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MICHAEL KAPLAN
DEPUTY SECRETARY OF STATE



ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

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

FILED: 10/27/2026 2:44 PM
ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Transitioning defined term “Client” to “Member”, “CCO Member”, or “Open Card Member” where appropriate.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2026 5:00 PM
The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT:
Kelsey Gleeson
503-979-4579
medicaid.rules@oha.oregon.gov
500 Summer Street NE
Salem, OR 97301

Filed By:
Kelsey Gleeson
Rules Coordinator

HEARING(S)
Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/17/2026
TIME: 9:00 AM - 9:45 AM
OFFICER: Kelsey Gleeson

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 669-254-5252
CONFERENCE ID: 1658671365
SPECIAL INSTRUCTIONS:
Meeting ID: 165 867 1365
Passcode: 215425

NEED FOR THE RULE(S):

In the Oregon Health Authority’s (OHA) external communications, the agency has referred to individuals receiving

services from the Oregon Health Plan (Medicaid) as a “Member” for many years. This rule language change aligns rule language with external communications.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE:

The purpose of this rule change is to improve plain language and grammar. These changes are consistently applied to all rules within chapter 410 (Medical Assistance Programs). The Oregon Health Authority does not expect a disproportional impact to racial equity within any specific community as a result of this rulemaking.

FISCAL AND ECONOMIC IMPACT:

The purpose of this rule change is to improve clarity, plain language, and grammar. These changes do not effect policy, operations, or service delivery. The Oregon Health Authority does not expect any fiscal or economic impact to any entity or individual as a result of this rulemaking.

COST OF COMPLIANCE:
(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s).
None.

(2) Effect on Small Businesses:
None.

(a) Estimate the number and type of small businesses subject to the rule(s);
None.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);
None.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).
None.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses were invited with the general public to participate in the rules advisory committee.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-122-0010, 410-122-0020, 410-122-0040, 410-122-0090, 410-122-0182, 410-122-0184, 410-122-0186, 410-122-0200, 410-122-0202, 410-122-0203, 410-122-0204, 410-122-0205, 410-122-0206, 410-122-0208, 410-122-0209, 410-122-0210, 410-122-0211, 410-122-0220, 410-122-0250, 410-122-0260, 410-122-0300, 410-122-0320, 410-122-0325, 410-122-0330, 410-122-0360, 410-122-0365, 410-122-0375, 410-122-0380, 410-122-0400, 410-122-0420, 410-122-0475, 410-122-0510, 410-122-0515, 410-122-0520, 410-122-0525, 410-122-0540, 410-122-0560, 410-122-0580, 410-122-0590, 410-122-0600, 410-122-0630, 410-122-0640, 410-122-0655, 410-122-0658, 410-122-0660, 410-122-0662, 410-122-0678, 410-122-0680, 410-122-0700, 410-122-0710, 410-122-0720, 410-122-0730

AMEND: 410-122-0010

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0010
Definitions ¶

In addition to the definitions in OAR 410-120-0000, the following definitions in these rules apply:-¶
(1) "Activities of Daily Living (ADL's)" means activities related to personal care including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing that are necessary to maintain or improve the ~~client~~Member's health.-¶
(2) "Acquisition Cost" has the meaning given to the term in OAR Chapter 410 Division 120.-¶
(3) "Buy-up" means a situation in which a ~~client~~Member wants to upgrade to a higher level of service than he or she is eligible for; e.g., a heavy-duty walker instead of a standard walker.-¶
(4) "Complex Rehabilitation Technology" has the meaning given in 2025 Oregon Laws Chapter 258, Section 2.-¶
(5) "Consecutive Months" means any period of continuous use where no more than a 60-day break occurs.-¶
(6)/"Division" means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.-¶
(7) "DMEPOS" is an acronym for durable medical equipment, prosthetics, orthotics, and supplies.-¶
(8) "Durable Medical Equipment" means/equipment and appliances that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, can be reusable or removable,/and is appropriate for use in any non-institutional setting in which normal life activities take place. Some examples include wheelchairs, crutches, and hospital beds.-¶
(9) "EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment program which provides comprehensive and preventive health care services to OHP ~~client~~Members in accordance with federal regulations and as defined in OAR Chapter 410 Division 151.-¶
(10) "EPSDT Beneficiary" has the meaning given that term in OAR Chapter 410 Division 120 and OAR Chapter 410 Division 151.-¶
(11) "Healthcare Professionals" has the meaning given that term in OAR Chapter 410 Division 120.-¶
(12) "Home" for purposes of purchase, rental, and repair of durable medical equipment (DME) means a place of permanent residence such as an assisted living facility, 24-hour residential care facility, adult foster home, child foster home, or a private home. This does not include hospitals, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, any setting that exists primarily for the purpose of providing medical/nursing care, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Separate payment may not be made to DME providers for equipment and medical supplies provided to a ~~client~~Member when the cost of such items is already included in the capitated (per diem) rate paid to a facility or organization.-¶
(13) "Instrumental activities of daily living (IADLs)" means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.-¶
(14) "Licensed Practitioner of the Healing Arts (LPHA)" means a ~~p~~Physician or other ~~p~~Practitioner licensed in the ~~S~~state of Oregon who is authorized within the scope of the LPHA's practice, as defined under state law, to diagnose

