

Secretary of State  
**NOTICE OF PROPOSED RULEMAKING**  
A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410	
Agency and Division	Administrative Rules Chapter Number	
Sandy Cafourek	500 Summer St. NE, Salem, OR 97301	503-945-6430
Rules Coordinator	Address	Telephone

**RULE CAPTION**

Adding PDF Links to Durable Medical Equipment (DMEPOS) Tables and Updating Rule Language

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**Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.**

**RULEMAKING ACTION**

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing

**ADOPT:**

**AMEND:** OAR 410-122-0204, 410-122-0240, 410-122-0300, 410-122-0360, 410-122-0365, 410-122-0380, 410-122-0475, 410-122-0480, 410-122-0510, 410-122-0525, 410-122-0640, 410-122-0678

**REPEAL:**

**RENUMBER:**

**AMEND & RENUMBER:**

Stat. Auth.: ORS 413.042 and 414.065

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Other Auth.:

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Stats. Implemented: ORS 414.065

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**RULE SUMMARY**

Amending this rule to add pdf links to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) tables on the Secretary of State website and update rule language.

The agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

*February 19, 2016*  
January ~~22, 2015~~, by 5 p.m. Send comments to: [dmap.rules@state.or.us](mailto:dmap.rules@state.or.us)

**Last Day for Public Comment** (Last day to submit written comments to the Rules Coordinator)

	<i>Karen Wheeler</i>	<i>12/16/15</i>
Signature	Printed name	Date

**Note:** Notices must be submitted by the 15th day of the month to be published in the next month's *Oregon Bulletin*. A Rulemaking Hearing may be requested in writing by 10 or more people, or by an association with 10 or more members, within 21 days following notice publication or 28 days from the date notice was sent to people on the agency's interested party mailing list, whichever is later. In such cases a Hearing Notice must be published in the *Oregon Bulletin* at least 14 days before the hearing.

Secretary of State

**STATEMENT OF NEED AND FISCAL IMPACT**

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) 410  
Agency and Division Administrative Rules Chapter Number

Adding PDF Links to Durable Medical Equipment (DMEPOS) Tables and Updating Rule Language  
Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of OAR 410-122-0204, 410-122-0240, 410-122-0300, 410-122-0360, 410-122-0365, 410-122-0380, 410-122-0475, 410-122-0480, 410-122-0510, 410-122-0525, 410-122-0640, 410-122-0678

Statutory Authority: ORS 413.042 and 414.065

Other Authority:

Stats. Implemented: ORS 414.065

Need for the Rule(s): The Authority needs to amend this rule to add pdf links to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) tables on the Secretary of State website and update rule language.

Documents Relied Upon, and where they are available: None

Fiscal and Economic Impact: None

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): Amending this rule will have no fiscal impact on the Authority, other state agencies, units of local government, the public, or businesses, including small businesses.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:  
None

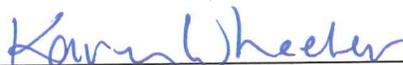
b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: None

c. Equipment, supplies, labor and increased administration required for compliance: None

How were small businesses involved in the development of this rule? Amending this rule affects no small businesses.

Administrative Rule Advisory Committee consulted?: No. If not, why?: This filing is to add pdf links to tables on the Secretary of State website and to update rule language.

  
Signature

  
Printed Name

  
Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

## 410-122-0204

### Nebulizer

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

(a) Equipment:

(A) Small volume nebulizer:

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

(ii) The physician ~~must~~ 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) 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 ~~should~~ 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);

(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 ~~must~~ 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 ~~would may~~ not be separately billed when an E0585 system ~~was 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 ~~should~~ 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 ~~must~~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 ~~which~~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 ~~must~~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 ~~must~~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 ~~which~~that justifies the medical appropriateness ~~must~~shall be on file with the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider;

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

(4) Table 122-0204-1.

(5) Table 122-0204-2.

