

(~~g~~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~~h) 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;

(~~i~~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;

(~~j~~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;

(~~k~~l) If the AHI or RDI is calculated based on less than two hours of ~~continuous recorded~~ 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);

(~~l~~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)(~~a~~b) that supports a diagnosis of OSA, if available.

(10) Table 122-0202 — PAP Devices.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 81-2014, f. 12-23-14, cert. ef. 1-1-15
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 11-2009, f. & cert. ef. 6-1-09
DMAP 44-2008(Temp), f. 12-17-08, cert. ef. 1-1-09 thru 6-15-09
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05
OMAP 76-2004, f. 9-30-04, cert. ef. 10-1-04
OMAP 46-2004, f. 7-22-04, cert. ef. 8-1-04
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00

410-122-0203
Oxygen and Oxygen Equipment

~~Unless stated otherwise within this rule, this rule is retroactive and applies to services rendered on or after January 1, 2009. Prior authorization (PA) requirements referenced in Table 122-0203-2 are effective January 1, 2010.~~

(1) Indications and limitations of coverage and medical appropriateness: ~~the~~The Division may cover home oxygen therapy services. Refer to Table 122-0203-1 and the following guidelines:

(a) For children under age ~~19~~ 21 when the treating practitioner has determined oxygen services to be medically appropriate; or

Commented [JK30]: Age defined in EPSDT

(b) For adults age ~~19~~ 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 of Medical Assistance Programs~~ Division ~~(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 will not provide reimbursement in accordance with Medicare rules and regulations;

(C) Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplemental Information for additional details on Medicare's reimbursement limitation of 36 monthly rental payments;

(c) For adults ~~19~~ 21 years of age and older who are not eligible for Medicare (only eligible for Medicaid/OHP), PA is required ~~effective January 1, 2010~~ and all of the following conditions must be met:

(A) The treating practitioner has ~~determined that the client has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy~~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 ~~physician~~ treating practitioner or by a qualified provider or supplier of laboratory services; and

(D) The provision of oxygen and oxygen equipment will improve the client's condition.

~~(D) The qualifying blood gas study was obtained under the following conditions:~~

~~(i) If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to the hospital discharge date; or~~

~~(ii) If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the client is in a chronic stable state — i.e., not during a period of acute illness or an exacerbation of their underlying disease;~~

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

~~(d) Group I coverage duration and indications:~~

~~(A) Initial coverage for clients meeting Group I criteria is limited to 12 months or the practitioner-specified length of need, whichever is shorter. See information on recertification in section 3(g) and (6);~~

(~~B~~d) Group I criteria include any of the following:

(~~i~~A) An arterial partial pressure of oxygen (PO2) at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake) while breathing room air; or

(~~ii~~B) An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during sleep for a client who demonstrates an arterial PO2 at or above 56 mm Hg ~~for at least 5 minutes taken during sleep for a client who demonstrates an arterial PO2 at or above 56 mm Hg~~ or an arterial oxygen saturation at or above 89 percent while awake. In this instance, oxygen and oxygen equipment is only necessary during sleep; or

(~~iii~~C) A decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent from baseline saturation, ~~for at least five minutes~~ taken during sleep and associated with symptoms of hypoxemia such as ~~(e.g.,~~ impairment of cognitive processes and ~~[~~nocturnal restlessness or insomnia~~])~~ (not all-inclusive).~~or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia~~In this instance, oxygen and oxygen equipment is only necessary during sleep; or

(~~iv~~D) An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a client who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this ~~case~~instance, portable oxygen and oxygen equipment is only necessary while awake and during exercise~~is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air~~;

(e) Group II ~~coverage duration and indications~~criteria include any of the following:

~~(A) Initial coverage for clients meeting Group II criteria is limited to three months or the practitioner-specified length of need, whichever is shorter. See information on recertification in section 3(g) and (6);~~

(~~B~~A) ~~Group II criteria include the presence of an~~An arterial PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent; and any of the following: ~~at rest (awake), during sleep for at least five minutes, or during exercise (as described under Group I criteria) and any of the following:~~

(i) Dependent edema suggesting congestive heart failure; or

(ii) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure; gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or

(iii) Erythrocythemia with a hematocrit greater than 56 percent;

(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:~~indications include a presumption of non-coverage. Criteria include arterial PO2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent;~~

(i) Absence of hypoxemia defined in Group I and Group II above, and

(ii) A medical condition with distinct physiologic, cognitive, and/or functional symptoms documented in high-quality, peer-reviewed literature to be improved by oxygen therapy, such as cluster headaches (not all-inclusive);

(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) 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 will determine coverage;

(j) Oxygen therapy and related services, equipment or supplies are not ~~covered~~ 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 will improve the oxygenation of tissues with impaired circulation;

(D) Terminal illnesses that do not affect the ~~respiratory system~~ability to breathe;

~~(E) Group III clients~~;

Commented [JK31]: look at Medicare policy article for information related to documentation requirements for continued coverage.

Commented [JK32]: Check medicare rules?

Commented [JK33]: If there is no evidence to support that increased PO2 will improve any of these conditions in the absence of hypoxema, then I believe we can leave this in rule by adding that it would not be medically appropriate or medically necessary.
Consider stating O2 is “generally” not covered for this conditions but could be considered on a case-by-case basis with client specific clinical documentation to support that it is medically necessary and medically appropriate for the individual. Discuss with Medical Director.

(~~F~~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;

(~~G~~F) Topical hyperbaric oxygen chambers (A4575);

(~~H~~G) When furnished by an airline (responsibility of the client);

(I) When provided/used outside the United States and its territories.

(2) Testing Specifications:

(a) The term blood gas study in this policy refers to ~~either an~~both arterial blood gas (ABG) studies and ~~test or an~~ pulse oximetry ~~test~~:

(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 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) ~~The test~~All oxygen qualification testing must be performed by a qualified practitioner or other medical professional qualified to conduct oximetry~~by a qualified provider (a laboratory, a physician, etc.)~~:

(A) A DMEPOS provider is not considered a qualified provider or a qualified laboratory for purposes of this policy;

(B) Division will 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 ~~oxygen~~ oximetry study obtained during exercise, there must be documentation of three ~~oxygen~~ oximetry studies performed within the same testing session in the client's medical record ~~is required~~:

(A) Testing at rest without oxygen;

Commented [JK34]: I believe this is in General Rules as well. I believe that there was a time when you couldn't take O2 equipment on a plane or it had to be stored. I believe now if client is on O2 they can take their O2 equipment with them and use it while on the plane. So we may not need this in rule any longer.

Commented [JK35]: I believe this is in General Rules as well. Check this.

(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;

(ef) Only the qualifying test value (i.e., testing during exercise without oxygen) is ~~reported on the Certificate of Medical Necessity (CMN). The other results do not have to be routinely submitted but must be available on request~~used for qualification. All three tests must be available upon request by the Division;

(~~f~~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) Certification:

~~(a) A completed and signed CMN is required to receive payment for oxygen;~~

(~~b~~a) The blood gas study must be the most recent study obtained within 30 days prior to the initial date~~, indicated in Section A of the CMN~~;

(~~c~~b) There is an exception to the 30-day test requirement for clients who were started on oxygen while enrolled in a ~~Division health maintenance organization (HMO)~~Coordinated Care Organization (CCO) and transition to fee-for-service. For those clients, the blood gas study does not have to be obtained 30 days prior to the Initial Date, but must be the most recent qualifying test obtained while in the ~~HMO~~CCO;

(d) The client must be seen and evaluated by the treating practitioner within 30 days prior to the date of Initial Certification;

(e) Initial CMN is required for any of the following situations:

(A) With the first claim to the Division for home oxygen, (even if the client was on oxygen prior to becoming eligible for Division coverage;

(B) When there has been a change in the client's condition that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended;

(C) When an initial CMN does not meet coverage criteria and the client was subsequently retested and meets coverage criteria;

(D) When a Group I client with a length of need less than or equal to 12 months was not retested prior to a revised certification/recertification, but a qualifying study was subsequently performed;

(E) When the client initially qualified in Group II, repeat blood gas studies were not performed between the 61st and 90th day of coverage, but a qualifying study was subsequently performed;

(F) When there was a change of DMEPOS provider due to an acquisition and the previous provider did not file a recertification when it was due and the requirements for the recertification were not met when it was due;

(G) When the equipment is replaced in the following situations:

(i) The reasonable useful lifetime of prior equipment has been reached; or

(ii) Irreparable damage, theft or loss of the originally dispensed equipment:

(I) Irreparable damage refers to a specific accident or a natural disaster (e.g., fire, flood); and

(II) Irreparable damage does not refer to wear and tear over time;

(f) For initial CMN of replacement equipment described in (3)(e)(G):

(A) Repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN;

(B) There is no requirement for a practitioner visit that is specifically related to the completion of the CMN for replacement equipment;

(g) Recertification CMN is required in the following situations:

(A) Group I — 12 months after initial certification (i.e., with the thirteenth month's claim);

(B) Group II — 3 months after initial certification (i.e., with the fourth month's claim);

(C) Recertification following initial certification done in section (3)(e)(A & B):

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

(ii) For clients initially meeting Group II criteria, the most recent blood gas study that was performed between the 61st and 90th day following initial certification must be reported on the recertification CMN. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy but the client continues to use oxygen and a test is obtained at a later date, if that test meets Group I or II criteria, coverage would resume beginning with the date of that test;

(iii) For clients initially meeting Group I or II criteria, the client must be seen and re-evaluated by the treating practitioner within 90 days prior to the date of any recertification. If the practitioner visit is not obtained within the 90-day window but the client continues to use oxygen

and the visit is obtained at a later date, coverage would resume beginning with the date of that visit;

(h) Recertification following replacement equipment described in (3)(e)(G):

(A) Repeat testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN;

(B) There is no requirement for a practitioner visit that is specifically related to the completion of the CMN for replacement equipment;

(i) The DMEPOS provider must submit a revised CMN in the following circumstances. The Division does not require a practitioner visit in these situations. Submission of a revised CMN does not change the recertification schedule specified elsewhere:

(A) When the prescribed maximum flow rate changes from one of the following categories to another. In this situation, the blood gas study must be the most recent study obtained within 30 days prior to the initial date:

(i) Less than 1 liter per minute (LPM);

(ii) 1-4 LPM;

(iii) Greater than 4 LPM;

(B) If the change is from less than 1 LPM or 1-4 LPM to greater than 4 LPM, a repeat blood gas study with the client on 4 LPM must be performed within 30 days prior to the start of the greater than 4 LPM flow. In this situation, the blood gas study must be the most recent study obtained within 30 days prior to the initial date;

(C) When the length of need expires — if the practitioner-specified less than lifetime length of need on the most recent CMN. In this situation, the blood gas study must be the most recent study obtained within 30 days prior to the initial date;

(D) When a portable oxygen system is added subsequent to initial certification of a stationary system. In this situation, the Division does not require a repeat blood gas study unless the initial qualifying study was performed during sleep, in which case a repeat study must be performed while the client is awake or during exercise (within 30 days of revised date);

(E) When a stationary system is added subsequent to initial certification of a portable system. In this situation, the Division does not require a repeat blood gas study. A revised CMN does not need to be submitted with claims but must be kept on file by DMEPOS provider;

(F) When there is a new treating practitioner but the oxygen order is the same. In this situation, the Division does not require a repeat blood gas study. The revised certification does not have to be submitted with the claim;

(G) If there is a new DMEPOS provider and that provider does not have the prior CMN. In this situation, the Division does not a repeat blood gas study. The revised certification does not have to be submitted with the claim;

(H) If the indications for a revised CMN are met at the same time that a recertification CMN is due, file the CMN as a recertification CMN.

Commented [JK36]: Will complete review of oxygen rule before RAC

(4) Portable Oxygen Systems:

(a) A portable oxygen system may be covered if the client is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen is not covered;

(b) If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system. See exception in (5) 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 4 LPM:

(a) The Division will pay a higher allowance for a stationary system for a flow rate of greater than 4 LPM only when:

(A) Basic oxygen coverage criteria have been met; and

(B) A blood gas study performed while the client is on 4 LPM meets Group I or II criteria;

(b) Payment is limited to the standard fee schedule allowance if a flow rate greater than 4 LPM is billed and the coverage criteria for the higher allowance are not met;

(c) If a client qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen:

(A) The Division will pay for either the stationary system (at the higher allowance) or the portable system (at the standard fee schedule allowance for a portable system), but not both;

(B) In this situation, if both a stationary system and a portable system are requested for the same rental month, the Division will not cover the portable oxygen system.

(6) Documentation Requirements: The DMEPOS provider must submit documentation which supports conditions of coverage as specified in this rule are met:

(a) A CMN which has been completed, signed, and dated by the treating practitioner:

(A) The CMN may act as a substitute for a written order if it is sufficiently detailed;

(B) The CMN for home oxygen is CMS Form 484 (DME form 484.03). Section B (order information), must be completed by the ~~physician or the~~ practitioner, not the DMEPOS provider. The DMEPOS provider may use Section C for a written confirmation of other details of the oxygen order, or the 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;

(C) The ABG PO2 must be reported on the CMN if both an arterial blood gas and oximetry test were performed on the same day under the condition reported on the CMN (i.e., at rest/awake, during exercise, or during sleep);

(D) A report of the sleep study documenting the qualifying desaturation for clients who qualify for oxygen based only on a sleep oximetry study. The oxygen saturation value reported in question 1b of the Oxygen CMN must be the lowest value (not related to artifact) during the five minute qualifying period reported on the sleep oximetry study;

(b) The 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;

(c) The following special instructions apply to replacement equipment for those situations described in (3)(e)(G):

(A) Initial date ~~should~~ shall 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) The recertification date ~~should~~ shall be 12 months following the initial date when the value on the initial CMN (for the replacement equipment) meets Group I criteria or 3 months following the initial date when the qualifying blood gas value on the initial CMN meets the Group II criteria (Note: The initial date ~~should~~ shall also be entered on the recertification CMN.);

(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;

(d) In the following situations, a new order must be obtained and kept on file by the DMEPOS provider, but neither a new CMN nor a repeat blood gas study are required:

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

(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).

(7) Oxygen contents:

(a) The Division allowance for rented oxygen systems includes oxygen contents;

(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 separately payable only when they are used with a client-owned system that was purchased prior to June 1, 1989. The Division does not cover accessories used with a client-owned system that was purchased on or after June 1, 1989.

(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 month rental. Do not report in cubic feet or pounds;

(c) Use the appropriate modifier if the prescribed flow rate is less than 1 LPM (QE) or greater than 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 clients are both using the same concentrator. In this situation, this code must only be requested for one 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 LPM order equivalency;

(g) Contact the PDAC for guidance on the correct coding of these items.