and treat individuals with physical or mental disabilities or psychosocial, emotional, and behavioral disorders.¶
(15) "Lifetime Need" means 99 months or more.¶
(16) "Manufacturer Part Number (MPN)" means:¶
(a) Each manufacturer provides an MPN to identify that manufacturer's part. It is a specification used by the manufacturer to store a part in an illustrated part catalog (graphics and text).¶
(b) An MPN uniquely identifies a part when used together with manufacturer code (external manufacturer), which is the own name used by the manufacturer and not the manufacturer name provided by other.¶
(17) "Medical Records" means the ~~p~~Practitioner's office records, ~~h~~Hospital records, ~~n~~Nursing ~~f~~Facility records, ~~h~~Home ~~h~~Health ~~a~~Agency records, records from other healthcare professionals, and diagnostic and test reports. This documentation must be made available to the ~~Health Systems Division (Division)~~Division upon request.¶
(18) "Medical Supplies" means health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.¶
(19) "Medically Appropriate" has the meaning given that term in OAR Chapter 410 Division 120 for adult beneficiaries and OAR Chapter 410 Division 151 for EPSDT ~~b~~Beneficiaries.¶
(20) "Medically Necessary" has the meaning given that term in OAR Chapter 410 Division 120 for adult beneficiaries and OAR Chapter 410 Division 151 for EPSDT ~~b~~Beneficiaries.¶
(21) "Mobility-related Activities of Daily Living (MRADL's)" means personal care activities including, but not limited to, tasks such as toileting, feeding, dressing, grooming, and bathing in customary locations.¶
(22) "Morbidity" means a diseased state, often used in the context of a "morbidity rate" (i.e., the rate of disease or proportion of diseased people in a population). In common clinical usage, any disease state including diagnosis and complications is referred to as morbidity.¶
(23) "Morbidity Rate" means the rate of illness in a population. The number of people ill during a time period is divided by the number of people in the total population.¶
(24) "Practitioner" means an individual licensed pursuant to federal and state law to engage in the provision of health care services within the scope of the practitioner's license and certification. /For ordering and provision of durable medical equipment, prosthetics, orthotics and medical suppliers this includes both physicians and non-physician practitioners (i.e., physician associate, nurse practitioners, and certified nurse specialists) as defined in section 1861 of the Social Security Act).¶
(25) "Prosthetic and Orthotic Devices" means devices that replace all or part of an internal body organ, including ostomy bags and supplies directly related to ostomy care and replacement of such devices and supplies. Prosthetic and orthotic devices also include leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the ~~client~~Member's physical condition.¶
(26) "Purchase price" means:¶
(a) Delivery;¶
(b) Assembly;¶
(c) Adjustments, if needed; and¶
(d) Training in the use of the equipment or supply.¶
(27) "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.¶
(28) "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.¶
(29) "The Division Maximum Allowable Rate" means the maximum amount paid by the Division for a service.¶
(30) "Young Adults with Special Health Care Needs (YSHCN)"/has the meaning given that term in OAR Chapter 410 Division 120 and OAR Chapter 410 Division 200.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-122-0020