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

Stat. Auth.: ORS 413.042 & 414.065  
Stats. Implemented: ORS 414.065

#### **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 (O<sub>2</sub> 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 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 progress notes, physician-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 who has diagnosed the infant as having clinically significant apnea or known risk factors for life-threatening apnea. The physician's order must 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 must shall ensure that documentation corroborates that all criteria in this rule are met;

(e) The DMEPOS provider must 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.]~~

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

#### **410-122-0300**

##### **Light Therapy**

(1) Phototherapy (bilirubin light therapy):

(a) ~~The Division of Medical Assistance Programs (Division)~~ may cover home phototherapy 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;

(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 must 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  $\geq 12$  mg/dl total serum bilirubin; or

- (ii) 49–72 hours old  $\geq 15$  mg/dl total serum bilirubin; or
- (iii) >72 hours old  $\geq 17$  mg/dl total serum bilirubin; or
- (B) Jaundice in preterm infant <37 weeks when total serum bilirubin level is  $\geq 10$ mg/dl;
- (e) Treatment days will be determined based on lab values.

(2) Documentation Requirements:

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

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

(3) Table 122-0300 Light Therapy.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

**410-122-0360**

**Canes and Crutches**

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

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

(3) Table 122-0360.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

**410-122-0365**

**Standing and Positioning Aids**

(1) Indications and coverage: If a client has one aid that meets his/her medical needs, regardless of who obtained it, the Division of Medical Assistance Programs (DMAP) will may not provide another aid of same or similar function.

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

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

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

(c) The physician's order;

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

(e) Each item requested ~~must~~ 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 ~~must~~ shall be submitted by a physical therapist, occupational therapist, or prescribing practitioner when requesting a PA;

(3) Gait Belts:

(a) Covered when:

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

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

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

(i) A minor correction of ambulation; or

(ii) Needs ~~m~~Minimal or standby assistance to walk alone; or

(iii) Requires assistance with transfer;

(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 ~~must~~shall meet the following criteria in addition to the criteria in Table 122-0365:

(a) The client ~~must~~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 ~~must~~shall be following a therapy program initially established by a physical or occupational therapist; and,

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

(d) The caregiver ~~and/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 ~~for~~ balance, stability, or positioning assistance; or

(B) Has extensor tone of the trunk muscles; or

(C) Needs ~~for~~ 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 and/or strength to center hips; or

(B) Has asymmetrical tone which that causes hips to pull to one side; or

(C) Has spasticity; or

(D) Has low tone or high tone; or

(E) Needs for 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 which 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 and/or shoulder and cannot reach actuator in some positions;

(i) Arm troughs may be covered when a client:

(A) Has increased tone which ~~that~~ pulls arms backward so hands cannot come to midline; or

(B) Has poor tone, strength, or control ~~is so poor~~ that causes arms to hang out to side and backward; causing pain and risking injury; or

(C) ~~Needs~~ 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 Needs for safety.

(7) Table 122-0365.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

**410-122-0380**

**Hospital Beds**

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

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

(A) Has a medical condition ~~which~~ 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 ~~must~~ shall have been considered and ruled out;

(D) Requires traction equipment ~~which~~ 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) when all of the following criteria are met:

(A) Criteria for a fixed height hospital bed are met;

(B) Frequent changes or an immediate need for a change in body position are required;

(C) The client 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 ~~must~~ 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 ~~prior authorization (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 ~~must~~ shall be received by the authorizing authority prior to the third date of service.

(2) Documentation requirements: Submit documentation ~~which that~~ has been reviewed, signed, and dated by the prescribing practitioner and ~~which 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.~~]

Stat. Auth.: ORS 413.042 & 414.065  
Stats. Implemented: ORS 414.065

#### **410-122-0475**

### **Therapeutic Shoes for Diabetics**

(1) Indications and Coverage:

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

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

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

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

(A) Rigid rocker bottoms;

(B) Roller bottoms;

(C) Metatarsal bars;

(D) Wedges;

(E) Offset heels.

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

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

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

(2) Documentation:

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

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

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

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

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

(E) Foot deformity of either foot; or

(F) Poor circulation in either foot; and

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

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

**(3) Table 122-0475.**

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

**410-122-0480**

### **Pneumatic Compression Devices (Used for Lymphedema)**

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

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

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

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

(c) Post-radiation fibrosis;

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

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

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

(C) The ulcer(s) hasve failed to heal after six months of continuous treatment;:-

(e) Congenital anomalies.