(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.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 40-2009, f. 12-15-09, cert. ef. 1-1-10
DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09
DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 76-2003, f. & cert. ef. 10-1-03
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00

410-122-0204
Nebulizer

Commented [JK37]: Check all codes in this rule

(1) Indications and limitations of coverage and medical appropriateness:

(a) Equipment:

(A) Small volume nebulizer:

(i) A small volume nebulizer (A7003, A7004, A7005) and related compressor (E0570) may be covered to administer inhalation drugs based on evidence-based clinical practice guidelines;

(ii) The ~~physician~~ practitioner shall have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, the MDI was not sufficient for the administration of needed inhalation drugs.

(B) Large volume nebulizer:

(i) A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or saline (A4217 or A7018) may be covered when it is medically appropriate to deliver humidity to a client with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent;

(ii) Combination code E0585 will be covered for the same indications as in (1)(a)(B)(i);

(C) The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ will consider other uses of compressors/generators individually on a case-by-case basis to determine their medical appropriateness, such as a battery powered compressor (E0571);

(b) Accessories:

(A) A large volume pneumatic nebulizer (E0580) and water or saline (A4217 or A7018) are not separately payable and may not be separately billed when used for clients with rented home oxygen equipment;

(B) The Division does not cover use of a large volume nebulizer, related compressor/generator, and water or saline when used predominately to provide room humidification;

(C) A non-disposable unfilled nebulizer (A7017 or E0585) filled with water or saline (A4217 or A7018) by the client or caregiver is an acceptable alternative to the large volume nebulizer when used as indicated in (1)(a)(B)(i) of this rule;

(D) Kits and concentrates for use in cleaning respiratory equipment are not covered;

(E) Accessories are separately payable if the related aerosol compressor and the individual accessories are medically appropriate. The following table lists each covered compressor/generator and its covered accessories. Other compressor/generator/accessory combinations are not covered;

(F) Compressor/Generator (Related Accessories): E0565 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7017, A7525, E1372); E0570 (A7003, A7004, A7005, A7006, A7013, A7015, A7525); E0571 (A7003, A7004, A7005, A7006, A7013, A7015, A7525); E0572 (A7006, A7014); E0585 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7525);

Commented [JK38]: This references billing practices as opposed to coverage – certain equipment can't be billed together per NCCI etc

(G) This array of accessories represents all possible combinations, but it may not be appropriate to bill any or all of them for one device;

(H) Table 122-0204-1 lists the usual maximum frequency of replacement for accessories. The Division will not cover claims for more than the usual maximum replacement amount unless the request has been prior approved by the Division before dispensing. The provider shall submit requests for more than the usual maximum replacement amount to the Division for review.

(2) Coding guidelines:

(a) Accessories:

(A) Code A7003, A7005, and A7006 include the lid, jar, baffles, tubing, T-piece, and mouthpiece. In addition, code A7006 includes a filter;

(B) Code A7004 includes only the lid, jar, and baffles;

(C) Code A7012 describes a device to collect water condensation, which is placed in line with the corrugated tubing, used with a large volume nebulizer;

(D) Code E0585 is used when a heavy-duty aerosol compressor (E0565), durable bottle type large volume nebulizer (A7017), and immersion heater (E1372) are provided at the same time. If all three items are not provided initially, the separate codes for the components would be used for billing;

(E) Code A7017 is billed for a durable, bottle type nebulizer when it is used with an E0572 compressor or a separately billed E0565 compressor;

(F) Code A7017 may not be separately billed when an E0585 system is also being billed. Code E0580 (Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flow meter) describes the same piece of equipment as A7017 but shall only be billed when this type of nebulizer is used with a client-owned oxygen system.

(b) Equipment:

(A) In this policy, the actual equipment (i.e., electrical device) will generally be referred to as a compressor (when nebulization of liquid is achieved by means of air flow). The term nebulizer is generally used for the actual chamber in which the nebulization of liquid occurs and is an accessory to the equipment. The nebulizer is attached to an aerosol compressor in order to achieve a functioning delivery system for aerosol therapy;

(B) Code E0565 describes an aerosol compressor, which can be set for pressures above 30 psi at a flow of 6-8 L/m and is capable of continuous operation;

(C) A nebulizer with compressor (E0570) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It is only AC powered;

(D) A portable compressor (E0571) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It shall have battery or DC power capability and may have an AC power option;

(E) A light duty adjustable pressure compressor (E0572) is a pneumatic aerosol compressor that can be set for pressures above 30 psi at a flow of 6-8 L/m but is capable only of intermittent operation.

(3) Documentation requirements:

(a) When billing for an item in Table 122-0204, medical records shall corroborate that all criteria in this rule are met;

(b) When billing for quantities of supplies greater than those described in Table 122-0204-1 as the usual maximum amounts, there shall be clear documentation in the client's medical records corroborating the medical appropriateness of the current use;

(c) When a battery powered compressor (E0571) is dispensed, supporting documentation that justifies the medical appropriateness shall be on file with the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider;

(d) The DMEPOS provider shall maintain these medical records and make them available to the Division upon request.

(4) Table 122-0204-1.

(5) Table 122-0204-2.

Commented [JK39]: Revise tables? Check codes

[ED. NOTE: Table referenced is available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16
DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00

410-122-0210
Ventilators

(1) Indications and limitations of coverage:

(a) Mechanical ventilatory support may be provided to a client for the purpose of life support during therapeutic support of suboptimal cardiopulmonary function, or therapeutic support of chronic ventilatory failure;

(b) A ventilator may be covered by the Division for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. This includes both positive and negative pressure types;

(c) A ventilator for pediatric home ventilator management may be covered on a case-by-case basis based on medical appropriateness, evidence-based medicine and best health practices.

(2) Primary Ventilators:

(a) A primary ventilator may be covered if supporting documentation indicates:

(A) A client is unable to be weaned from the ventilator or is unable to be weaned from use at night; or

(B) Alternate means of ventilation were used without success; or

(C) A client is ready for discharge and has been on a ventilator more than 10 days;

(b) ~~E0450, E0460, E0461~~E0465, E0466 or E0472 may be covered if:

(A) A client has no respiratory drive either due to paralysis of the diaphragm or a central brain dysfunction; or

(B) A client has a stable, chronic condition with no orders to wean from the ventilator; or

(C) A client has had a trial with blood gases and has no signs or symptoms of shortness of breath or increased work of breathing; or

(D) A client has uncompromised lung disease;

(c) ~~E0463 or E0464~~E0465 or E0466 may be covered if supporting documentation indicates:

(A) A client has chronic lung disease where volume ventilation may further damage lung tissue; or

(B) A client has a compromised airway or musculature and has respiratory drive and a desire to breathe; or

(C) A client will eventually be weaned from the ventilator; or

(D) A client has compromised respiratory muscles from muscular dystrophies or increased resistance from airway anomalies or scoliosis conditions.

(3) Secondary Ventilators:

(a) A secondary ventilator, identical or similar to the primary ventilator, may be covered when necessary to serve a different medical need of a client;

(b) For example (not all-inclusive), a secondary ventilator may be covered when:

(A) A client requires one type of ventilator (e.g., a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g., positive pressure respiratory assist device with a nasal mask) during the rest of the day; or

(B) A client is confined to a wheelchair who requires a ventilator permanently mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed.

(4) Reimbursement Rates:

(a) Reimbursement rates for ventilators are calculated based on consideration that break down or malfunction of a ventilator could result in immediate life-threatening consequences for a client. Therefore, ventilators are reimbursed on a monthly rental payment for as long as the equipment is medically appropriate;

(b) Payment includes:

(A) The durable medical equipment (DME) provider ensuring that an appropriate and acceptable contingency plan to address emergency situations or mechanical failures of the primary ventilator is in place. This could mean that the provider furnishes a backup ventilator;

(B) Any equipment, supplies, services, including respiratory therapy (respiratory care) services, routine maintenance and training necessary for the effective use of the ventilator;

(c) Secondary Ventilators: The maximum reimbursement rate is one-half the maximum allowable fee for the primary ventilator.

(5) The client must have a telephone or reasonable access to one.

(6) A backup ventilator provided as a precautionary measure for emergency situations in which the primary ventilator malfunctions is not separately payable by the Division.

(7) Prior authorization (PA):

(a) PA is not required when ~~E0450, E0460, E0461, E0463, E0464~~E0465, E0466 or E0472 is dispensed as the primary ventilator. The provider is responsible to ensure all rule requirements are met;

(b) PA is required for a secondary ventilator:

(A) Payment authorization is required prior to the second date of service and before submitting claims. See Oregon Administrative Rule (OAR) 410-120-0000 (General Rules);

(B) Payment authorization will be given once all required documentation has been received and any other applicable rules and criteria have been met; and

(C) Payment authorization is obtained from the same authorizing authority as specified in OAR 410-122-0040.

(8) Documentation Requirements:

(a) For services requiring payment authorization or PA, submit documentation that supports coverage criteria in this rule are met;

(b) Documentation that coverage criteria have been met must be present in the client's medical records, kept on file with the DME provider and made available to the Division on request. Table 122-0210

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 76-2004, f. 9-30-04, cert. ef. 10-1-04
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96

HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 32-1992, f. & cert. ef. 10-1-92
HR 10-1992, f. & cert. ef. 4-1-92

410-122-0240
Apnea Monitors for Infants

(1) Indications and limitations of coverage and medical appropriateness:

(a) For infants less than 12 months of age with documented apnea, or who have known risk factors for life-threatening apnea, the Division may cover home apnea monitors and related supplies for any of the following indications:

(A) Up to three months for:

(i) Apnea of prematurity: Sudden cessation of breathing that lasts for at least 20 seconds, is accompanied by bradycardia (heart rate less than 80 beats per minute), or is accompanied by oxygen desaturation (O2 saturation less than 90 percent or cyanosis) in an infant younger than 37 weeks gestational age;

(ii) Apparent life-threatening event (ALTE): An episode that is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking, or gagging;

(iii) Documented gastroesophageal reflux disease (GERD) that results in apnea, bradycardia, or oxygen desaturation;

(iv) Documented prolonged apnea of greater than 20 seconds in duration;

(v) Documented apnea accompanied by bradycardia to less than 80 beats per minute;

(vi) Documented apnea accompanied by oxygen desaturation (below 90 percent), cyanosis, or pallor;

(vii) Documented apnea accompanied by marked hypotonia;

(viii) When off medication for bradycardia previously treated with caffeine, theophylline, or similar agents;

(B) Upon discharge from an acute care facility for up to one month post-diagnosis for diagnosis of pertussis with positive cultures;

(C) As the later sibling of an infant who died of Sudden Infant Death Syndrome (SIDS), until the later sibling is one month older than the age at which the earlier sibling died and remains event-free;

(D) On a case-by-case basis for:

(i) Infants with tracheostomies or anatomic abnormalities that make them vulnerable to airway compromise;

(ii) Infants with neurologic or metabolic disorders affecting respiratory control;

(iii) Infants with chronic lung disease (bronchopulmonary dysplasia), especially those requiring supplemental oxygen, continuous positive airway pressure, or mechanical ventilation;

(b) Infant apnea monitors are usually considered medically appropriate for no longer than approximately three months except for specific conditions listed above;

(c) The rental fee includes all training, instruction, assistance, 24-hour on-call support, and any other needed services for effective use of the apnea monitor, including cardiopulmonary resuscitation training. The durable medical equipment prosthetics orthotics and supplies (DMEPOS) provider is responsible for ensuring delivery of these services;

(d) The Division may cover related supplies necessary for the effective functioning of the apnea monitor for a three-month period based on the following limitations:

(A) Electrodes, per pair (A4556) — 3 units;

(B) Lead wires, per pair (A4557) — 2 units;

(C) Conductive paste or gel (A4558) — 1 unit;

(D) Belts (A4649) — 2 units;

(e) The cost of apnea monitor rental includes the cost of cables;

(f) The Division does not cover apnea monitors with memory recording (E0619) when the attending ~~physician~~ practitioner is monitoring the infant with ongoing sleep studies and pneumograms.

(2) Coding guidelines: For billing purposes, use diagnosis code 798.0, Sudden Infant Death Syndrome (SIDS), for later siblings of infants who died of SIDS.

(3) Documentation requirements: Submit the following information with the prior authorization (PA) request:

(a) Documentation (medical records including hospital records, sleep studies, ~~physician's~~ practitioner's progress notes, ~~physician~~practitioner-interpreted report from an apnea monitor with memory recording, etc.) of the episode or episodes that led to the diagnosis;

(b) An order from the ~~physician~~ practitioner who diagnosed the infant as having clinically significant apnea or known risk factors for life-threatening apnea. The ~~physician's~~ practioner's order shall indicate the specific type of apnea monitor (with or without recording feature) and detailed information about the type and quantity of related supplies needed;

(c) For an apnea monitor with recording feature (E0619), submit documentation that supports why an apnea monitor without recording feature (E0618) is not adequate to meet the medical need;

(d) When dispensing and billing for an item in Table 122-0240, the provider shall ensure that documentation corroborates that all criteria in this rule are met;

(e) The DMEPOS provider shall maintain documentation and make it available to the Division upon request.

(4) Table 122-0240.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 32-1992, f. & cert. ef. 10-1-92
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0250
Breast Pumps

(1) Indications and limitations of coverage and medical appropriateness:

(a) The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ may cover ~~electric~~ a breast pump~~s for any of the following conditions:~~ 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;

~~(A) Medical appropriateness for infant:~~

~~(i) Pre-term;~~

~~(ii) Term and hospitalized beyond five days;~~

~~(iii) Separated from mother for an undetermined length of time;~~

~~(iv) Cleft palate or cleft lip;~~

~~(v) Cranial-facial abnormalities;~~

~~(vi) Inability to suck adequately;~~

~~(vii) Re-hospitalized for longer than two days;~~

~~(viii) Failure to thrive;~~

~~(B) Medical appropriateness for mother:~~

~~(i) Breast abscess;~~

~~(ii) Mastitis;~~

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

~~(iv) Short-term treatment with medications that may be transmitted to the infant;~~

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

~~(b)~~(c) ~~Documentation that transition to breast feeding started as soon as the infant was stable enough to begin breast feeding~~A breast pump shall not be provided until a need is determined following birth;

(d) 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 needed or separately reimbursable;

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

~~(d) An electric breast pump starter kit will be reimbursed separately from the breast pump rental;~~

~~(e) Electric breast pump rental cannot exceed 60 days,~~

~~(f) An electric breast pump may only be purchased when cost effective for one of the following conditions:~~

~~(i) Cleft palate or cleft lip;~~

~~(ii) Cranial-facial abnormalities;~~

~~(iii) Inability to suck adequately;~~

~~(iv) Infant is separated from mother for an undetermined length of time;~~

~~(g) Electric breast pump rental charges apply to the purchase price;~~

(~~h~~f) The following services are not covered:

(i) Accessories;

(ii) An electric breast pump for the comfort and convenience of the mother;

(iii) Supplemental Nutrition System (SNS);

(iv) Heavy duty, hospital grade breast pumps;

(v) Replacement parts.

Commented [JK40]: Review this for not covered

~~(2) Documentation requirements:~~

~~(a) For services that require prior authorization (PA): Submit documentation for review which supports conditions of coverage as specified in this rule are met;~~

~~(b) For services that do not require PA:~~ (2) Medical records which support conditions of coverage as specified in this rule are met must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request.