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

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 prescribing practitioner prior to dispensing items to a ~~client.~~ Member.¶
(2) For any durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), a provider must have a written order signed and dated by the prescribing ~~p~~Practitioner prior to submitting a claim to the Division.~~-~~¶
(3) A ~~p~~Provider may dispense some items based on a verbal order from the prescribing ~~p~~Practitioner, except those items requiring a written order prior to delivery or as specified in a particular rule:~~-~~¶
(a) A ~~p~~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~~Member's name;~~-~~¶
(B) Practitioner's name;~~-~~¶
(C) Description of the item;~~-~~¶
(D) Start date of the order;~~-~~¶
(E) Primary ICD-10 ~~d~~Diagnosis ~~c~~Code for the equipment/supplies requested.~~-~~¶
(c) For items that are dispensed based on a verbal order, the ~~p~~Provider must obtain a written order that meets the requirements outlined below for written orders.~~-~~¶
(4) When specified in rule, a ~~n~~Nurse ~~p~~Practitioner or ~~c~~Clinical ~~n~~Nurse ~~s~~Specialist may provide the dispensing order and sign the detailed written order only when the following are met:~~-~~¶
(a) They are treating the ~~client~~Member for the condition for which the item is needed; and~~-~~¶
(b) They are practicing independently of a ~~p~~Physician; and~~-~~¶
(c) All of the above are permitted when within their scope of practice and licensure with the ~~S~~state of Oregon.¶
(5) When specified in rule, a ~~p~~Physician ~~a~~Associate may provide the dispensing order and sign the detailed written order only when the following are met:¶
(a) They are treating the ~~client~~Member 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 ~~S~~state of Oregon.¶
(6) The DMEPOS ~~p~~Provider must have on file a written order, information from the prescribing ~~p~~Practitioner concerning the ~~client~~Member's diagnosis and medical condition, and any additional information required in a specific rule.¶
(7) The Division accepts any of the following forms of orders: 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 ~~p~~Provider shall ensure the authenticity and validity of a facsimile image, electronically maintained or photocopied order;~~-~~¶
(c) A ~~p~~Provider must also ensure the security and integrity of all electronically maintained orders;~~-~~¶
(d) The written order may serve as the order to dispense the item if the written order is obtained before the item is dispensed.~~-~~¶
(8) A written order must be legible and contain the following elements:~~-~~¶
(a) ~~Client~~Member's name; and¶
(b) Detailed description of the item that can either be a general description (e.g., lightweight wheelchair base) or a brand name/model number including ~~m~~Medically ~~a~~Appropriate options or additional features; and¶
(c) The detailed description of the item may be completed by someone other than the ~~p~~Practitioner. However, the prescribing ~~p~~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~~Member's medical record;~~-~~¶
(C) The ordering ~~p~~Practitioner shall ensure the authenticity of the signature;~~-~~¶
(d) Primary ICD-10 ~~d~~Diagnosis ~~c~~Code for the equipment and supplies requested; and~~-~~¶

(e) Quantity to be dispensed, if applicable; and¶
(f) Order date; and¶
(g) Treating ~~p~~Practitioner's name; and¶
(h) Treating ~~p~~Practitioner's signature:¶
(A) This signature must be handwritten or electronic, and it must be in the ~~client~~Member's medical record;¶
(B) The ordering/treating ~~p~~Practitioner shall ensure the authenticity of the signature; and¶
(C) Use of signature stamps may not be used on any medical record.¶
(9) The DMEPOS ~~p~~Provider shall obtain as much documentation from the ~~client~~Member's medical record as necessary for assurance that the Division coverage criteria for an item is met.¶
(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:¶
(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 ~~p~~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 rental item.¶
(d) Any other medical documentation required by rule.¶
(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.¶
(12) A new order is required:¶
(a) When required by Medicare for a Medicare ~~c~~Covered ~~s~~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 ~~p~~Practitioner:¶
(A) A new order is required when an item is being replaced because the item is worn or the ~~client~~Member's condition has changed;¶
(B) The ~~p~~Provider's records shall include ~~client~~Member-specific information regarding the need for the replacement item;¶
(C) This information shall be maintained in the ~~p~~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 ~~m~~Medical ~~a~~Appropriateness of the item.¶
(e) When there is a change in a DMEPOS ~~p~~Provider or in cases where two or more ~~p~~Providers merge, the recipient ~~p~~Provider shall make all reasonable attempts to secure copies of all written orders from the transferring ~~p~~Provider. This document shall be kept on file by the recipient ~~p~~Provider and made available upon request by the Division;¶
(f) On a regular basis (even if there is no change in the order) when it is so specified in the documentation section of a particular rule.¶
(13) A ~~p~~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: 414.065