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

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

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

(6) Documentation:

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

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

(A) The client's diagnosis and prognosis;

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

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

(D) The clinical response to an initial treatment with the device. The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment

session and parameters, and ability of the client (or caregiver) to apply the device for continued use in the home;

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

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

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

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

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

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

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

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

(7) Procedure Codes — Table 122-0480.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

## **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 ~~which~~ 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 of Medical Assistance Programs (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);

(ii) Failed fusion of a joint other than in the spine, where a minimum of nine months has elapsed since the last surgery;

(iii) Congenital pseudarthrosis;

(B) Non-union of a long bone fracture ~~must~~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 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;

(ii) Following a multilevel spinal fusion surgery;

(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 ~~must~~shall include multiple views of the fracture site accompanied by a written interpretation by the treating physician 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.

~~(23)~~ Coding guidelines: Use E1399 for ultrasonic conductive coupling gel.

~~(34)~~ Documentation requirements:

(a) Submit the following with the ~~prior authorization (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) ~~which~~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) Additional medical records may be requested by the Division;

(d) The client's medical records ~~must~~shall reflect the need for the stimulator requested. The client's medical records include, but are not limited to, the physician's office

records, hospital records, nursing home records, home health agency records, records from other healthcare professionals, and test/diagnostic reports.

(45) Table 122-0510.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

#### **410-122-0525**

#### **External Insulin Infusion Pump**

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

(a) ~~The Division of Medical Assistance Programs (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 ~~must~~shall be seen and evaluated by the treating physician at least every three months;

(c) The external insulin infusion pump ~~must~~shall be ordered and follow-up care rendered by a physician 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 and K0552;

(e) Code A4221 includes catheter insertion devices for use with external insulin infusion pump infusion cannulas and are not separately payable;

(f) A4221 is limited to one unit of service per week.

(2) Coding guidelines:

(a) Code A4221 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 ~~prior authorization (PA)~~, the DMEPOS provider ~~must~~shall submit medical justification ~~which~~that supports ~~that~~ the criteria in this rule are met;

(b) When billing and dispensing for an item in Table 122-0525, the DMEPOS provider ~~must~~shall ensure that medical records corroborate ~~that~~ all criteria in this rule are met;

(c) The DMEPOS provider ~~must~~shall keep medical records on file and make them available to the Division upon request.

(4) Table 122-0525.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

## **410-122-0640**

### **Eye Prostheses**

(1) Indications and coverage:

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

(b) For clients under age 21, the prescribing practitioner ~~must~~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 mustshall 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) mustshall 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 mustshall be documentation in the patient's medical records that corroborates the order and supports the medical appropriateness of the items. This documentation mustshall 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.]~~

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

#### **410-122-0678**

#### **Dynamic Adjustable Extension/Flexion Device**

(1) Indications and limitations of coverage and medical appropriateness: The Division of Medical Assistance Programs (Division) may cover some dynamic adjustable extension/flexion devices for a covered condition when all of the following conditions are met:

(a) As an adjunct to physical therapy for clients with signs and symptoms of persistent joint stiffness in the sub-acute injury or post-operative period (> 3 weeks but < 4 months after injury or surgical procedure) when the device is applied and managed under the direct supervision of a physical therapist;

(b) As an adjunct to physical therapy in the acute post-operative period for clients who are undergoing additional surgery to improve the range of motion of a previously affected joint when the device is managed under the direct supervision of a physical therapist;

(c) For this episode, the device has not been billed to the Division with a current procedure terminology (CPT) code, healthcare common procedure coding system (HCPCS) code, or diagnosis code by any other healthcare provider;

(d) Reimbursement is limited to a maximum of four months per episode;

(e) Reimbursement is on a month-to-month rental basis only.