(3) Procedure Codes:

(a) E0602 — Breast pump, manual, any type — the Division will purchase;

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

~~(A) The Division will purchase or rent on a monthly basis;~~

~~(B) PA required; .~~

~~(c) E1399 — Electric breast pump starter kit;~~

~~(A) The Division will purchase;~~

~~(B) PA required.~~

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 17-1996, f. & cert. ef. 8-1-96
HR 9-1993, f. & cert. ef. 4-1-93
HR 10-1992, f. & cert. ef. 4-1-92

410-122-0300
Light Therapy

(1) ~~Phototherapy (bilirubin light therapy):~~The Division may cover home phototherapy when medically appropriate and for the following conditions:

(a) ~~The Division may cover home phototherapy for~~ 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~~;~~.

Commented [JK41]: Add language relating to phototherapy for skin conditions – see guideline note 21

~~(b) E0202 includes equipment rental, supplies, delivery, set-up, pick-up, training, instruction, and 24 hour on-call service necessary for the effective use of the equipment;~~

~~(c) Documentation by the treating physician shall indicate home phototherapy is the appropriate treatment modality;~~

~~(d) Home phototherapy may be covered for any of the following conditions:~~

(A) Jaundice in healthy term (>37 weeks) infant ready to be discharged or recently discharged from the hospital; feeding well/appears well with serum bilirubin values as follows:

(i) 25–48 hours old ≥12 mg/dl total serum bilirubin; or

(ii) 49–72 hours old ≥15 mg/dl total serum bilirubin; or

(iii) >72 hours old ≥ 17 mg/dl total serum bilirubin; or

(B) Jaundice in preterm infant <37 weeks when total serum bilirubin level is ≥10mg/dl;

(e<u>C</u>) Treatment days <u>for jaundice</u> will be determined based on lab values.

<u>(b) For severe inflammatory skin conditions identified in the Health Evidence Review Commission's Prioritized List of Health Services, guideline note 21.</u>

(2) Documentation Requirements:

<u>(a) Documentation by the treating practitioner shall indicate home phototherapy is the appropriate treatment modality;</u>

(~~a~~<u>b</u>) For services that require PA: Submit documentation for review that supports conditions of coverage as specified in this rule are met;

(~~b~~<u>c</u>) For services that do not require PA: Medical records that support conditions of coverage as specified in this rule are met shall be on file with the DMEPOS provider and made available to the Division upon request.

<u>(3) E0202 includes equipment rental, supplies, delivery, set-up, pick-up, training, instruction, and 24 hour on-call service necessary for the effective use of the equipment.</u>

(~~3~~<u>4</u>) Table 122-0300 Light Therapy.

[ED. NOTE: Tables referenced are available from the agency.]

<u>[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]</u>

Commented [JK42]: Moved this language to different section of this rule

Commented [JK43]: Moved this language to different section of this rule

Commented [JK44]: Must have prescription and followed by doctor

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91

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 will 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 will 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 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 month's rental of a wheelchair. (See 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 will 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;

(g) The Division may cover an adult tilt-in-space wheelchair (E1161) when a client meets all of the following conditions:

(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) 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) 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) Documentation must be complete and detailed enough so a third party would be able to understand the nature of the provider's ATP involvement, if any, in the evaluation;

(H) 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 30 days or less;

(B) The conditions of coverage for a manual tilt-in-space wheelchair as described in section (1) (g) (A) (~~E~~H) 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 hours per day in the wheelchair.

(B) If the expected duration of need is less than three months (e.g., postoperative recovery), a high-strength lightweight wheelchair is rarely medically appropriate.

(L) The Division may cover an ultra-lightweight wheelchair (K0005) when ~~a client has medical needs that require determination on a case-by-case basis~~ the client meets the following criteria:~~;~~

(i) The client must be a full-time manual wheelchair user; or

(ii) 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 or K0004 manual wheelchair; and

(iii) 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; and

(iv) 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;

(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 will 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 ~~45~~ 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.

Commented [JK45]: Consistent with Medicare criteria

(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) A complete manual wheelchair base includes:

(A) A complete frame;

(B) Propulsion wheels;

(C) Casters;

(D) Brakes;

(E) A sling seat, seat pan which can accommodate a wheelchair seat cushion, or seat frame structured is such a way as to be capable of accepting a seating system;

(F) A sling back, other seat back support which can accommodate a wheelchair back cushion, or a back frame structured in such a way as to be capable of accepting a back system;

(G) Standard leg and footrests;

(H) Armrests;

(I) Safety accessories.

(j) 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 – 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 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), treating ~~physician~~practitioner~~, or nurse practitioner~~. The person 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;

(ii~~i~~) Client identification and rehab technology supplier identification information that may be completed by the DMEPOS provider; and

(~~iii~~iv) Signature and date by the treating ~~physician~~ practitioner ~~or nurse 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 ~~physician~~practitioner~~, or nurse 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 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, treating ~~physician~~practitioner~~, or nurse 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, treating ~~physician~~practitioner~~, or nurse 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 will 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 will be billed separately.

(c) A written order by the treating ~~physician~~ practitioner ~~or nurse 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 ~~physician~~ practitioner ~~or nurse 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) For an ultralight wheelchair (K0005), documentation from a PT, OT, treating ~~physician~~practitioner~~, or nurse practitioner~~ that includes a description of the client's mobility needs within the home. This 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;

(f) When code K0009 is requested, send all information from a PT, OT, treating ~~physician~~practitioner~~, or nurse practitioner~~ that justifies the medical appropriateness for the item;

(g) Any additional documentation that supports indications of coverage are met as specified in this policy;

(h) For a manual wheelchair rental, submit all of the following:

(A) A written order from the treating ~~physician~~ practitioner ~~or nurse 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 ~~physician~~ practitioner ~~or nurse 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.

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 12-2018, amend filed 03/07/2018, effective 03/08/2018
DMAP 36-2017(Temp), f. 9-14-17, cert. ef. 9-15-17 thru 3-13-18
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30- 94, cert. ef. 1-1-95
HR 26-1994, f. & cert. ef. 7-1-94
HR 18-1994(Temp), f. & cert. ef. 4-1-94
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 32-1992, f. & cert. ef. 10-1-92
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91

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 mobility, 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 will 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 will 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) Presence of a caregiver does not preclude coverage of a PWC if the client is willing and able to safely operate the PWC;

(~~F~~G) The client is willing to use the requested PWC on a regular basis;

(~~G~~H) There is objective evidence that demonstrates that the client cannot use a power-operated vehicle (POV);

(~~H~~I) The client has sufficient mental and physical capabilities to safely operate the PWC;

Commented [JK46]: Recommended that we add this, however, it may not be necessary at this point with additional changes to other rules below.

Commented [JK47]: Expand and revise this to match 0325?

(~~I~~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;

(~~J~~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 ~~physician~~ practitioner ~~or nurse practitioner~~ must conduct a face-to-face examination of the client within six (6) months prior to ~~before~~ 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 face-to-face examination and prior to delivery of the device:

(A) When this examination is performed during a hospital or nursing facility stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(B) The ~~physician~~ practitioner ~~or nurse 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~~provide the assessment for the wheelchair. This individual 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

Commented [JK48]: This is sometimes misinterpreted. How is it determined that caregiver can adequately propel a manual wheelchair? Reviewer cannot assume they can adequately propel a manual wheelchair. So do we require documentation or just attestation through PT eval?

Per Medicare –
If these limitations exist, can they be ameliorated or compensated sufficiently such that the pwc will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in mobility-related activities of daily living in the home? A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the mobility-related activity of daily living is to be considered in this determination.
Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely? a. Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device. b. A history of unsafe behavior in other venues may be considered.

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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 ~~physician~~ practitioner~~or nurse practitioner~~, then once the ~~physician~~ practitioner ~~or nurse practitioner~~ has received and reviewed the written report of this examination, the ~~physician or nurse~~ practitioner must see the client and perform any additional examination that is needed. The ~~physician's or nurse~~ practitioner's report of the visit ~~should~~ shall state concurrence or any disagreement with the PT/OT examination. In this situation, the ~~physician or nurse~~ practitioner must provide the DMEPOS provider with a copy of both examinations within 45 days of the face-to-face examination with the ~~physician or nurse~~ practitioner;

(ii) If the ~~physician or nurse~~ 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 ~~physician or nurse~~ practitioner visit. However, it is also acceptable for the ~~physician or nurse~~ 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 ~~physician or nurse~~ 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 ~~physician or nurse~~ 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 ~~provider's~~ ATP must be employed by ~~a~~ the provider in a full-time, part-time, or contracted capacity as is acceptable by state law. The ~~provider's~~ 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 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 ~~provider's~~ 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;

(k) The delivery of the PWC must be within 120 days following ~~completion of the face-to-face examination~~approval of the PA request by the Division;

(L) A PWC may not be ordered by a podiatrist;

(m) The following services are not generally covered as they are not medically necessary or medically appropriate:

(A) A PWC for functionally ambulatory clients;

(B) A PWC used to replace private or public transportation such as automobile, bus, or taxi;

(C) A PWC with a captain's chair for a client who needs a separate wheelchair seat and/or back cushion;

(D) 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, wheelchair gloves, head lights, and tail lights;

(E) 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:

(A) A Group 1 PWC (K0813-K0816) or a Group 2 PWC (K0820-K0829) ~~Heavy Duty (HD), Very Heavy Duty (VHD), or Extra Heavy Duty (EHD) wheelchair (K0824-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;

~~(B) A Group 2 Standard PWC with a sling or solid seat (K0820, K0822) may be covered when:~~

~~(i) The coverage criteria for a PWC are met; and~~

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Commented [JK49]: Medicare requires delivery within 180 days following receipt of an approved PA. Leave at 120 days and hope for this timeframe or change to 180?

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~~(ii) The client is using a skin protection and/or positioning seat and/or back cushion that meets the coverage criteria defined in OAR 410-122-0340 Wheelchair Options/Accessories.~~

(~~C~~B) A Group 2 Single Power Option PWC (K0835 – K0840) may be covered when the coverage criteria for a PWC are met; and

(i) ~~The client either:~~Criterion I or II is met; and

(ii) Criteria III and IV are met.

Commented [JK50]:

(I) The client r~~R~~equires 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 m~~M~~eets the coverage criteria for a power tilt or recline seating system and the system is being used on the wheelchair~~.~~; and

(~~ii~~III) 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 ~~physician~~ 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 ~~physician~~ practitioner may have no financial relationship with the DMEPOS provider~~.~~; and

(~~D~~C) A Group 2 Multiple Power Option PWC (K0841-K0843) may be covered when the coverage criteria for a PWC are met, and if:

(i) ~~The client either:~~Criterion I or II is met; and

(ii) Criteria III and IV are met.

(I) Meets the coverage criteria for a power tilt or recline seating system and the system is being used on the wheelchair; or

Commented [JK51]: This criteria has been added to 0340

(II) Uses a ventilator that is mounted on the wheelchair~~.~~; and

(~~ii~~III) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT, OT, ~~nurse practitioner,~~ or ~~physician~~ 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, ~~nurse practitioner,~~ or ~~physician~~ practitioner may have no financial relationship with the DMEPOS provider~~.~~; and

(~~E~~D) 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 ~~physician~~ 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, ~~physician,~~ or ~~nurse~~ practitioner may have no financial relationship with the DMEPOS provider~~.~~;

(~~F~~E) 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)(~~E~~D) (i-ii) are met; and

(ii) The Group 2 Single Power Option in section (2)(a)(~~C~~B)~~)(i)(I) or (II) and section (2)(a)(C)(ii)~~ or Multiple Power Options section (2)(a)(~~D~~C)~~)(i)(I) or (II) and section (2)(a)(D)(ii)~~ (respectively) are met.

(~~G~~F) Requests for Group 4 PWCs will 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) A push-rim activated power assist device (E0986) for a manual wheelchair may be covered if all of the following criteria are met:

(i) All of the criteria for power wheelchair are met; and

(ii) The client has been self-propelling in a manual wheelchair 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;

(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, ~~or~~ swingaway, or detachable non-elevating legrests 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~~fixed/, swingaway or detachable footrests or a foot platform ~~with/~~without angle adjustment ~~footplate/platform~~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;

Commented [JK52]: Check medicare wc accessories regs – put in table?

(G) Armrests. There is no separate billing or payment if fixed, ~~or~~ 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);

(e) 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: 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 ~~physician or nurse~~ 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 will be ameliorated or compensated by use of the wheelchair;

(II) How these other conditions will be ameliorated or compensated sufficiently such that the provision of a PWC will 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 ~~should~~ 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 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 ~~physician's or nurse~~ 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 ~~physician's or nurse~~ practitioner's face-to-face examination. The face-to-face examination must occur no more than six months prior to the start of services. 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 ~~physician or nurse~~ 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) ~~Physician's or nurse practitioner's~~Practitioner's signature;

(G) Date of ~~physician's or nurse~~ 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 will 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 ~~physician or nurse~~ 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 will 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 ~~physician or nurse~~ 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.

(4) Prior Authorization:

(a) All codes in this rule require PA and may be purchased, rented, and repaired;

(b) Codes specified in this rule are not covered for clients residing in nursing facilities;

(c) 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) Rented equipment is considered purchased when the Division fee schedule allowable for purchase is met or the actual charge from the provider is met, whichever is the lowest.

(5) Table 122-0325.

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 12-2018, amend filed 03/07/2018, effective 03/08/2018
DMAP 36-2017(Temp), f. 9-14-17, cert. ef. 9-15-17 thru 3-13-18
DMAP 57-2012, f. & cert. ef 12-27-12
DMAP 31-2012(Temp), f. 6-29-12, cert. ef. 7-1-12 thru 12-27-12
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00

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 ~~should~~ 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 will 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 will 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 ~~physician~~ practitioner or nurse practitioner must conduct a face-to-face examination of the client before writing the order:

(A) The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the face-to-face examination and prior to delivery of the device;

(B) When this examination is performed during a hospital or nursing facility stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(C) The ~~physician or nurse~~ 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 ~~physician or nurse~~ practitioner, then once the ~~physician or nurse~~ practitioner has received and reviewed the written report of this examination, the ~~physician or nurse~~ practitioner must see the client and perform any additional examination that is needed. The ~~physician's or nurse~~ practitioner's report of the visit shall state concurrence or any disagreement with the PT/OT examination. In this situation, the ~~physician or nurse~~ practitioner must provide the DMEPOS provider with a copy of both examinations within 45 days of the face-to-face examination with the ~~physician or nurse~~ practitioner;

(ii) If the ~~physician or nurse~~ 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 ~~physician or nurse~~ practitioner visit. However, it is also acceptable for the ~~physician or nurse~~ 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 ~~physician or nurse~~ 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 ~~physician or nurse~~ 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) 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 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;

(f) 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;

(h) 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.

(2) 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.