AMEND: 410-122-0040

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0040
Prior Authorization ¶

(1) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) ~~p~~Providers shall obtain ~~p~~Prior ~~a~~Authorization (PA) for Healthcare Common Procedure Coding System (HCPCS) Level II codes as specified in rule, unless otherwise noted.~~-~~¶
(a) Providers shall request PA as follows:~~-~~¶
(A) For Medically Fragile Children's Unit (MFCU) ~~client~~Members, from the Oregon Department of Human Services (Department) MFCU;~~-~~¶
(B) For ~~client~~CCO Members enrolled in a Coordinated Care Organization (CCO), from the CCO;~~-~~¶
(C) For ~~client~~Members enrolled in a prepaid health plan (PHP), from the PHP;~~-~~¶
(D) For all other ~~client~~members, from the ~~Health Systems~~ Division./~~-~~¶
(b) For DMEPOS ~~p~~Provided after normal working hours, ~~p~~Providers must submit PA requests within five (5) working days from the initiation of service.~~-~~¶
(c) See OAR 410-120-1320 for more information about PA.~~-~~¶
(2) Effective January 1, 2026, the Division shall provide notice of determination no later than 72 hours following receipt of PA requests for costs to repair complex rehabilitation technology as defined in Section 2 of Enrolled SB 549 (2025). The 72-hour period of time shall be determined by the time and date stamp on the receipt of request.
Statutory/Other Authority: ORS 414.065, SB 549 (2025)
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0090

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0090
Face-to-Face Encounter Requirements (for ~~Fee-For-Service Client~~Open Card Members) ¶

(1) For initial ordering of DME items identified in section (9) of this rule and for those DME items identified as requiring a face-to-face visit in Division 122 rules, an in-person or telehealth face-to-face encounter that is related to the primary reason the ~~client~~Member requires the medical equipment or supplies must occur no more than six (6) months prior to the start of services.~~-~~¶
(2) Telehealth encounters used to satisfy the face-to-face encounter requirement for a DMEPOS item must meet the requirements outlined in the OHA Prioritized List of Health Services Telehealth, Teleconsultations, and Online/Telephonic Services Ancillary Guideline Note.¶
(3) The face-to-face encounter shall be conducted and documented by one of the following practitioners:~~-~~¶
(a) A ~~p~~Physician;~~-~~¶
(b) A ~~n~~Nurse ~~p~~Practitioner or ~~c~~Clinical ~~n~~Nurse ~~s~~Specialist, as authorized by ~~S~~state law;~~-~~¶
(c) A ~~p~~Physician ~~a~~Associate, as authorized by and in accordance with ~~S~~state law;~~-~~¶
(d) A licensed ~~p~~Practitioner of the ~~h~~Healing ~~a~~Arts acting within the scope of practice authorized under ~~S~~state law;~~-~~¶
(4) The ~~p~~Practitioner responsible for ordering the services must document the face-to-face encounter and clinical findings supporting that the ~~client~~Member was evaluated or treated for a condition that supports the need for the DME items ordered within six months prior to completing the written order;~~-~~¶
(5) If a dually eligible ~~client~~Member is evaluated for medical equipment or supplies under Medicare and transitions to Medicaid, the Medicare face-to-face encounter documentation shall meet the Medicaid face-to-face requirement.~~-~~¶
(6) The DME supplier shall maintain and provide documentation of the qualifying face-to-face encounter, written order/prescription, and the supporting documentation when the item requires ~~p~~Prior ~~a~~Authorization or at the Division's request.~~-~~¶
(7) The supporting documentation shall include subjective and objective ~~client~~Member-specific information used for diagnosing, treating, and managing a clinical condition for which the DMEPOS is ordered.~~-~~¶
(8) The DME supplier shall have documentation on file that supports all coverage criteria in the DMEPOS rules are met.~~-~~¶
(9) The list of required DME items subject to face-to-face requirements is posted and maintained by CMS. Please refer to the CMS.gov website for an active link to this list.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-122-0182