(2) Documentation requirements:

(a) Submit medical records ~~which~~that support the conditions of coverage, as specified in this rule, have been met, including the treatment plan from the physical therapist;

(b) The treatment plan ~~must~~shall include:

(A) Baseline measurements (pre-intervention measurements) of range of motion (ROM) limitations;

(B) Weekly ROM measurements with documented 10 degree improvement.

(3) Table 0678 — Dynamic Adjustable Extension/Flexion Devices.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

**Table 122-0204-1**

Dispensing more than the usual maximum replacement amount must be supported by documentation in the client's medical record.

<b>Accessory</b>	<b>Usual maximum replacement</b>
A4619	One/month
A7003	Two/month
A7004	Two/month (in addition to A7003)
A7005	One/6 months
A7006	One/month
A7010	One unit (100 ft.)/2 months
A7011	One/year
A7012	Two/month
A7013	Two/month
A7014	One/3 months
A7015	One/month
A7017	One/3 years
A7525	One/month
E1372	One/3 years

**Table 122-0204-2 – Nebulizer Code**

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

Code	Description	PA	PC	RT	MR	RP	NF
A4217	Sterile water/saline, 500 ml		PC				
A4619	Face Tent		PC				
A7003	Administration set, with small volume non-filtered pneumatic nebulizer, disposable		PC				
A7004	Small volume non-filtered pneumatic PC nebulizer, disposable		PC				
A7005	Administration set, with small volume non-filtered pneumatic nebulizer, non-disposable		PC				
A7006	Administration set, with small volume filtered pneumatic nebulizer		PC				
A7010	Corrugated tubing, disposable, used with large volume nebulizer (1 unit of service = 100 feet)		PC				
A7011	Corrugated tubing, non-disposable, used with large volume nebulizer (1 unit of service = 10 feet)		PC				
A7012	Water collection device, used with large volume nebulizer		PC				
A7013	Filter, disposable, used with aerosol compressor		PC				
A7014	Filter, non-disposable, used with aerosol compressor or ultrasonic generator		PC				
A7015	Aerosol mask, used with DME nebulizer		PC				
A7017	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen		PC	RT	13		
A7018	Water, distilled, used with large volume nebulizer (1 unit of service = 1,000 ml)		PC				
A7525	Tracheostomy mask, each		PC				
E0565	Compressor, air power source for equipment which is not self-contained or cylinder driven		PC	RT	13	RP	
E0570	Nebulizer, with compressor		PC	RT	13	RP	
E0571	Aerosol compressor, battery powered, for use with small volume nebulizer		PC	RT	13		

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

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
E0572	Aerosol compressor, adjustable pressure, light duty for intermittent use		PC	RT	13		
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter		PC	RT	13		
E0585	Nebulizer, with compressor and heater		PC	RT	13	RP	
E1372	Immersion external heater for nebulizer		PC	RT	13	RP	

**Table 122-0240 – APNEA Monitor**

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

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
A4649	Surgical supplies; miscellaneous	PA	PC				
A4556	Electrodes (e.g., apnea monitor) per pair	PA	PC				
A4557	Lead wires (e.g., apnea monitor) per pair	PA	PC				
A4558	Conductive paste or gel	PA	PC				
E0618	Apnea monitor without recording feature, monthly rental	PA		RT			
E0619	Apnea Monitor with recording feature, monthly rental	PA		RT			

**Table 122-0300 – Light Therapy**

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

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

**Table 122-0360 – Canes and Crutches**

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

Code	Description	PA	PC	RT	MR	RP	NF
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**Canes**

A4636	Replacement, handgrip, cane, crutch or walker, each		PC				
A4637	Replacement, tip, cane, crutch, walker, each		PC				
E0100	Cane, includes canes of all materials, adjustable or fixed, with tips		PC				
E0105	Quad or three prong, includes canes of all materials, adjustable or fixed, with tips		PC	RT	13		