(3) Documentation requirements: 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 ~~physician or nurse~~ 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 will be ameliorated or compensated;

(II) How these other conditions will be ameliorated or compensated sufficiently such that the additional provision of ~~mobility assistive equipment (MAE)~~ POV will 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 ~~physician's or nurse~~ practitioner's written order, received by the DMEPOS provider within 30 days after the ~~physician's or nurse~~ 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 ~~physician or nurse~~ 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) ~~Physician's or nurse practitioner's~~Practitioner's signature;

(F) Date of ~~physician's or nurse~~ 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) 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) Procedure Codes:

(A) K0800 Power operated vehicle, Group 1 standard, patient weight capacity up to and including 300 pounds — PA;

(B) K0801 Power operated vehicle, Group 1 heavy duty, patient weight capacity, 301 to 450 pounds — PA;

(C) K0802 Power operated vehicle, Group 1 very heavy duty, patient weight capacity, 451 to 600 pounds — PA.

(D) K0806 Power operated vehicle, Group 2 standard, patient weight capacity up to and including 300 pounds – PA

(E) K0807 Power operated vehicle, Group 2 heavy-duty, patient weight capacity 301 to 450 pounds – PA

(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 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
History:
DMAP 12-2018, amend filed 03/07/2018, effective 03/08/2018
DMAP 36-2017(Temp), f. 9-14-17, cert. ef. 9-15-17 thru 3-13-18
DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15
DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00

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 cover options/accessories whose primary benefit is allowing the client to perform leisure or recreational activities;

(c) Arm of Chair:

(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 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 ~~the Division includes payment for~~ seat widths or seat depths of 15-19 inches is included in the payment for the base code. These seat dimensions ~~may~~ 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 (~~E2360~~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 ~~that~~ 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:

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(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 ~~clinician~~ , 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, ~~that~~ 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 use of the code for the specific product being billed: E2601-E2608, ~~E2611~~E2610-E2616, E2620-E2625, ~~E2621,~~ 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 found 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) may be billed in addition to codes E0955-E0957. It ~~may~~ shall not be billed in addition to codes E0950, E0954, E0960, E1020 or E2325 as mounting hardware is included in the allowance for these codes. It ~~may~~ shall not be used for mounting hardware related to a wheelchair seat cushion or back cushion code;

(k) A power ~~Power~~ seating system~~s~~ - tilt only, recline only, or combination tilt and recline, with or without elevating leg rests may be covered if the client meets all coverage criteria for a power wheelchair and one of the following criteria is met:

(A) The client is at high risk for development of a pressure ulcer and is unable to perform a functional weigh shirt; or

(B) The client utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or

(C) The power seating system is needed to manage increased tone or spasticity;

(~~A~~D) A power-tilt seating system (E1002):

(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 ~~45~~ 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~~E) A power recline seating system (E1003-E1005):

(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) It does not include a headrest;

(iii) 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~~F) A power tilt and recline seating system (E1006-E1008):

(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.

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to ~~45~~ 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.

(G) 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;

(~~D~~H) 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;

(~~E~~I) 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;

(~~F~~J) 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~~.~~;

(K) 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~~l) Codes E2300, 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) E2300, power seat elevation system, may be covered when one of the following is met and documentation demonstrates:

(i) The client must routinely transfer between uneven surfaces and the seat elevation feature allows them to independently transfer; 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

(iii) The seat elevation feature has been demonstrated to allow the client to independently access areas in the home necessary to perform their MRADLs.

(iv)

(~~F~~G) E2310 or E2311 may be ~~considered for coverage~~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;

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(~~G~~H) 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 power seating actuators through the drive control (for example, seat elevator and single actuator power elevating leg rests). Control of these items 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 or more powered seating actuators through the drive control;

(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.

(~~E~~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, 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;

(~~F~~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;

(~~G~~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;

(~~H~~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.;

(~~I~~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;

(~~J~~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;

(~~K~~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;

(~~L~~Q) When code E2321 is used for a chin control interface, the chin cup is billed separately with code E2324;

(~~M~~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;

(~~N~~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;

(~~O~~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;

(~~P~~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;

(~~Q~~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;

(~~R~~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;

(~~S~~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;

(~~T~~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) Is used in the following situations:~~

(~~I~~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~~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.

~~(ii) The KC modifier is never used at the time of initial issue of a wheelchair;~~

~~(iii) The KC modifier specifically states replacement; therefore, the RP modifier is not required.~~

(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 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 hours per day in the wheelchair and has one or more of the following conditions~~/needs~~:

(i) ~~Quadriplegia~~The client is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or

(ii) ~~Fixed hip angle~~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.~~

(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 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.

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 12-2018, amend filed 03/07/2018, effective 03/08/2018
DMAP 36-2017(Temp), f. 9-14-17, cert. ef. 9-15-17 thru 3-13-18
DMAP 17-2012, f. 3-30-12, cert. ef. 4-1-12
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 26-1994, f. & cert. ef. 7-1-94
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 32-1992, f. & cert. ef. 10-1-92
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0360
Canes and Crutches

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

(2) A white cane shall be covered for a visually impaired client when prescribed by a practitioner~~is considered to be a self-help item and is not covered by the Division~~. Providers shall use E1399 for billing this item.

Commented [JK56]: Medicare considers this a self-help device rather than a medical device, so it is statutorily not covered.
I recommend covering these with HCPCS code E1399.

(3) Table 122-0360.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 26-1994, f. & cert. ef. 7-1-94
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 32-1992, f. & cert. ef. 10-1-92
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0365
Standing and Positioning Aids

(1) Indications and coverage: Standing frame systems and accessories are covered when:

(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)

(b) 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,

(b) The client is following a home therapy program for the stander established by a physical or occupational therapist; and

(c) The home is able to accommodate the equipment; and

(d) The weight of the client does not exceed manufacturer's weight capacity; and

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

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

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

Commented [JK57]: This criteria is from

(h) 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 by other accessories;

(k) Abductors may be covered to reduce tone for proper alignment and weight bearing;

(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.

~~(2) Documentation to be submitted for PA and kept on file by the Durable Medical Equipment (DME) provider:~~

~~(a) Documentation of medical appropriateness, which has been reviewed and signed by the prescribing practitioner;~~

~~(b) The care plan outlining positioning and treatment regime and all DME currently available for use by the client;~~

~~(c) The physician's order;~~

~~(d) The documentation for a customized positioner shall include objective evidence that commercially available positioners are not appropriate;~~

~~(e) Each item requested shall be itemized with description of product, make, model number, and manufacturers' suggested retail price (MSRP);~~

~~(f) Submit Positioner Justification form (DMAP 3155) or reasonable facsimile with recommendation for most appropriate equipment. This shall be submitted by a physical therapist, occupational therapist, or prescribing practitioner when requesting a PA;~~

(~~3~~5) Gait Belts:

(a) Covered when:

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

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

(C) The client can walk independently but needs:

(i) A minor correction of ambulation; or

(ii) Minimal or standby assistance to walk alone; or

(iii) Requires assistance with transfer;

(b) Use code E0700.

(6) Documentation that shall be kept on file by the Durable Medical Equipment (DME) provider includes:

(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) The documentation for a customized positioner shall include objective evidence that commercially available positioners are not appropriate;

(e) Each item requested shall be itemized with description of product, make, model number, and manufacturers' suggested retail price (MSRP);

(f) 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;

Commented [JK58]: This section is revised and further down in the rule

Commented [JK59]: Remove PA from table

Commented [JK60]: What are commercially available positioners?

(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.

~~(b) Use code E0700.~~

~~(4) Standing frame systems, prone standers, supine standers or boards, and accessories for standing frames are covered when:~~

~~(a) The client has been sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit; and,~~

~~(b) The client is following a therapy program initially established by a physical or occupational therapist; and~~

~~(c) The home is able to accommodate the equipment; and~~

~~(d) The weight of the client does not exceed manufacturer's weight capacity; and~~

~~(e) The client has demonstrated an ability to utilize the standing aid independently or with caregiver; and~~

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

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

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

~~(5) 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.~~

~~(6) 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 by other accessories;~~

~~(k) Abductors may be covered to reduce tone for proper alignment and weight bearing;~~

~~(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.~~

(7) Table 122-0365.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Commented [JK61]: Need to figure out how to remove PA from E0700 and revise table 122-0365 to change descriptions to match HCPCS code description to include "any size including pediatric" to E0637 and E0638, change rule # reference in E0641,and revise E0638 to include prone, and supine standers. Should not be billing E1399 in addition to the E code. This table is currently in PDF only. Add E0642? Remove PA from E0637 and E0638?

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16
DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00

410-122-0375
Walkers

(1) Indications and Limitations of Coverage:

(a) A standard walker (E0130, E0135, E0141, E0143) and related accessories are covered if both of the following criteria are met:

(A) When prescribed by a treating practitioner for a client with a medical condition impairing ambulation and there is a potential for increasing ambulation; and

(B) When there is a need for greater stability and security than provided by a cane or crutches;

(b) For an adult gait trainer, use the appropriate walker code. If a gait trainer has a feature described by one of the walker attachment codes (E0154-E0157), that code may be separately billed;

(c) A heavy duty walker (E0148, E0149) is covered for clients who meet coverage criteria for a standard walker and who weigh more than 300 pounds

(d) A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for clients who meet coverage criteria for a standard walker and who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand;

(e) When a walker with an enclosed frame (E0144) is dispensed to a client, documentation must support why a standard folding wheeled walker, E0143, was not provided as the least costly medically appropriate alternative;

(f) Enhancement accessories of walkers are non-covered;

(g) Leg extensions (E0158) are covered only for patients six feet tall or more.

(2) Coding Guidelines:

(a) A wheeled walker (E0141, E0143, E0149) is one with either two, three or four wheels. It may be fixed height or adjustable height. It may or may not include glide-type brakes (or equivalent). The wheels may be fixed or swivel;

(b) A glide-type brake consists of a spring mechanism (or equivalent) which raises the leg post of the walker off the ground when the patient is not pushing down on the frame;

(c) Code E0144 describes a folding wheeled walker which has a frame that completely surrounds the patient and an attached seat in the back;

(d) A heavy duty walker (E0148, E0149) is one which is labeled as capable of supporting patients who weigh more than 300 pounds. It may be fixed height or adjustable height. It may be rigid or folding;

(e) Code E0147 describes a 4-wheeled, adjustable height, folding-walker that has all of the following characteristics:

(A) Capable of supporting patients who weigh greater than 350 pounds;

(B) Hand operated brakes that cause the wheels to lock when the hand levers are released;

(C) The hand brakes can be set so that either or both can lock both wheels;

(D) The pressure required to operate each hand brake is individually adjustable;

(E) There is an additional braking mechanism on the front crossbar;

(F) At least two wheels have brakes that can be independently set through tension adjustability to give varying resistance;

(f) The only walkers that may be billed using code E0147 are those products listed in the Product Classification List on the Medicare Pricing, Data Analysis and Coding (PDAC) contractor's web site;

(g) An enhancement accessory is one which does not contribute significantly to the therapeutic function of the walker. It may include, but is not limited to style, color, hand operated brakes (other than those described in code E0147), or basket (or equivalent);

(h) A4636, A4637, and E0159 are only used to bill for replacement items for covered, patient-owned walkers. Codes E0154, E0156, E0157, and E0158 can be used for accessories provided with the initial issue of a walker or for replacement components. Code E0155 can be used for replacements on covered, patient-owned wheeled walkers or when wheels are subsequently

added to a covered, patient-owned non-wheeled walker (E0130, E0135). Code E0155 cannot be used for wheels provided at the time of, or within one month of, the initial issue of a non-wheeled walker;

(i) Hemi-walkers must be billed using code E0130 or E0135, not E1399;

(j) A gait trainer is a term used to describe certain devices that are used to support a client during ambulation. Gait trainers are billed using one of the codes for walkers. If a gait trainer has a feature described by one of the walker attachment codes (E0154, E0155, E0157) that code may be separately billed. Other unique features of gait trainers are not separately payable and may not be billed using E1399;

(k) Column II code is included in the allowance for the corresponding Column I code when provided at the same time and must not be billed separately at the time of billing the Column I code:

(l) See attached Table 122-0375-1

(l) Providers ~~should~~ shall contact PDAC for guidance on the correct coding of these items.

(3) Documentation: An order for each item billed must be signed and dated by the treating practitioner, kept on file by the DMEPOS provider, and made available to the Division upon request. The treating practitioner's records must contain information that supports the medical appropriateness of the item ordered, including height and weight.

(4) Table 122-0375-1.

(5) Table 122-0375-2.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00

410-122-0380
Hospital Beds

(1) Indications and limitations of coverage and medical appropriateness: The Division may cover some hospital beds for a covered condition including:

(a) A fixed height hospital bed (E0250, E0251, E0290, ~~and~~ E0291, E0328) when the client meets at least one of the following criteria:

Commented [JK62]: Medicare covers E0328 – pediatric hospital beds including mattress, with same hospital bed coverage. Need to open reference on this code if we cover it. Check MFS

(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, ~~and~~ E0295, and E0329) when all of the following criteria are met:

Commented [JK63]: Medicare covers. This is a pediatric hospital bed, semi-electric. If we cover will need to open reference file for this code. Check MFS

(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 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 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 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 and E0297) are not covered since the height adjustment feature is considered a convenience feature;

(g) Payment Authorization: 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 (DMEPOS) provider is still responsible to ensure all rule requirements are met. Payment authorization is required prior to submitting any claims to the Division regardless of the date of service, including the initial and second dates of service, and will be given once all required documentation has been received and any other applicable 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.

(2) Documentation requirements: Submit documentation that has been reviewed, signed, and dated by the prescribing practitioner and that supports conditions of coverage as specified in this rule are met including:

(a) For all hospital beds:

(A) Primary diagnosis code for the condition necessitating the need for a hospital bed;

(B) The type of bed currently used by the client and why it doesn't meet the medical needs of the client;

(b) For semi-electric beds: Why a variable height bed cannot meet the medical needs of the client;

(c) For heavy duty and extra heavy duty beds: The client's height and weight.