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0182
Legend ¶

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

AMEND: 410-122-0184

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

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

(1) For indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness, the Division may cover reasonable and necessary repairs, servicing, and replacement of ~~m~~Medically ~~a~~Appropriate, covered durable medical equipment, prosthetics, and orthotics, including those items purchased or in use before the ~~client~~Member enrolled with the Division:/-¶
(a) Repairs:/-¶
(A) To repair means to fix or mend and to put the equipment back in good condition after damage or wear to make the equipment serviceable;/-¶
(B) Repairs (parts and labor) of DMEPOS items are performed on the base item. The replacement of parts or components that make up the base item is considered a repair;/-¶
(C) If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment may be made for the amount of the excess;/-¶
(D) Payment for repairs is not covered when:/-¶
(i) The skill of a technician is not required;/-¶
(ii) The equipment has been previously denied;/-¶
(iii) Equipment is being rented, including separately itemized charges for repair;/-¶
(iv) Equipment, parts and labor are covered under a manufacturer's or supplier's warranty./-¶
(E) Code K0739 may not be used on an initial claim for equipment. Payment for any labor involved in assembling, preparing, or modifying the equipment on an initial claim is included in the allowable rate./-¶
(b) Servicing:/-¶
(A) Additional payment for routine periodic servicing, such as testing, cleaning, regulating, and checking the ~~client~~Member'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 ~~m~~Medically ~~a~~Appropriate ~~client~~Member-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~~Member during the authorized rental period. The Division may authorize payment for covered servicing of capped rental items after six months have passed from the end of the final paid rental month. Use the corresponding Healthcare Common Procedure Coding System (HCPCS) code for the equipment in need of servicing at no more than the rental fee schedule allowable amount;/-¶
(C) Up to one (1) month's rental shall be reimbursed at the level of either the equipment provided, or the equipment being repaired, whichever is less costly;/-¶
(D) Maintenance and servicing that includes parts and labor covered under a manufacturer's or supplier's warranty is not covered./-¶
(i) Providers must notify ~~client~~Members of warranty coverage and honor all warranties under applicable ~~S~~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~~Member in accordance with ORS 646A.460 to 646A.476.//-¶
(ii) If the dispensing ~~p~~Provider is unable to fulfill the warranty and the equipment continues to be ~~m~~Medically ~~a~~Appropriate, the ~~p~~Provider is responsible for any costs incurred to have a different ~~p~~Provider repair or replace the equipment.//-¶
(c) Replacement refers to the provision of an identical or nearly identical item:/-¶
(A) Temporary Replacement: One (1) month's rental of temporary replacement equipment (K0462) may be reimbursed when ~~client~~Member-owned equipment, such as a wheelchair, is being repaired. The equipment in need of repair must be unavailable for use for more than one (1) day;/-¶
(B) Permanent Replacement: Situations involving the provision of ~~m~~Medically ~~a~~Appropriate items when there is a change in the ~~client~~Member's condition that warrants a new device, the ~~client~~Member has outgrown the equipment, or when reasonable wear and tear renders the item non-functioning and not repairable, and there is coverage for the specific item identified in chapter 410, division 122;/-¶
(C) Equipment that the ~~client~~Member owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster./-¶

(D) Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment:/-¶
(i) Reasonable useful lifetime of DME is no less than five (5) years unless otherwise specified in Chapter 410, Division 122 rules;/-¶
(ii) Computation of the useful lifetime is based on when the equipment is delivered to the ~~client~~Member, not the age of the equipment;/-¶
(iii) Replacement of the base item due to wear is not covered during the reasonable useful lifetime of the equipment;/-¶
(iv) During the reasonable useful lifetime, repair up to the cost of replacement (but not actual replacement for ~~m~~Medically ~~a~~Appropriate equipment owned by the ~~client~~Member) may be covered./-¶
(E) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment may not be covered./-¶
(d) Delivery:/-¶
(A) Providers may deliver directly to the ~~client~~Member 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~~Member;/-¶
(C) Provider shall have documentation on file containing a description of the item delivered to the ~~client~~Member to determine the accuracy of claims coding including, but not limited to, an invoice or statement in the ~~p~~Provider records.//-¶
(D) A ~~p~~Provider may deliver DMEPOS to a ~~client~~Member in a ~~h~~Hospital or ~~n~~Nursing ~~f~~Facility for the purpose of fitting or training the ~~client~~Member in its proper use. This may be done up to two (2) days prior to the ~~client~~Member's anticipated discharge to home. On the claim, bill the ~~d~~Date of ~~s~~Service as the date of discharge and specify the place of service as the ~~client~~Member's home. The item must be for subsequent use in the ~~client~~Member's home;/-¶
(E) A ~~p~~Provider may deliver DMEPOS to a ~~client~~Member's home in anticipation of a discharge from a ~~h~~Hospital or ~~n~~Nursing ~~f~~Facility. The ~~p~~Provider may arrange for actual delivery approximately two (2) days prior to the ~~client~~Member's anticipated discharge to home. On the claim, bill the ~~d~~Date of ~~s~~Service as the date of discharge and specify the place of service as the ~~client~~Member's home;/-¶
(F) No payment is made on ~~d~~Dates of ~~s~~Service the ~~client~~Member receives training or fitting in the ~~h~~Hospital or ~~n~~Nursing ~~f~~Facility for a particular DMEPOS item./-¶
(e) For Dispensing Refills:/-¶
(A) For DMEPOS products that are supplied as refills to the original order, ~~p~~Providers must contact the ~~client~~Member or designee prior to dispensing the refill to check the quantity on hand and continued need for the product;/-¶
(B) Contact with the ~~client~~Member or designee regarding refills must take place no sooner than ~~thirty (~~30~~)~~ calendar days prior to the expected end of the current supply./Contact with the ~~client~~Member or designee regarding refills may only take place no sooner than approximately ~~fourteen (~~14~~)~~ calendar days prior to the delivery/shipping date;/-¶
(C) For subsequent deliveries of refills, the ~~p~~Provider shall deliver the DMEPOS product no sooner than ~~ten (~~10~~)~~ calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. The Division shall allow for the processing of claims for refills delivered/shipped prior to the ~~client~~Member exhausting their supply, but the ~~p~~Provider must not dispense supplies that exceed a ~~client~~Member's expected utilization;/-¶
(D) Supplies dispensed are based on the ~~p~~Practitioner's order. Regardless of utilization, a ~~p~~Provider may not dispense more than a three (3) -month quantity of supplies at a time. This three (3) -month dispensing restriction for supplies may be further limited by rule limitations of coverage;/-¶
(E) The ~~p~~Provider may not automatically ship, dispense, or deliver a quantity of supplies on a predetermined regular basis, even if the ~~client~~Member 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 eligible for reimbursement:/-¶
(A) Pick-up, delivery, shipping, and handling charges for DMEPOS, whether rented or purchased including travel time:/-¶
(i) These costs are included in the calculations for allowable rates;/-¶
(ii)These charges are not billable to the ~~client~~Member./-¶
(B) Supplies used with DME or a prosthetic device prior to discharge from a ~~h~~Hospital or ~~n~~Nursing ~~f~~Facility;/-¶
(C) Surgical dressings, urological supplies, or ostomy supplies applied in the ~~h~~Hospital or ~~n~~Nursing ~~f~~Facility, including items worn home by the ~~client~~Member./-¶