**Crutches**

A4635	Underarm pad, crutch, replacement, each		PC				
A4636	Replacement, handgrip, cane, crutch or walker, each		PC				
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips		PC	RT	13	RP	
E0111	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips		PC	RT	13	RP	
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips		PC	RT	13		
E0113	Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip		PC	RT	13		
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips		PC	RT	13	RP	
E0116	Crutch, underarm, other than wood, adjustable or fixed, each, with pad, tip and handgrip		PC	RT	13	RP	
E0117	Crutch, underarm, articulating, spring assisted, each		PC	RT	13	RP	
E0153	Platform attachment, forearm, crutch, each		PC	RT	13	RP	

**Table 122-0365 – Standing and Positioning Aids**

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

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
E0637	Combination sit to stand system, any size, with seat lift feature, with or without wheels	PA	PC	RT		RP	
E0638	Standing frame system, any size, with or without wheels  Must meet the criteria listed in section (4) of this rule  Not covered for electric mobility option	PA	PC	RT		RP	
E0641	Standing frame system, multi-position, any size, including pediatric, with or without wheels  Must meet the criteria listed in section (4) of this rule  Not covered for electric mobility option	PA	PC	RT		RP	
E0642	Standing frame system, mobile (dynamic stander), any size including pediatric  Must meet the criteria listed in section (4) of this rule  Not covered for electric mobility option	PA	PC	RT		RP	
E0700	Safety equipment (for gait belt only)	PA	PC				

***E1399 - DME, miscellaneous***

E1399	Prone stander, supine stander or board Must meet the criteria listed in section (4) of this rule	PA	PC	RT	13	RP	
E1399	Accessories  Covered if the client:  Must meet the criteria listed in section (4) of this rule, and  Cannot be successfully positioned in equipment without specified accessories	PA	PC			RP	

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

Code	Description	PA	PC	RT	MR	RP	NF
E1399	<p>Sidelyer includes accessories</p> <p>Covered if the criteria in section (5) of this rule is met and one of the following:                      The client has contractures that are capable of being reduced or fixed contractures, or                      The client has positioning and support needs that cannot be met with other positioning devices, or                      Positioning is needed to prevent reflux during feeding.</p>	PA	PC			RP	
E1399	<p>Custom positioner</p> <p>Labor is included in the purchase price</p> <p>Not used for positioners that are ready-made and subsequently modified to fit an individual client</p> <p>Positioners are considered customized when it is virtually impossible to meet another person's positioning needs in the equipment</p> <p>Covered if:</p> <p>The configuration of the client's body cannot be supported by commercially available positioners due to size, orthopedic deformities, physical deformities or pressure ulcers, and</p> <p>The criteria in section (5) of this rule is met.</p>	PA	PC			RP	

**Table 122-0380 – Hospital Beds**

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

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

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
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***Fixed Height***

E0250	Hospital Bed, fixed height, with any type side rails, with mattress	*	PC	RT	13	RP	
E0251	Hospital Bed, fixed height, with any type side rails, without mattress	*	PC	RT	13	RP	
E0290	Hospital Bed, fixed height, without side rails, with mattress	*	PC	RT	13	RP	
E0291	Hospital Bed, fixed height, without side rails, without mattress	*	PC	RT	13	RP	

***Variable Height***

E0255	Hospital bed, variable height (Hi-Lo), with any type side rails, with mattress	*	PC	RT	13	RP	
E0256	Hospital bed, variable height (Hi-Lo), with any type side rails, without mattress	*	PC	RT	13	RP	
E0292	Hospital bed, variable height (Hi-Lo), without side rails, with mattress	*	PC	RT	13	RP	
E0293	Hospital bed, variable height (Hi-Lo), without side rails, without mattress	*	PC	RT	13	RP	

***Semi-Electric***

E0260	Hospital Bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	*	PC	RT	13	RP	
E0261	Hospital Bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	*	PC	RT	13	RP	
E0294	Hospital Bed, semi-electric (head and foot adjustment) without side rails, with mattress	*	PC	RT	13	RP	
E0295	Hospital Bed, semi-electric (head and foot adjustment) without side rails, without mattress	*	PC	RT	13	RP	

***Heavy-Duty and Extra Heavy-Duty***

E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	*	PC	RT	13	RP	
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For the code legend see OAR 410-122-0182.