(3) Table 122-0380 — Hospital Beds.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16
DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 32-1992, f. & cert. ef. 10-1-92
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0400
Pressure Reducing Support Surfaces

(1) Indications and limitations of coverage and medical appropriateness:

(a) Group 1 (A4640, E0180–E0182, E0184–E0189, and E0196-E0199):

(A) The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ may cover a Group 1 support surface when the client meets:

(i) Criterion (I), or;

(ii) Criteria (II) or (III) and at least one of criteria (IV)–(VII):

(I) Completely immobile — i.e., client cannot make changes in body position without assistance;

(II) Limited mobility — i.e., client cannot independently make changes in body position significant enough to alleviate pressure;

(III) Any stage pressure ulcer on the trunk or pelvis;

(IV) Impaired nutritional status;

(V) Fecal or urinary incontinence;

(VI) Altered sensory perception;

(VII) Compromised circulatory status;

(B) The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provider must provide a support surface in which the client does not "bottom out";

(C) The Division does not cover foam overlays or mattresses without a waterproof cover, since these are not considered durable;

(D) The Division does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(E) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(b) Group 2 (E0193, E0277, and E0371–E0373):

(A) A Group 2 support surface may be covered for up to an initial three month rental period when the client meets:

(i) Criterion (I) and (II) and (III), or;

(ii) Criterion (IV), or;

(iii) Criterion (V) and (VI);

(I) Multiple stage II pressure ulcers located on the trunk or pelvis;

(II) Client has been on a comprehensive ulcer treatment program for at least the past month which includes the following: use of an appropriate Group 1 support surface; education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers; regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer); appropriate turning and positioning; appropriate wound care (for a stage II, III, or IV ulcer); appropriate management of moisture/incontinence; and nutritional assessment and intervention consistent with the overall plan of care;

(III) The ulcers have worsened or remained the same over the past month;

(IV) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis A large wound is generally any wound of eight square centimeters (length x width) or more. Individual client circumstances may be weighed. Undermining and/or tunneling, anatomic location on the body and the size of the client may be taken into account;

(V) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days)

(VI) The client has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days);

(B) The DMEPOS provider must provide a support surface in which the patient does not "bottom out";

(C) When a Group 2 surface is requested following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery

(D) The Division may cover continued use of a Group 2 support surface if healing continues;

(E) The Division does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(F) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(c) Division may consider coverage for bariatric pressure reducing support surfaces only coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility, subject to service limitations of Division rules, only when the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric pressure reducing support surface has been assigned code E1399 by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor;

(d) Group 3: Air-fluidized beds (E0194) are not covered.

(2) Definitions for Group 1 and Group 2:

(a) Bottoming out: Finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the patient's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion ~~should~~ shall be tested with the client in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side-lying position;

(b) Plan of care: Written guidelines developed to identify specific problems and needs of the client and interventions/regimen necessary to assist the client to achieve optimal health potential. Developing the plan of care includes establishing measurable client and nursing goals with time lines and determining nursing/caregiver/other discipline-assigned interventions to meet care objectives;

(c) The staging of pressure ulcers used in this rule is as follows:

(A) Stage I — Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II — Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III — Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV — Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers;

(3) Guidelines:

(a) Group 1:

(A) Codes E0185 and E0197–E0199 termed "pressure pad for mattress" describe non-powered pressure reducing mattress overlays and are designed to be placed on top of a standard hospital or home mattress;

(B) A gel/gel-like mattress overlay (E0185) is characterized by a gel or gel-like layer with a height of two inches or greater;

(C) An air mattress overlay (E0197) is characterized by interconnected air cells having a cell height of three inches or greater that are inflated with an air pump;

(D) A water mattress overlay (E0198) is characterized by a filled height of three inches or greater;

(E) A foam mattress overlay (E0199) is characterized by all of the following:

(i) Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., egg crate) or an overall height of at least three inches if it is a non-convoluted overlay; and

(ii) Foam with a density and other qualities that provide adequate pressure reduction; and

(iii) Durable, waterproof cover;

(F) Codes E0184, E0186, E0187 and E0196 describe non-powered pressure reducing mattresses;

(G) A foam mattress (E0184) is characterized by all of the following:

(i) Foam height of five inches or greater;

(ii Foam with a density and other qualities that provide adequate pressure reduction;

(iii) Durable, waterproof cover; and

(iv) Can be placed directly on a hospital bed frame;

(H) An air, water or gel mattress (E0186, E0187, E0196) is characterized by all of the following:

(i) Height of five inches or greater of the air, water, or gel layer (respectively);

(ii) Durable, waterproof cover; and

(iii) Can be placed directly on a hospital bed frame;

(I) Codes E0180, E0181, E0182, and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss) and are characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 2 inches or greater; and

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

(J) Alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0180, E0181, E0182, and A4640;

(K) Code A4640 or E0182 may only be billed when they are provided as replacement components for a client-owned E0180 or E0181 mattress overlay system;

(L) A Column II code is included in the allowance for the corresponding Column I code when provided at the same time: Column I (Column II), E0180 (A4640, E0182), E0181 (A4640, E0182);

(b) Group 2:

(A) Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following:

(a) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;

(b) Inflated cell height of the air cells through which air is being circulated is five inches or greater;

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

(d) A surface designed to reduce friction and shear; and

(e) Can be placed directly on a hospital bed frame;

(B) Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above;

(C) Code E0371 describes an advanced non-powered pressure-reducing mattress overlay which is characterized by all of the following:

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

(ii) Total height of three inches or greater;

(iii) A surface designed to reduce friction and shear; and

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces;

(D) Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 3 ? inches or greater;

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

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

(E) Code E0373 describes an advanced non-powered pressure reducing mattress which is characterized by all of the following:

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

(ii) Total height of five inches or greater;

(iii) A surface designed to reduce friction and shear;

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces; and

(v) Can be placed directly on a hospital bed frame;

(F) The only products that may be coded and billed using code E0371 or E0373 are those products for which a written coding determination specifying the use of these codes has been made by PDAC;

(G) Alternating pressure mattresses and low air loss mattresses are coded using code E0277;

(H) Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with three powered air cells on top of a three foam base would be coded as a powered overlay (code E0180 or E0181), not as a powered mattress (E0277).

(4) Documentation requirements: Submit the following information with the prior authorization request:

(a) Initial Requests:

(A) For all pressure reducing support surfaces, other than a Group I for a completely immobile client or a Group 2 surface following a myocutaneous flap or skin graft:

(i) An order for each item requested, signed and dated by the attending ~~physician~~practitioner;

(ii) Documentation that supports conditions of coverage are met as specified in this rule;

(iii) A plan of care which has been established by the client's ~~physician~~ practitioner or home care nurse (by the RN resident care manager for a client in a nursing facility), which generally includes the following: Education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers;

(II) Regular assessment by a nurse, physician, or other licensed healthcare practitioner;

(III) Appropriate turning and positioning including the number of hours per 24-period that the client will utilize the support surface;

(IV) Appropriate wound care (for a stage II, III, or IV ulcer);

(V) Appropriate management of moisture/incontinence;

(VI) Nutritional assessment and intervention consistent with the overall plan of care by a licensed healthcare practitioner (by a registered dietitian for a client in a nursing facility) within the last 90 days;

(VII) Client's weight and height (approximation is acceptable, if unable to obtain);

(VIII) Description of all pressure ulcers, which includes number, locations, stages, sizes and dated photographs;

(iv) Lab reports, if relevant;

(v) Other treatments and products that have been tried and why they were ineffective; Interventions and goals for stepping down the intensity of support surface therapy;

(vi) For pressure ulcers on extremities, why pressure cannot be relieved by other methods;

(B) For a Group I surface for a completely immobile client:

(a) An order for each item requested, signed and dated by the attending ~~physician~~practitioner;

(b) A plan of care which has been established by the client's ~~physician~~ practitioner or home care nurse (by the RN resident care manager for a client in a nursing facility), which generally includes the following:

(I) Education of the client, if appropriate, and caregiver on the prevention of pressure ulcers;

(ii) Regular assessment by a nurse, physician, or other licensed healthcare practitioner

(iii) Appropriate turning and positioning including the number of hours per 24-period that the client will utilize the support surface;

(iv) Appropriate management of moisture/incontinence, if appropriate;

(C) For a Group 2 surface following a myocutaneous flap or skin graft:

(i) An order for each item requested, signed and dated by the treating ~~physician~~practitioner;

(ii) Operative report;

(iii) Hospital discharge summary;

(iv) Plan of care;

(F) Required documentation may not be completed by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or anyone in a financial relationship of any kind with the DMEPOS provider;

(G) Medical records must corroborate that all criteria in this rule are met when dispensing and billing for an item in Table 122-0400-1 and Table-122-400-2;

(H) Medical records must be kept on file by the DMEPOS provider and made available to the Division upon request;

(b) Subsequent Requests: May be authorized contingent on progress towards healing:

(A) For all pressure reducing support surfaces, other than a Group I surface for a completely immobile client or a Group 2 surface following a myocutaneous flap or skin graft:

(i) Progress notes from the attending ~~physician~~practitioner;

(ii) Description of all pressure ulcers, including progress towards healing, by a licensed healthcare practitioner (by the RN resident care manager for a client in a nursing facility) which includes number, locations, stages, sizes and dated photographs;

(iii) Current plan of care;

(iv) Any other relevant documentation;

(B) For a Group I surface for a completely immobile client:

(i) Progress notes from the attending ~~physician~~practitioner;

(ii) Current plan of care;

(iii) Any other relevant documentation;

(C) For a Group 2 surface following a myocutaneous flap or skin graft:

(i) Progress notes from the attending ~~physician~~practitioner;

(ii) Current plan of care;

(iii) Any other relevant documentation.

(4) Table 122-0400-1 — Group 1.

(5) Table 122-0400-2 — Group 2.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0475
Therapeutic Shoes for Diabetics

(1) Indications and Coverage:

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

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

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

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

(A) Rigid rocker bottoms;

(B) Roller bottoms;

(C) Metatarsal bars;

(D) Wedges;

(E) Offset heels.

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

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

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

(2) Documentation:

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

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

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

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

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

(E) Foot deformity of either foot; or

(F) Poor circulation in either foot; and

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

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

(3) Table 122-0475.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00

410-122-0510
Osteogenesis Stimulator

(1) Definitions:

(a) An electrical osteogenesis stimulator is a device that provides electrical stimulation to augment bone repair;

(b) A noninvasive electrical stimulator is characterized by an external power source that is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site;

(c) An ultrasonic osteogenesis stimulator is a noninvasive device that emits low intensity, pulsed ultrasound signals to stimulate fracture healing. The device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via conductive coupling gel to stimulate fracture healing;

(2) Indications of coverage and medical appropriateness:

(a) Non-spinal Electrical Osteogenesis Stimulator:

(A) The Division may cover a non-spinal electrical osteogenesis stimulator (E0747) when any of the following criteria are met:

(i) Non-union of a long bone fracture (defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator); or

(ii) Failed fusion of a joint other than in the spine~~,~~ where a minimum of nine months has elapsed since the last surgery; or

(iii) Congenital pseudarthrosis;

(B) Non-union of a long bone fracture shall be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site and with a written interpretation by the treating ~~physician~~ practitioner stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;

(C) A long bone is limited to a clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal or metatarsal.

(b) Spinal Electrical Osteogenesis Stimulator:

(A) The Division may cover a spinal electrical osteogenesis stimulator (E0748) when any of the following criteria are met:

(i) Failed spinal fusion where a minimum of nine months has elapsed since the last surgery; or

(ii) Following a multilevel spinal fusion surgery; or

(iii) Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site;

(B) A multilevel spinal fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.);

(c) Ultrasonic Osteogenesis Stimulator:

(A) The Division may cover an ultrasonic osteogenesis stimulator (E0760) only when all of the following criteria are met:

(i) Non-union of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenic stimulator, each separated by a minimum of 90 days. Each radiograph shall include multiple views of the fracture site accompanied by a written interpretation by the treating ~~physician~~ practitioner stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs; and

(ii) The stimulator is intended for use prior to surgical intervention and with cast immobilization;

(B) Use of an ultrasonic osteogenic stimulator is not covered:

(i) For non-union fractures of the skull or vertebrae;

(ii) For tumor-related fractures;

(iii) For the treatment of a fresh fracture or delayed union; or

(iv) When used concurrently with other noninvasive osteogenic devices;

(C) The Division may cover ultrasonic conductive coupling gel as a separate service when an ultrasonic osteogenesis stimulator is covered.

(3) Coding guidelines: Use ~~E1399~~ A4559 for ultrasonic conductive coupling gel.

(4) Documentation requirements:

(a) Submit the following with the PA request:

(A) Documentation that supports the coverage criteria specified in this rule for the stimulator requested are met;

(B) Copies of x-ray and operative reports;

~~(b) For an electrical osteogenic stimulator, a Certificate of Medical Necessity (CMN) that has been completed, signed, and dated by the treating physician may substitute for a written order if it contains all the required elements of an order;~~

(~~c~~b) Additional medical records may be requested by the Division;

(~~d~~c) The client's medical records shall reflect the need for the stimulator requested. The client's medical records include, but are not limited to, the ~~physician's~~ practitioner's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals, and test/diagnostic reports.

(5) Table 122-0510.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 44-2004, f. & cert. ef. 7-1-04

OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 10-1992, f. & cert. ef. 4-1-92

410-122-0515
Neuromuscular Electrical Stimulator (NMES)

Indications and limitations of coverage and medical appropriateness:

(1) A neuromuscular electrical stimulator (NMES) uses electrodes to transmit an electrical impulse to the skin over selected muscle groups. There are two broad categories of NMES.

(2) NMES for treatment of muscle atrophy.

(3) NMES devices in this category stimulate the muscle when the client is in a resting state to treat muscle atrophy.

(4) The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ will cover 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) NMES to enhance functional activity of neurologically impaired clients: Specifically, the Division will cover NMES used to improve the ability to walk in clients with Spinal Cord Injury (SCI).

(6) This 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) The Division will only cover NMES/FES for SCI clients for walking, who meet the following criteria:

(a) Client has completed at least 32 physical therapy sessions, directly performed one-on-one with the physical therapist with the NMES/FES device over a trial period of three months, with the specific goal of using the NMES/FES device to achieve walking, not to reverse or retard muscle atrophy;

(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) The ~~physician~~ 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) The client meets all of the following characteristics:

(e) Intact lower motor units (L1 and below) (both muscle and peripheral nerve);

(f) 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) Demonstrated brisk muscle contraction to NMES and sensory perception of electrical stimulation sufficient for muscle contraction;

(h) High motivation, commitment and cognitive ability to use NMES/FES devices for walking;

(i) Can transfer independently and demonstrates independent standing tolerance for at least three minutes;

(j) Demonstrated hand and finger function to manipulate controls;

(k) At least six-month post recovery spinal cord injury and restorative surgery;

(l) Hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and

(m) Demonstrated willingness to use the device long-term;

(n) NMES/FES for walking is not covered in an SCI client with any of the following:

(A) Cardiac pacemaker;

(B) Severe scoliosis or severe osteoporosis;

(C) Skin disease or cancer at area of stimulation;

(D) Irreversible contracture;

(E) Autonomic dysflexia; or

(F) Treatment of muscle weakness due to the following conditions (not all-inclusive):

(i) Stroke; spinal cord injury; peripheral nerve injury; other central nervous system, spinal or peripheral nerve disease/condition affecting motor and/or sensory pathways to/from the muscles being stimulated;

(ii) Documentation requirements: Submit documentation that supports coverage criteria as specified in this rule are met.

(8) Procedure codes:

(a) A4595, Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES) — Includes all supplies necessary for the effective use of the device — Division will purchase — Prior authorization (PA) required;

(b) E0745, Neuromuscular stimulator, electronic shock unit — Division will rent — Purchased after no more than ~~13~~ 10 months of rental — PA required.