(2) Documentation Requirements:/-¶
(a) For repairs, servicing, and temporary replacement, a new ~~p~~Practitioner's order is not required;/-¶
(b) Submit the following documentation with the ~~p~~Prior ~~a~~Authorization (PA) request:/-¶
(A) For repairs and servicing:/-¶
(i) Narrative description, manufacturer and brand name/model name and number, serial number, and original date of purchase for the covered equipment in need of repair;/-¶
(ii) Itemized statement of parts needed for repair including the estimated ~~d~~Date of ~~s~~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~~Member's medical need for the item and statement that the ~~client~~Member 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 ~~d~~Date of ~~s~~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~~Member's medical need for the item and statement that the ~~client~~Member owns the equipment in need of repair; and/-¶
(v) Description of why the repair takes more than one (1) day to complete./-¶
(C) For permanent replacement, see specific coverage criteria in chapter 410, division 122 for more information;/-¶
(D) For proof of delivery, DMEPOS ~~p~~Providers shall:/-¶
(i) Maintain proof of delivery documentation to the ~~client~~Member in their records for seven (7) years;/-¶
(ii) Maintain documentation that supports conditions of coverage in this rule are met;/-¶
(iii) Make proof of delivery documentation available to the Division upon request./-¶
(c) Proof of delivery requirements are based on the method of delivery;/-¶
(d) A signed and dated delivery slip is required for items delivered directly by the ~~p~~Provider to the ~~client~~Member or designee. The delivery slip must include the following:/-¶
(A) When a designee signs the delivery slip, their relationship to the ~~client~~Member must be noted and the signature legible;/-¶
(B) The ~~client~~Member or designee's signature with the date the items were received;/-¶
(C) ~~Client~~Member'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~~Member or designee; and/-¶
(F) The date the ~~client~~Member receives the item is the ~~d~~Date of ~~s~~Service./-¶
(e) If the ~~p~~Provider uses a delivery or shipping service or mail order, proof of delivery must include the service's tracking slip and the ~~p~~Provider's own shipping invoice:/-¶
(A) The ~~p~~Provider's shipping invoice must include the:/-¶
(i) ~~Client~~Member'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~~Member'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 ~~d~~Date of ~~s~~Service, unless the actual date of delivery is available, then use this date as the ~~d~~Date of ~~s~~Service./-¶
(B) The delivery service's tracking slip must reference:/-¶
(i) Each ~~client~~Member's packages; and/-¶
(ii) The delivery address and corresponding package identification number given by the delivery service./-¶
(f) Providers must utilize a signed and dated return postage-paid delivery or shipping invoice from the ~~client~~Member or designee as a form of proof of delivery that must contain the following information:/-¶
(A) ~~Client~~Member's name;/-¶
(B) Quantity, brand name, serial number, and a detailed description of items being delivered;/-¶
(C) Required signatures from either the ~~client~~Member or the designee./-¶
(g) Delivery to ~~n~~Nursing ~~f~~Facilities or ~~h~~Hospitals:/-¶
(A) The ~~d~~Date of ~~s~~Service is the date the DMEPOS item is received by the ~~n~~Nursing ~~f~~Facility if delivered by the DMEPOS ~~p~~Provider;/-¶
(B) The ~~d~~Date of ~~s~~Service is the shipping date (unless the actual delivery date is known and documented) if the