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

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

**Table 122-0475 – Therapeutic Shoes for Diabetics**

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

Code	Description	PA	PC	RT	MR	RP	NF
A5500	For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe		PC				NF
A5501	For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of client's foot (custom molded shoe), per shoe		PC				NF
A5503	For diabetics only, (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe modification		PC				NF
A5504	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe		PC				NF
A5505	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe		PC				NF
A5506	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe		PC				NF
A5507	For diabetics only, not otherwise specified modification (include fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe		PC				NF
A5510	For diabetics only, direct formed, compression molded to client's foot without external heat source, multiple-density insert(s), prefabricated, per shoe		PC				NF
A5512	For diabetics only, multiple density insert direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer or		PC				NF

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

Code	Description	PA	PC	RT	MR	RP	NF
	3/16 inch material of shore a 40 durometer (or higher), prefabricated, each						
A 5513	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each		PC				NF

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

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

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
E0650	Pneumatic compressor, non-segmental home model		PC	RT		RP	NF
E0651	Pneumatic compressor, segmental home model (lymphedema pump) without calibrated gradient pressure		PC	RT		RP	NF
E0652	<p>Pneumatic compressor, segmental home model (lymphedema pump) with calibrated gradient pressure</p> <p>Documentation on file must show that E0650 or E0651, or other less costly alternatives, failed to manage the client's condition</p> <p>Must include measurements of pump pressure, dates and times applied, and serial multiple level measurements of the involved extremity</p> <p>If used for a painful focal lesion, documentation must support what prevented the use of E0650 or E0651</p> <p>Chamber pressure must be listed for all pumps used</p> <p>Must show the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a non-segmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber</p>		PC	RT		RP	NF
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor half arm, includes hand segment		PC	RT		RP	NF
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor full leg, includes foot segment		PC	RT		RP	NF

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

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor full arm, includes hand segment		PC	RT		RP	NF
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor half leg, includes foot segment		PC	RT		RP	NF
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg, includes foot segment		PC	RT		RP	NF
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm, includes hand segment		PC	RT		RP	NF
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg, includes foot segment		PC	RT		RP	NF
E0671	Segmental gradient pressure pneumatic appliance, full leg, includes foot segment		PC	RT		RP	NF
E0672	Segmental gradient pressure pneumatic appliance, full arm, includes hand segment		PC	RT		RP	NF
E0673	Segmental gradient pressure pneumatic appliance, half leg, includes foot segment		PC	RT		RP	NF

**Table 122-0510 – Electronic Stimulators**

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

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
E0747	Osteogenesis stimulator, electrical, non- invasive, other than spinal applications  One time payment per condition	PA	PC	RT	13		NF
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications  One time payment per condition	PA	PC	RT	13		NF
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	PA	PC	RT	13		NF
E1399	Durable medical equipment, misc.	PA					

**Table 122-0525 – External Insulin Infusion Pump**

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

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
<b><i>Equipment</i></b>							
E0784	External ambulatory infusion pump, insulin Supplies	PA	PC	RT	13	RP	NF
A4221	Supplies for maintenance of drug infusion catheter, per week	PA	PC				NF
K0552	Supplies for external drug infusion pump, syringe type, cartridge, sterile, each	PA	PC				NF
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each		PC				NF
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each		PC				NF
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each		PC				NF
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each		PC				NF
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each		PC				NF

**Table 122-0640 – Eye Prostheses**

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

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

**Table 122-0678 – Dynamic Adjustable Extension/Flexion Device**

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

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
E1800	Dynamic adjustable elbow extension/flexion device, includes soft interface material	PA		RT			NF
E1802	Dynamic adjustable forearm pronation/supination device, includes soft interface material	PA		RT			NF
E1805	Dynamic adjustable wrist extension/flexion device, includes soft interface material	PA		RT			NF
E1810	Dynamic adjustable knee extension/flexion device, includes soft interface material	PA		RT			NF
E1815	Dynamic adjustable ankle extension/flexion device, includes soft interface material	PA		RT			NF
E1825	Dynamic adjustable finger extension/flexion device, includes soft interface material	PA		RT			NF