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0520
Glucose Monitors and Diabetic Supplies

(1) Indications and limitations of coverage and medical appropriateness:

(a) The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ may cover home blood glucose monitors and related diabetic supplies for clients with diabetes who can self-monitor blood glucose (SMBG) or be monitored with assistance;

(b) Coverage of home blood glucose monitors is limited to clients meeting all of the following conditions:

(A) The client has diabetes that is being treated by a practitioner; and

(B) The glucose monitor and related accessories and supplies have been ordered by a practitioner who is treating the client's diabetes; and

(C) The client or caregiver has successfully completed a structured education and feedback program for self-monitoring of blood glucose and is scheduled to begin training in the use of the monitor, test strips, and lancing devices; and

(D) The client or caregiver is capable of using the test results to assure the client's appropriate glycemic control; and

(E) The device is designed for home use;

(c) Home blood glucose monitors with special features (E2100 or E2101) may be covered for clients who meet the basic coverage criteria (1)(b)(A)–(E) of this rule and the following:

(A) For code E2100, the treating practitioner certifies that the client has a severe visual impairment (i.e., best corrected visual acuity of 20/200 or worse) requiring use of this special monitoring system; or

(B) For code E2101, the treating practitioner certifies that the client has an impairment of manual dexterity severe enough to require the use of this special monitoring system;

(d) If a glucose monitor is covered, lancets, blood glucose test reagent strips, glucose control solutions, insulin syringes, and spring powered devices for lancets may also be covered. Coverage limitations for these supplies are as follows:

(A) For A4258, only one spring powered device every six months;

(B) For A4253 and A4259, the provider of the test strips and lancets shall maintain in their records the order from the treating practitioner. The provider shall verify that the client has nearly exhausted their supply, before dispensing more test strips and lancets. The amount of test strips and lancets covered is based on the needs of the client according to the following limitations:

(i) For clients with type 2 diabetes not requiring multiple daily insulin injections, up to 50 test strips (1 unit) and 100 lancets (1 unit) at the time of diagnosis;

(ii) For clients with type 2 diabetes who require diabetic medication that may result in hypoglycemia, up to 50 test strips and 100 lancets per 90 days. An additional 50 test strips may be covered with clinical documentation of an acute change in glycemic control or active diabetic medication adjustment;

(iii) For clients with Type 1 diabetes and those with type 2 diabetes requiring multiple daily insulin injections, up to 100 test strips and 100 lancets per month;

(iv) For clients with gestational diabetes, up to 150 test strips and 200 lancets per month no longer than 60 days beyond the duration of the pregnancy;

(v) Quantities exceeding these utilization guidelines require prior authorization and may be covered when:

(I) Basic coverage criteria in (1)(b)(A)-(E) for home glucose monitors and related accessories and supplies are met; and

(II) The treating practitioner has seen the client and evaluated their diabetes control within six months prior to ordering quantities of test strips and lancets that exceed the utilization guidelines and has documented in the client’s medical record the specific reason for the additional supplies for that particular client; and

(III) If refills of quantities of supplies that exceed utilization guidelines are dispensed, there shall be documentation in the ~~physician's~~ practitioner's records (e.g., a specific narrative statement that adequately specifies the frequency at which the client is actually testing or a copy of the client's log) that the client is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the client is regularly using quantities of supplies that exceed the utilization guidelines, new documentation shall be present at least every six months;

(C) Home blood glucose monitors are subject to a limit of one monitor per two calendar years;

(e) Diabetic supply providers may not dispense a quantity of supplies exceeding a client's expected utilization. Providers ~~should~~ shall stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering practitioner that the atypical utilization is, in fact, warranted. Regardless of utilization, a provider may not dispense more than a three-month quantity of glucose testing supplies (i.e., up to 300 test strips, 300 lancets, and 500 insulin syringes) at a time. Prior authorization (PA) shall be obtained prior to dispensing amounts in excess of these utilization limits;

(f) Providers may contact the treating practitioner to renew an order; however, the request for renewal may only be made with the client's continued monthly use of testing supplies and only with the client's or caregiver's request to the provider for order renewal;

(g) An order refill does not have to be approved by the ordering practitioner; however, a client or their caregiver shall specifically request refills of glucose monitor supplies before they are dispensed. The provider may not automatically dispense a quantity of supplies on a predetermined regular basis, even if the client has "authorized" this in advance;

(h) Purchase fee for a glucose monitor includes normal, low and high-calibrator solution/chips (A4256), a battery (A4233, A4234, A4235 or A4236), and a spring-powered lancet device (A4258);

(i) The following services are generally not covered as not medically necessary or medically appropriate, however, may be reviewed for individual medical appropriateness in accordance with OAR 410-122-0080(20):

(A) Peroxide (A4244), betadine, or phisoHex (A4246, A4247);

(B) Alternate site blood glucose monitors;

(C) Blood glucose monitors and related supplies prescribed on an "as needed" basis;

(D) Blood glucose test or reagent strips that use a visual reading and are not used in a glucose monitor;

(E) Disposable gloves;

(F) Home blood glucose disposable monitors;

Commented [JK64]: These are not necessary for blood glucose testing. I believe these were likely called out in rule because at one point in time we received a request.

Commented [JK65]: Not sure if these actually exist or if they have a different assigned code than standard glucose monitor

Commented [JK66]: Not necessary for blood glucose testing

(G) Jet injectors;

(H) Insulin delivery devices and related supplies other than those identified in this rule and OAR 410-122-0525;

(I) Reflectance colorimeter devices used for measuring blood glucose levels in clinical settings;

Commented [JK67]: These would be billed using professional fee in clinical setting

(J) Urine test or reagent strips or tablets.

(2) Guidelines:

(a) Insulin-treated means that the client is receiving insulin injections to treat their diabetes. Insulin does not exist in an oral form and therefore clients taking oral medication to treat their diabetes are not insulin-treated;

(b) A severe visual impairment is defined as a best corrected visual acuity of 20/200 or worse in both eyes;

(c) An order renewal is the act of obtaining an order for an additional period of time beyond that previously ordered by the treating practitioner;

(d) An order refill is the act of replenishing quantities of previously ordered items during the time period in which the current order is valid;

(e) A4256 describes control solutions containing high, normal, and low concentrations of glucose that can be applied to test strips to check the integrity of the test strips. This code does not describe the strip or chip which is included in a vial of test strips and which calibrates the glucose monitor to that particular vial of test strips;

(f) For glucose test strips (A4253), 1 unit of service = 50 strips. For lancets (A4259), 1 unit of service = 100 lancets.

(3) Documentation requirements:

(a) For supplies requiring prior authorization (PA), submit documentation that supports coverage criteria as specified in this rule are met;

(b) The order for home blood glucose monitors and/or diabetic testing supplies shall include all of the following:

(A) All item(s) to be dispensed;

(B) The specific frequency of testing;

(C) The treating practitioner’s signature;

(D) The date of the treating practitioner's signature;

(E) A start date of the order is only required if the start date is different than the signature date;

(c) A new order shall be obtained when there is a change in the testing frequency;

(d) For E2100 or E2101 in a client with impaired visual acuity, submit documentation that includes a narrative statement from the practitioner which indicates the client's specific numerical visual acuity (e.g., 20/400) and that this result represents "best corrected" vision;

(e) For E2101 clients with impaired manual dexterity, submit documentation that includes a narrative statement from the practitioner which indicates an explanation of the client's medical condition necessitating the monitor with special features;

(f) When requesting quantities of supplies that exceed utilization guidelines as specified in (1)(d)(B)(i)–(iv) (e.g., more than 100 blood glucose test strips per month for insulin-dependent diabetes mellitus), submit documentation supporting the medical appropriateness for the higher utilization as specified in (1)(d)(B)(v)(I)–(III) to the appropriate authorization authority for PA;

(g) Documentation that supports condition of coverage requirements for codes billed 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;

(h) The appropriate diagnosis code describing the condition that necessitates glucose testing shall be included on each claim for the monitor, accessories, and supplies;

(i) Diabetic supply providers are not prohibited from creating data collection forms in order to gather medically appropriate information; however, the Division will not rely solely on those forms to prove the medical appropriateness of services provided;

(j) A client's medical records shall support the justification for supplies dispensed and billed to the Division.

(4) Billing and Payment Guidelines:

(a) Diabetic supplies shall be billed using a National Drug Code (NDC). DMEPOS provider types shall submit claims with appropriate NDC and HCPCS codes to the Division via the Web Portal or Point of Sale Systems via professional claim format. Pharmacy provider types shall submit claims with appropriate NDC to the Division via the Web Portal or Point of Sale Systems via pharmacy claim format. Claims submitted on these systems without NDC's will not be processed. This NDC requirement applies to:

(A) Home glucose monitors; and

(B) Blood glucose test reagent strips;

(C) Lancets;

(D) Insulin syringes;

(E) Spring powered lancet devices;

(F) Calibrating solutions and chips;

(b) For specialized glucose monitors and the respective testing supplies, such as those with special features for the visually impaired and those with manual dexterity problems, the provider shall obtain PA. After PA the provider can submit a professional claim to the Division;

(c) Orders received from prescribing clinicians for blood glucose test reagent strips that exceed utilization guidelines outlined in section (1)(d)(B)(i)–(iv) will require PA from the Division. Diabetic supply providers may initially dispense up to utilization limits (i.e., 300 test strips, 300 lancets, and 500 insulin syringes) prior to obtaining PA for orders that exceed utilization guidelines. After PA is issued the remaining amount may be dispensed for a three-month time period.

(3) Procedure Codes: Table 122-0520 — Diabetic Supplies.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 82-2014, f. 12-23-14, cert. ef. 1-1-15
DMAP 42-2011, f. 12-21-11, cert. ef. 1-1-12
DMAP 12-2011, f. 6-29-11, cert. ef. 7-1-11
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 10-1994, f. & cert. ef. 2-15-94

HR 9-1993, f. & cert. ef. 4-1-93
HR 13-1991, f. & cert. ef. 3-1-91

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 per-cent 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 months prior to initiation of the insulin pump; and

(iii) Documented frequency of glucose self-testing an average of at least four times per day during the two months prior to initiation of the insulin pump and meets one or more of the following criteria while on the multiple injection regimen:

(I) Glycosylated hemoglobin level (HbA1C) greater than 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 ~~physician~~ practitioner at least every three months;

(c) The external insulin infusion pump shall be ordered and follow-up care rendered by a ~~physician~~ 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 ~~A4221~~ A4224 or A4225, and K0552;

(e) Code ~~A4221~~ A4224 includes catheter insertion devices for use with external insulin infusion pump infusion cannulas and are not separately payable;

(f) ~~A4221~~ A4224 is limited to one unit of service per week.

(2) Coding guidelines:

(a) Code ~~A4221~~ 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) Code K0552 describes a syringe-type reservoir that is used with the external insulin infusion pump (E0784).

(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.

Commented [JK68]: Revise table as well

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00

410-122-0540
Ostomy Supplies

(1) Indications and Limitations of Coverage and Medical Appropriateness: The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ may cover ostomy supplies for a client with a surgically created opening (stoma) to divert urine or fecal contents outside the body:

(a) Only one liquid barrier may be dispensed at a time:

(A) A liquid or spray (A4369); or

(B) Individual wipes or swabs (A5120);

(b) For a client with a continent stoma, only one of the following means to prevent/manage drainage may be covered on a given day:

(A) Stoma cap (A5055);

(B) Stoma plug (A5081); or

(C) Gauze pads (A6216);

(c) For a client with a urinary ostomy, only one of the following may be covered for drainage at night:

(A) Bag (A4357); or

(B) Bottle (A5102);

(d) Provision of ostomy supplies for a client is limited to a three month supply;

(e) The following services are not covered:

(A) Ostomy clamps;

(B) Ostomy supplies when a client is in a covered home health episode;

(C) Pouch covers.

(2) Documentation Requirements:

(a) For miscellaneous ostomy supplies (A4421) ,submit documentation which supports coverage criteria as specified in this rule are met to the responsible unit for prior authorization;

(b) Medical records which support conditions of coverage as specified in this rule are met must be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request;

(c) A client's medical records must support the justification for supplies billed to the Division including when a greater quantity of supplies than the amounts listed in this rule are dispensed (e.g., client has more than one ostomy).

(3) Table 122-0540-1, Maximum Quantity of Supplies — Monthly Basis.

(4) Table 122-0540-2, Maximum Quantity of Supplies — 6-Month Basis.

(5) Table 122-0540-3, Faceplate Systems.

(6) Table 122-0540-4, Procedure Codes.

[ED. NOTE: Tables referenced rule are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 17-2012, f. 3-30-12, cert. ef. 4-1-12
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03

OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0560
Urological Supplies

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The ~~Division of Medical Assistance Programs~~Division ~~(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 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 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 insertion tray per episode of indwelling catheter insertion;

(B) One 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 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 catheter (A4351, A4352) and an individual packet of lubricant (A4332); or

(B) One 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) Have AIDS;

(IV) Have 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 38º C [100.4º 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);

(B) 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 pouch (A4328) per day;

(j) Miscellaneous Supplies:

(A) Appliance cleaner (A5131): One unit of service (16 oz) per month when used to clean the inside of certain urinary collecting appliances (A5102, A5112);

(B) One external urethral clamp or compression device (A4356) every three months or sooner if the rubber/foam casing deteriorates;

(C) Adhesive catheter anchoring devices (A4333, three per week) and catheter leg straps (A4334, one 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;

(k) 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 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 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.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98

HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0580
Bath Supplies

(1) Indications and limitations of coverage and medical appropriateness

(a) The Division may cover bath supplies when medically appropriate and cost-effective.

(~~a~~b) The Division may cover ~~bath supplies when medically appropriate and cost-effective including~~ a rehab shower/commode chair when all of the following criteria are met:

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

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

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

(D) Less costly alternatives have been considered 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) 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) Use E1399 for a rehab shower/commode chair and accessories that are not included in the base for the rehab shower/commode chair.

(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 ordered;

(b) For a rehab shower/commode chair, 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.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Commented [JK69]: Table won't open on SOS website. Will need to get one from archives

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 26-1994, f. & cert. ef. 7-1-94
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 32-1992, f. & cert. ef. 10-1-92
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0590
Patient Lifts

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

(2) The areas within the client's residence where the lift will be utilized must be able to accommodate and allow for the effective use of the lift. The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ does not reimburse for adapting the living quarters.

(3) A sling or seat for a client lift may be covered as an accessory when ordered as a replacement for the original equipment item.

(4) E0621 is included in the allowance for E0630 when provided at the same time.

(5) E0635 may be covered only when a client weighs 450 pounds or more;

(6) Procedure codes:

(a) E0621 — Sling or seat, client lift, canvas or nylon — Purchase — Prior authorization (PA) required;

(b) E0630 — Client lift, hydraulic with seat or sling (considered purchased after ~~13~~ 10 months of rental) — Purchase, rent or repair — PA required;

(c) E0635 — Client lift, electric, with seat or sling — Rent only. This item is a capped rental and becomes the property of the client after ~~13~~ 10 months of continuous rental or when the usual purchase price is reached, whichever is lesser. May be covered for a nursing facility client — PA required.