DMEPOS ~~p~~Provider uses a delivery or shipping service./~~-~~¶
(h) For those ~~client~~Members who are residents of an assisted living facility, a ~~twenty-four (24)~~ 24-hour residential facility, an adult foster home, a child foster home, a private home or other similar living environment, ~~p~~Providers must ensure supplies are identified and labeled for use only by the specific ~~client~~Member 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 - Wheelchair component or accessory, not otherwise specified - PA is required when the billed charge for an item is greater than $150;/~~-~~¶
(d) E1399 - Durable medical equipment, miscellaneous, - PA is required when the billed charge for an item is greater than $150;/~~-~~¶
(e) K0462 - Temporary replacement for ~~client~~Member-owned equipment being repaired, any type - No PA required./
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-122-0186

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0186
Payment Methodology ¶

(1) Effective October 1, 2024, the Division utilizes a payment methodology for covered durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that is generally based on the 2024 Medicare fee schedule.///-¶
(a) The Division fee schedule amount is 80 percent of 2024 Medicare Fee Schedule for items covered by Medicare and the Division using a state-wide average of the ~~r~~Rural and ~~u~~Urban Medicare rates except for://-¶
(A) Complex Rehabilitation items and services other than power wheelchairs, fee schedule amounts are 88 percent of 2024 Medicare Fee Schedule (See Table 122-0186-1 for list of Complex Rehabilitation codes subject to this pricing); and//-¶
(B) Rental rates for Group 1 power wheelchairs (K0813-K0816) and Group 2 power wheelchairs with no added power option (K0820-K0829) fee schedule amounts are 55 percent of 2024 Medicare Fee Schedule; and//-¶
(C) Group 2 power wheelchairs (K0835-K0843) and Group 3 power wheelchairs (K0848-K0864) fee schedule amounts are 58.7 percent of 2024 Medicare Fee Schedule; and//-¶
(D) Unlisted procedures (e.g. E1399, K0108, A9999) are based upon 75 percent of Manufacturer's Suggested Retail Price (MSRP). If MSRP is not available, the amount is based upon ~~a~~Acquisition ~~c~~Cost plus 20 percent .//-¶
(b) For new codes added by the Center for Medicare and Medicaid Services (CMS) after October 1, 2024; payment shall be based on the most current Medicare fee schedule and shall follow the same payment methodology as stated in ~~section~~paragraphs (1)(a)(A-D) of this rule. For new codes that do not appear on the current Medicare fee schedule, rates shall be based on the actuarial calculations used for rate setting for the CCO rate for the service and shall be published as a single state-wide rate;//-¶
(c) DMEPOS rates are published on the Fee-For-Service (FFS) Medical-Dental Fee Schedule. These schedules, along with their effective dates, are posted on the OHP FFS Fee Schedule web page.-¶
(d) The Division shall reimburse any manually priced codes and any new codes that require manual pricing using the methodology as stated in subsections (10)(b-c) and section (11) of this rule.-¶
(2) DMEPOS ~~p~~Providers are required to use the Healthcare Common Procedure Coding System (HCPCS) to identify billing codes for DMEPOS items or services. DMEPOS ~~p~~Providers shall use the product classification list on the Medicare Pricing, Data Analysis and Coding (PDAC) contractor website on the ~~d~~Date of ~~s~~Service for coding verification. An official product review coding decision from an organization such as PDAC is not necessary./-¶
(3) DMEPOS ~~p~~Providers are required to use the HCPCS to identify miscellaneous billing codes for items or services. DMEPOS ~~p~~Providers shall use the product classification list on the Medicare PDAC contractor website on the ~~d~~Date of ~~s~~Service for coding verification. An official product review coding decision from an organization such as PDAC is not necessary./-¶
(4) DMEPOS ~~p~~Providers are required to use specific miscellaneous HCPCS code to identify an item or service when directed in accordance with Division 122 rules (e.g. standing frames, bath equipment, adaptive car seats).//-¶
(5) DMEPOS ~~p~~Providers are required to determine whether there is an existing national HCPCS code that adequately describes the DMEPOS before using a miscellaneous or not otherwise classified HCPCS code to bill an item or service. When a HCPCS code exists, the ~~p~~Provider shall use that code to bill the item or service;/-¶
(a) In the absence of an existing HCPCS code that describes a given product, DMEPOS ~~p~~Providers shall use a miscellaneous or not otherwise classified HCPCS code (e.g. E1399, K0108, A9999) that best represents the item or service;/-¶
(b) DMEPOS ~~p~~Providers billing separately for a service or component that is included in another HCPCS code shall use miscellaneous HCPCS code A9900 to bill the item or supply. DMEPOS ~~p~~Providers must not "unbundle" services so that a ~~p~~Provider payment is higher than the amount allowed by this rule;//-¶
(6) Information about the PDAC and the PDAC's product classification list can be found at http://www.dmepdac.com./-¶
(7) Prior ~~a~~Authorization (PA) is required for all miscellaneous and not otherwise classified HCPCS codes (e.g. E1399, K0108, A9999, A9900) when the billed charge is greater than $150 per each unit. The DMEPOS ~~p~~Provider shall submit the following documentation://-¶
(a) A copy of the items from subsections (10)(b) and (c) that will be used to bill; //-¶
(b) Name of the manufacturer, description of the item, including product name or model name and number, and serial number when applicable;-¶