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01

410-122-0600
Toilet Supplies

(1) The Division may consider coverage for commodes when:

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

(A) A single room; or

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

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

(b) Extra-wide/heavy-duty commodes may be covered when a client weighs 300 pounds or more and meets the conditions of coverage for commodes;

(c) Only bariatric commodes coded as E1399 (durable medical equipment, miscellaneous) may be covered for a client residing in a nursing facility, subject to service limitations of Division rules, when all of the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric commode has been assigned code E1399 by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor.

(d) A commode with detachable arms (E0165) may be covered if the detachable arms feature is necessary to facilitate transferring the client or if the client has a body configuration that requires extra width.

(e) A commode with integrated seat lift mechanism (E0170, E0171) is covered if it is medically appropriate and client meets criteria for a seat lift mechanism. A commode with seat lift mechanism is intended to allow the client to walk after standing.

(f) Toilet seat lift mechanisms (E0172) and footrests (E0175) are not primarily medical in nature,.

(2) Documentation requirements:

(a) Documentation must include the practitioner's order, the client's height and weight and information supporting the medical appropriateness for the commode dispensed;

(b) For codes requiring prior authorization (PA), submit documentation which supports conditions of coverage are met as specified in this rule.

(3) Procedure Codes: Table 122-0600 Toilet Supplies.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Commented [JK70]: Create rule for seat lift mechanism like Medicare's crietria. Check codes to see if they are all open.

Commented [JK71]: Medicare criteria for E0172 states "A toilet seat lift mechanism (E0172) is a device with seat that can be raised with orwithout a forward tilt while the bene is seated, allowing the bene to ambulate once he/she is in more upright position. It may be manual or electric and is attached to the toilet)

Commented [JK72]: Remove Bariatric commode as this is covered by code E0168

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
HR 17-1996, f. & cert. ef. 8-1-96
HR 26-1994, f. & cert. ef. 7-1-94
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 32-1992, f. & cert. ef. 10-1-92
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0630
Incontinent Supplies

(1) The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ may cover incontinent supplies for urinary or fecal incontinence 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 gloves per month).

(2) Incontinent supplies are not covered:

(a) For nocturnal enuresis; or

(b) For children under the age of three.

(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 equal one 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.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 62-2015, f. 10-29-15, cert. ef. 11-1-15

DMAP 17-2012, f. 3-30-12, cert. ef. 4-1-12
DMAP 42-2011, f. 12-21-11, cert. ef. 1-1-12
DMAP 22-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-25-12
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09
OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 76-2003, f. & cert. ef. 10-1-03
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 64-2001, f. 12-28-01, cert. ef. 1-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00

410-122-0640
Eye Prostheses

Commented [JK73]: Repeal this rule or refer to Speech and Audiology rules? .

(1) Indications and coverage can be found in OAR 410-129 rules. ~~:~~

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

~~(b) For clients under age 21, the prescribing practitioner shall determine and document medical appropriateness of the eye prosthesis and related services;~~

~~(c) For clients age 21 and older, coverage is limited as follows:~~

~~(A) Polishing and resurfacing will be allowed on a twice per year basis;~~

~~(B) Replacement is covered every five years if documentation supports medical appropriateness. An exception to this limitation is allowed when clinical documentation supports medical appropriateness for more frequent replacement;~~

~~(C) One enlargement (V2625) or reduction (V2626) of the prosthesis is covered. Additional enlargements or reductions are rarely medically indicated and are therefore covered only when clinical documentation supports medical appropriateness.~~

~~(2) Documentation requirements:~~

~~(a) An order for each item shall be signed and dated by the treating physician, kept on file by the supplier, and made available upon request;~~

~~(b) Documentation of medical appropriateness that has been reviewed and signed by the prescribing practitioner (for example, CMN) shall be kept on file by the supplier and made available upon request;~~

~~(c) When billing for an item or service at a greater frequency than allowed, there shall be documentation in the patient's medical records that corroborates the order and supports the medical appropriateness of the items. This documentation shall be kept on file by the supplier and available upon request.~~

~~(3) Procedure Codes – Table 122-0640.~~

~~[ED. NOTE: Tables referenced are available from the agency.]~~

~~[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]~~

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16
DMAP 60-2014, f. 10-3-14, cert. ef. 10-7-14
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
HR 17-1996, f. & cert. ef. 8-1-96
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0658
Gradient Compression Stockings/Sleeves

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The ~~Division of Medical Assistance Programs~~ Division ~~(Division)~~ may cover gradient compression stockings/sleeves for the following indications:

(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; 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 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 per affected limb every six 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) 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) Table 122-0658

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 59-2015, f. 10-28-15, cert. ef. 11-1-15
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08

410-122-0660
Orthotics and Prosthetics

(1) Indications and limitations of coverage and medical appropriateness:

(a) The ~~Division of Medical Assistance Programs~~Division ~~(Division)~~ may cover some orthotics and prosthetics for covered conditions;

(b) Use the current Healthcare Common Procedure Coding System (HCPCS) Level II Guide for current codes and descriptions;

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

(d) For clients under age 19, the prescribing practitioner shall determine and document medical appropriateness;

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

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

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

(h) See Division 129, Speech-Language Pathology, Audiology and Hearing Aid Services for coverage criteria for speech and audiology prosthetic devices and accessories.

(i) See OAR 410-122-0658 for coverage criteria for mastectomy sleeves (L8010).

(2) Documentation requirements:

(a) For services that require prior authorization (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: Medical records that support conditions of coverage as specified in this rule are met shall be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request.

(3) Table 122-0660-1: Codes requiring PA.

~~(4) Table 122-0660-2: Exclusions of Coverage.~~

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 60-2015, f. 10-29-15, cert. ef. 11-1-15
DMAP 17-2012, f. 3-30-12, cert. ef. 4-1-12
DMAP 40-2009, f. 12-15-09, cert. ef. 1-1-10
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06
OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 8-2002, f. & cert. ef. 4-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98
HR 7-1997, f. 2-28-97, cert. ef. 3-1-97
HR 17-1996, f. & cert. ef. 8-1-96
HR 41-1994, f. 12-30-94, cert. ef. 1-1-95
HR 26-1994, f. & cert. ef. 7-1-94
HR 10-1994, f. & cert. ef. 2-15-94
HR 9-1993, f. & cert. ef. 4-1-93
HR 10-1992, f. & cert. ef. 4-1-92
HR 13-1991, f. & cert. ef. 3-1-91

410-122-0662
Ankle-Foot Orthoses and Knee-Ankle-Foot Orthoses

(1) Indications and limitations of coverage and medical appropriateness: The ~~Division of Medical Assistance Programs~~Division ~~(Division)~~ may cover some ankle-foot orthotics (AFOs) and knee-ankle-foot Orthotics (KAFOs) and related services for a covered condition, for this episode, when the covered 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, and in addition specifically for:

Commented [JK74]: Excluded table removed from rule on SoS but still referenced in rule. Will remove

Commented [JK75]: Who can provide custom orthotics and prosthetics? What specialties?

(a) AFOs not used during ambulation: A static AFO (L4396) may be covered when (A)-(E) are met:

(A) The client has a plantar flexion contracture of the ankle (Internal Classification of Diseases (ICD)-10 diagnosis code M24.571, M24.572) with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a nonfixed contracture);

(B) There is a reasonable expectation of the ability to correct the contracture;

(C) The contracture is interfering or expected to interfere significantly with the client's functional abilities;

(D) The static AFO is used as a component of a therapy program that includes active stretching of the involved muscles and/or tendons;

(E) The pre-treatment passive range of motion is measured with a goniometer and an appropriate stretching program carried out by professional staff (in a nursing facility) or caregiver (at home) is documented in the client's treatment plan;

(b) AFOs and KAFOs used during ambulation:

(A) AFOs described by codes L1900, L1902-L1990, L2106-L2116, L4350, L4360 and L4386 with weakness or deformity of the foot and ankle requiring stabilization fro medical reasons and with potential to benefit functionally;

(B) KAFOs described by codes L2000-L2038, L2126-L2136 and L4370 when conditions of coverage are met for an AFO and additional knee stability is required:

(C) AFOs and KAFOs that are molded-to-patient model, or custom-fabricated when basic coverage criteria for an AFO or KAFO are met and one of the following criteria is met:

(i) The client could not be fit with a prefabricated AFO;

(ii) The condition necessitating the orthotic is expected to be permanent or of longstanding duration (more than six months);

(iii) There is a need to control the knee, ankle or foot in more than one plane;

(iv) The client has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury;

(v) The client has a healing fracture that lacks normal anatomical integrity or anthropometric proportions;

(c) No more than one replacement interface (L4392) may be covered every six months for a covered static AFO;

(d) Evaluation of the client, measurement and/or casting and fitting of the orthotic are included in the allowance for the orthotic;

(e) Repairs/Replacement:

(A) Repairs to a covered orthotic due to wear or to accidental damage when necessary to make the orthotic functional. If the expense for repairs exceeds the estimated expense of providing another entire orthot, no payment will be made for the amount in excess;

(B) Replacement of a complete orthotic or component of an orthotic due to loss, significant change in the client's condition or irreparable accidental damage if the device is still medically appropriate and conditions of coverage are met;

(C) L4205 (Repair of orthotic device, labor component, per 15 minutes):

(i) May only bill for the actual time involved in the repair of an orthotic;

(ii) May not use this code for any labor involved in the evaluation, fabrication or fitting of a new or full replacement orthotic;

(iii) Use for the labor component of repair of a previously provided orthotic;

(D) Labor Allowance:

(i) Included in the replacement of an orthotic component coded with a specific L code;

(ii) Not included in the replacement of an orthotic component coded with L4210;

(E) Replacement items with specific HCPCS codes:

(i) Use L4392 and L4394 for replacement soft interfaces used with ankle contracture orthotics or foot drop splints;

(ii) Use L2999 (Lower extremity orthotics, not otherwise specified) for replacement components that do not have a specific HCPCS code;

(iii) Addition codes L4002 — L4130, L4392 for replacement components are not payable at initial issue of a base orthotic;

(f) The codes specified in this rule may be covered for a client residing in a nursing facility;

(g) Quantities of supplies greater than those described in the policy as the usual maximum amounts only when supported by documentation clearly and maximum amounts only when supported by documentation clearly and specifically explaining the medical appropriateness of the excess quantities.

(2) Exclusions: The following services are not covered;

(a) A static AFO and replacement interface for:

(A) A fixed contracture; or

(B) A foot drop without an ankle flexion contracture;

(C) When used solely for the prevention or treatment of a heel pressure ulcer;

(b) A component of a static AFO that is used to address positioning of the knee or hip;

(c) A foot drop splint/recumbent positioning device (L4398) or replacement interface (L4394) for a non-ambulatory client when used solely for the prevention or treatment of a pressure ulcer;

(d) An AFO or KAFO and any related addition for an ambulatory client when used solely for treatment of edema and/or prevention or treatment of a pressure ulcer;

(e) Walking boots used primarily to relieve pressure, especially on the sole of the foot or used solely for the prevention or treatment of a pressure ulcer;

(f) Elastic support garments (L1901);

(g) Socks (L2840, L2850) used in conjunction with orthotics;

(h) Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out;

(i) A foot pressure off-loading/supportive device (A9283);

(j) L coded additions to AFOs and KAFOs (L2180-L2550, L2750-L2768, L2780-L2830) if either the coverage criteria for the base orthotic is not met or the specific addition is not medically appropriate.

(3) Coding Guidelines:

(a) A prefabricated orthotic is one that is manufactured in quantity without a specific client in mind. A prefabricated orthotic may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific client (i.e., custom fitted). An orthotic that is assembled from prefabricated components is considered prefabricated. Any orthotic that does not meet the definition of a custom-fabricated orthotic is considered prefabricated;

(b) A custom-fabricated orthotic is individually made for a specific client starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve

some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item;

(c) A molded-to-patient model orthotic is a particular type of custom-fabricated orthotic in that an impression of the specific body part is made (by means of a plaster cast, computer-aided design and computer-aided manufacturing (CAD-CAM) technology, etc.). This impression is used to make a positive model (of plaster or other material) of the body part. The orthotic is then molded on this positive model;

(d) Ankle-foot orthotics extend well above the ankle (usually to near the top of the calf) and are fastened around the lower leg above the ankle. These features distinguish them from foot orthotics that are shoe inserts that do not extend above the ankle. A nonambulatory ankle-foot orthotic may be either an ankle contracture splint, night splint or a foot drop splint;

(e) A static AFO (L4396) is a prefabricated ankle-foot orthotic that has all of the following characteristics:

(A) Designed to accommodate an ankle with a plantar flexion contracture up to 45°;

(B) Applies a dorsiflexion force to the ankle;

(C) Used by a client who is minimally ambulatory or nonambulatory;

(D) Has a soft interface;

(f) A foot drop splint/recumbent positioning device (L4398) is a prefabricated ankle-foot orthotic that has all of the following characteristics:

(A) Designed to maintain the foot at a fixed position of 0° (i.e., perpendicular to the lower leg);

(B) Not designed to accommodate an ankle with a plantar flexion contracture;

(C) Used by a client who is nonambulatory;

(D) Has a soft interface.

(4) HCPCS Modifiers:

(a) EY — No physician or other licensed health care provider order for this item or service;

(b) GY — Item or service statutorily excluded or does not meet the definition of any Medicare benefit:

(A) If an AFO or a KAFO is used solely for the treatment of edema and/or for the prevention or treatment of a pressure ulcer, the GY modifier must be added to the base code and any related additional code;

(B) If a walking boot (L4360, L4386), static AFO (L4396) or foot drop splint/recumbent positioning device (L4398) is used solely for the prevention or treatment of a pressure ulcer, the GY modifier must be added to the base code and to the code for the replacement liner (L4392, L4394);

(C) When the GY modifier is added to a code there must be a short narrative statement indicating why the GY modifier was used — e.g., "used to prevent pressure ulcer" or "used to treat pressure ulcer" or "used to treat edema". This statement must be entered in the narrative field of an electronic claim or attached to a hard copy claim;

(c) KX — Requirements specified in the medical policy have been met. The provider must add a KX modifier to the AFO/KAFO base and additional codes only if all the coverage criteria of this policy have been met and evidence of such is retained in the provider's files;

(d) LT — Left Side; RT — Right Side:

(A) The right (RT) and left (LT) modifiers must be used with orthotic base codes, additions and replacement parts;

(B) When the same code for bilateral items (left and right) is billed on the same date of service, bill both items on the same claim line using the LTRT modifiers and 2 units of service.

(5) Documentation Requirements:

(a) L2999 is the only code in this rule that requires prior authorization (PA): For a PA request, submit documentation for review that supports conditions of coverage as specified in this rule are met, including the plan of care, if applicable;

(b) For services that do not require PA: Documentation from the medical record that supports conditions of coverage as specified in this rule are met must be kept on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider;

(c) Prior to billing for each new or full replacement item, the DMEPOS provider must first have received a completed written, signed and dated ~~physician's~~ practitioner's order that includes:

(A) The treating diagnosis code that justifies the need for the orthotic device;

(B) Detailed description of the item including all options or additional features;

(C) The unique features of the base code plus every addition that will be billed on a separate claim line;

(d) For custom-fabricated orthotics, documentation must support the medical appropriateness of that type device rather than a prefabricated orthotic;

(e) For L2999:

(A) The request for PA must include the following information:

(i) A narrative description of the item (for custom fabricated items); or

(ii) The manufacturer's name and model name/number (for pre-fabricated items); and

(iii) Justification of medical appropriateness for the item;

(iv) For replacement components, a HCPCS code or the manufacturer's name and model name/number of the base orthotic;

(v) The manufacturer's name and model name/number must be entered in the narrative field of an electronic claim;

(f) Repair of orthotic devices:

(A) A ~~physician's~~ practitioner's order is not required;

(B) A detailed description of the reason for the repair, part that is being repaired or replaced must be on file with the DMEPOS provider;

(C) The following information must be entered in the narrative field of an electronic claim:

(i) L4210 must include a description of each item that is billed;

(ii) L4205 must include an explanation of what is being repaired;

(D) All codes for repairs of orthotics billed with the same date of service must be submitted on the same claim;

(g) The provider must include the ICD-10 diagnosis code for the underlying condition on the claim for a static AFO (L4396) or replacement interface material (L4392);

(h) All codes for orthotics billed with the same date of service must be submitted on the same claim;

(i) When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, there must be documentation in the client's medical record supporting the medical appropriateness for the higher utilization;

(j) The client's medical record must support the medical appropriateness for items and all additions billed to the Division and this documentation must be made available to the Division on request.

(5) Table 122-0662

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 40-2009, f. 12-15-09, cert. ef. 1-1-10
DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08

410-122-0700
Negative Pressure Wound Therapy Pumps

(1) Indications and limitations of coverage and medical appropriateness — Initial Coverage: The Division may cover a negative pressure wound therapy (NPWT) pump and supplies on a monthly basis for up to four months on the most recent covered wound when either criterion (a) or (b) is met:

(a) Ulcers and wounds in the home setting or nursing facility:

(A) The client has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology;

(B) A complete wound therapy program described by criterion (i) and criteria (ii), (iii), or (iv), as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT:

(i) For all ulcers or wounds, the wound therapy program must include a minimum of all of the following general measures, which have either been addressed, applied, or considered and ruled out prior to application of NPWT:

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

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

(III) Debridement of necrotic tissue if present;

(IV) Evaluation of and provision for adequate nutritional status;

(ii) For Stage III or IV pressure ulcers:

(I) Appropriate turning and positioning of the client;

(II) Use of a Group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see 410-122-0400 Pressure Reducing Support Surfaces). If the ulcer is not on the trunk or pelvis, a Group 2 or 3 support surface is not required; and

(III) Appropriate management of the client's moisture and incontinence;

(iii) For neuropathic (for example, diabetic) ulcers:

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

(II) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities;

(iv) For venous insufficiency ulcers:

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

(II) Leg elevation and ambulation have been encouraged;

(b) Ulcers and wounds encountered in an inpatient setting:

(A) An ulcer or wound as described in subsection (1)(a) is encountered in the inpatient setting and, after wound treatments described in subsection (1)(a) have been tried or considered and ruled out, NPWT is initiated because the treating ~~physician~~ practitioner considers it the best available treatment option;

(B) The client has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical appropriateness for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the client that will not allow for healing times achievable with other topical wound treatments);

(c) In either situation described in subsection (1)(b), NPWT will be covered when treatment continuation is ordered beyond discharge to the home setting;

(d) If criterion in subsection (1)(a) or (1)(b) above is not met, the NPWT pump and supplies are not covered;

(e) NPWT pumps (E2402) must be capable of accommodating more than one wound dressing set for multiple wounds on a client. A request for more than one NPWT pump per client for the same time period is not covered;

(f) For the purposes of this rule, a licensed health care professional may be a physician, physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or physical therapist (PT). The practitioner must be licensed to assess wounds and/or administer wound care.

(2) Indications and limitations of coverage and medical appropriateness — Continued Coverage: For wounds and ulcers described in subsection (1)(a) or (1)(b), for clients placed on an NPWT pump and supplies, the Division will only approve continued coverage when the licensed medical professional does all the following duties:

(a) On a regular basis:

(A) Directly assesses the wound(s) being treated with the NPWT pump; and

(B) Supervises or directly performs the NPWT dressing changes;

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

(3) Coverage for a NPWT pump and supplies ends when any of the following occur:

(a) Criteria in section (2) are not met;

(b) The treating physician determines that adequate wound healing has occurred for NPWT to be discontinued;

(c) Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound;

(d) Four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using an NPWT pump in the treatment of the most recent wound. Coverage beyond four months will be given individual consideration based upon required additional documentation;

(e) Equipment or supplies are no longer being used for the client, whether or not by the physician's order.

(4) The Division will not cover NPWT pump and supplies if one or more of the following are present:

(a) Necrotic tissue with eschar in the wound, if debridement is not attempted;

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

(c) Cancer present in the wound;

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

(5) The Division will only cover NPWT pumps and their supplies that have been specifically designated as being qualified for use of HCPCS codes E2402, A6550 and A7000 via written instructions from the Medicare Pricing, Data Analysis and Coding (PDAC) contractor.

(6) The Division covers a maximum of 15 dressing kits (A6550) per wound per month, unless there is documentation that the wound size requires more than one dressing kit for each dressing change.

(7) The Division covers a maximum of 10 canister sets (A7000) per month, unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day). For high-volume exudative wounds, a stationary pump with the largest capacity canister must be used. The Division does not cover excess use of canisters related to equipment failure (as opposed to excessive volume drainage).

(8) Guidelines:

(a) Equipment:

(A) Negative pressure wound therapy (NPWT) is the controlled application of subatmospheric pressure to a wound. Specifically, an electrical pump (described in the definition of code E2402) intermittently or continuously conveys subatmospheric pressure through connecting tubing to a specialized wound dressing (described in the descriptor of HCPCS code A6550). The dressing includes a resilient, open-cell foam surface dressing, sealed with an occlusive dressing that is meant to contain the subatmospheric pressure at the wound site and thereby promote wound healing. Drainage from the wound is collected in a canister (described in the definition of HCPCS code A7000);

(B) Code E2402 describes a stationary or portable NPWT electrical pump which provides controlled subatmospheric pressure that is designed for use with NPWT dressings, (A6550) to promote wound healing. Such an NPWT pump is capable of being selectively switched between continuous and intermittent modes of operation and is controllable to adjust the degree of subatmospheric pressure conveyed to the wound in a range from 25 to greater than or equal to 200 mm Hg subatmospheric pressure. The pump can sound an audible alarm when desired pressures are not being achieved (that is, where there is a leak in the dressing seal) and when its wound drainage canister (A7000) is full. The pump is designed to fill the canister to full capacity;

(b) Supplies:

(A) Code A6550 describes a dressing set which is used in conjunction with a stationary or portable NPWT pump (E2402), and contains all necessary components, including but not limited to a resilient, open-cell foam surface dressing, drainage tubing, and an occlusive dressing which creates a seal around the wound site for maintaining subatmospheric pressure at the wound;

(B) Code A7000 describes a canister set which is used in conjunction with a stationary or portable NPWT pump (E2402) and contains all necessary components, including but not limited to a container, to collect wound exudate. Canisters may be various sizes to accommodate stationary or portable NPWT pumps;

(c) The staging of pressure ulcers used in this rule is as follows:

(A) Stage I — Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II — Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III — Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV — Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

(9) Documentation Requirements: Submit the following information with the prior authorization request:

(a) For initial coverage:

(A) A statement from the attending physician which describes the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care as specified in subsection (1)(a);

(B) From the treating clinician, history, previous treatment regimens (if applicable), and current wound management for which an NPWT pump is being requested to include the following:

(i) Changes in wound conditions, including precise, quantitative measurements of wound characteristics (wound length and width (surface area), and depth), quantity of exudates (drainage), presence of granulation and necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.);

(ii) Dated photographs of ulcers or wounds with specific location(s) identified within the last 30 days;

(iii) Length of sessions of use;

(iv) Dressing types and frequency of change;

(v) Wound healing progress;

(b) For Continued Coverage:

(A) Progress notes from the attending physician within the last 30 days;

(B) Updated wound measurements and what changes are being applied to effect wound healing including information specified in paragraph (9)(a)(B);

(c) For both initial and continued coverage of an NPWT pump and supplies, any other medical records that corroborate that all criteria in this rule are met;

(d) When requesting quantities of supplies greater than those specified in this rule as the usual maximum amounts, include documentation supporting the medical appropriateness for the higher utilization.

(10) Table 122-0700.

[ED. NOTE: Tables referenced are available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 25-2004, f. & cert. ef. 4-1-04
OMAP 47-2002, f. & cert. ef. 10-1-02
OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01
OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01
OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00
OMAP 13-1999, f. & cert. ef. 4-1-99
OMAP 11-1998, f. & cert. ef. 4-1-98

410-122-0720
Pediatric Wheelchairs

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division may cover a pediatric wheelchair when 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 completing an MRADL entirely;

Commented [JK76]: RAC will help with this. Pediatric wheelchairs are not only for pediatric patients. EPSDT will come into play, however, the rules support when the wheelchair and accessories would be medically appropriate and medically necessary.
Add language related to EPSDT – for individuals under age 21

(ii) Places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a MRADL; or

(iii) Prevents the client from completing an MRADL within a reasonable timeframe.

(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation;

(C) If the client will be using the wheelchair in the home, the client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for use of the pediatric wheelchair that is being requested;

(D) Use of a pediatric wheelchair will 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;

(E) The client is willing to use the requested pediatric 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 pediatric wheelchair in the home and community during a typical day. Proper assessment of upper extremity function ~~should~~ 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) Only when conditions of coverage as specified in section (1)(a) of this rule are met may the Division authorize a pediatric wheelchair for any of the following situations:

(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 pediatric wheelchair will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs, a pediatric 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 pediatric 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 pediatric wheelchair.

(B) For a purchase request, when a client's current wheelchair is no longer medically appropriate or repair or modifications to the wheelchair exceed replacement cost;

(C) When a covered, client-owned wheelchair is in need of repair (for one month's rental of a wheelchair). See OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing.

(c) A pediatric tilt-in-space wheelchair (E1231- E1234) may be covered when a client meets all of the following conditions:

(A) A standard base with a reclining back option will not meet the client's needs;

(B) Requires assistance for transfers;

(C) The 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.

(d) One month's rental for a manual pediatric tilt-in-space wheelchair (E1231-E1234) 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 30 days or less;

(B) The conditions of coverage for a manual tilt-in-space wheelchair as described in section (1) (c) (A) (E) 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.

(e) The Division does not reimburse for another wheelchair if the client has a medically appropriate wheelchair, regardless of payer;

(f) If the client will be using the wheelchair in the home, the client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. The Division does not reimburse for adapting living quarters;

(g) 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, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves;

(h) 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;

(i) Power mobility devices and related options and accessories 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;

(j) The ~~provider's~~ ATP must be employed by a provider in a full-time, part-time, or contracted capacity as is acceptable by state law. The provider's ATP, if part-time or contracted, must be under the direct control of the provider;

(k) Documentation must be complete and detailed enough so a third party would be able to understand the nature of the provider's ATP involvement, if any, in the licensed/certified medical professional (LCMP) specialty evaluation;

(L) The ~~provider's~~ ATP may not conduct the provider evaluation at the time of delivery of the power mobility device to the client's residence;

(m) A Group 5 (Pediatric) power wheelchair (PWC) with Single Power Option (K0890) or with Multiple Power Options (K0891) may be covered when:

(A) The coverage criteria for a PWC in OAR 410-122-0325, Power Wheelchair Base) are met;

(B) The client is expected to grow in height; and

(C) Either of the following criteria is met:

(i) The Group 2 Single Power Option in OAR 410-122-0325, Power Wheelchair Base, (2)(a)(C)(i)(I-II); or

(ii) Multiple Power Options in OAR 410-122-0325, Power Wheelchair Base, (2) (a)(D) (i) (I-II).

(D) The delivery of a PWC must be within 120 days following completion of the face-to-face examination with the physician;

(E) A PWC may not be ordered by a podiatrist.

(n) For more information on coverage criteria regarding repairs and maintenance, see OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing.

(2) Coding Guidelines:

(a) 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);

(b) 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);

(c) Wheelchair "poundage" (pounds) represents the weight of the usual configuration of the wheelchair with a seat and back, but without front riggings.

(3) Documentation requirements:

(a) Functional mobility evaluation:

(A) Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers must submit medical documentation that supports conditions of coverage in this rule are met for purchase and modifications of all covered, client-owned pediatric wheelchairs;

(B) Information must include but is not limited to:

(i) Medical justification, needs assessment, order, and specifications for the wheelchair, completed by a PT, OT, or treating physician. The individual who provides this information must have no direct or indirect financial relationship, agreement, or contract with the DMEPOS provider requesting authorization;

(ii) Client identification and rehab technology supplier identification information that may be completed by the DMEPOS provider; and

(iii) Signature and date by the treating physician and 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, or treating physician that specifically indicates:

(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.

(B) Pertinent information from a PT, OT, or treating physician about the following elements that support coverage criteria are met for a pediatric 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, pediatric wheelchair, power-operated vehicle (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 individual:

(I) Transferring between a bed, chair, and a 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 physician that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home;

(D) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions, and options, including growth capabilities;

(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 client will 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 or 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 will be billed separately.

(c) A written order by the treating physician, identifying the specific type of pediatric 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 pediatric 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 physician, received by the DMEPOS provider, and submitted to the authorizing authority;

(d) For a PWC request, see OAR 410-122-0325 Power Wheelchair Base for documentation requirements;

(e) Any additional documentation that supports indications of coverage are met as specified in this policy;

(f) For a manual wheelchair rental, submit all of the following:

(A) A written order from the treating physician, 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 physician, received by the DMEPOS provider, and submitted to the authorizing authority.

(B) HCPCS codes;

(C) If the client will be using the wheelchair in the home, documentation from the DMEPOS provider that supports that the client's home can accommodate and allow for the effective use of the requested wheelchair.

(g) The above documentation must be kept on file by the DMEPOS provider; and

(h) Documentation that the 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 410-122-0720 – Pediatric Wheelchairs.

[ED. NOTE: To view attachments referenced in rule text, click here to view rule.]

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: ORS 414.065
History:
DMAP 12-2018, amend filed 03/07/2018, effective 03/08/2018
DMAP 36-2017(Temp), f. 9-14-17, cert. ef. 9-15-17 thru 3-13-18
DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10
DMAP 15-2009, f. 6-12-09, cert. ef. 7-1-09
DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08
DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08
DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07
OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07
OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05
OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05
OMAP 44-2004, f. & cert. ef. 7-1-04
OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03