(c) An explanation of why the item or service is needed by the beneficiary;/-¶
(d) A picture of the item upon request by the Division.-¶
(8) All miscellaneous and not otherwise classified HCPCS codes (e.g. E1399, K0108, A9999, A9900) with a billed charge of $150 or less per each unit do not require PA; however, are subject to service limitations of the Division's rules; and//-¶
(a) The payment amount shall not exceed 75 percent of MSRP; and/-¶
(b) The DMEPOS ~~p~~Provider must retain documentation of the quote, invoice, or bill to allow the Division to verify through audit procedures./-¶
(9) The Division may at any time before or after payment review items that exceed the maximum allowable on a case-by-case basis and may ask the DMEPOS ~~p~~Provider to submit the following documentation for reimbursement://-¶
(a) Documentation which supports that the ~~client~~Member 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 ~~p~~Provider) that clearly explains why the less costly alternative is not sufficient to meet the ~~client~~Member's medical needs, and;//-¶
(c) The expected hours of usage per day, and;//-¶
(d) The expected outcome or change in the ~~client~~Member's condition.//-¶
(10) The Division shall reimburse for the lowest level of service that meets ~~m~~Medical ~~a~~Appropriateness. (See OAR 410-120-1280 Billing; and 410-120-1340 Payment)./Reimbursement is calculated using the lesser of the following://-¶
(a) The Division fee schedule amount, using the above methodology in subsections (1)-(a) and (1)(b); or//-¶
(b) ~~Seventy-five (~~75~~)~~ percent of MSRP, verifiable with quote from the manufacturer that clearly states the amount indicated is MSRP; or//-¶
(c) The billed charge submitted.//-¶
(11) When MSRP is not available, the Division shall use the DMEPOS ~~p~~Provider's ~~a~~Acquisition ~~c~~Cost plus 20 percent, verifiable with a quote from the ~~p~~Provider that clearly states the amount indicated is ~~a~~Acquisition ~~c~~Cost, in place of the MSRP in subsection (10)(b) of this rule./-¶
(12) For rented equipment, the equipment is considered paid for and owned by the ~~client~~Member when the Division fee schedule allowable is met or the actual charge from the ~~p~~Provider is met, whichever is lowest. The DMEPOS ~~p~~Provider must transfer title of the equipment to the ~~client~~Member.//
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0186.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341164

AMEND: 410-122-0200

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0200
Pulse Oximeter for Home Use ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness:~~-~~¶
(a) The Division may cover a tamper-proof (calibrated, preset, and sealed) pulse oximeter for home use when all of the following criteria are met:~~-~~¶
(A) The ~~client~~Member has frequently fluctuating oxygen saturation levels that are clinically significant;~~-~~¶
(B) Measurements are integral in dictating ~~a~~Acute therapeutic intervention;~~-~~¶
(C) The absence of readily available saturation measurements represents an immediate and demonstrated health risk;~~-~~¶
(D) The ~~client~~Member has a caregiver trained to provide whatever care is needed to reverse the low oxygen saturation level ordered by the ~~p~~Practitioner;~~-~~¶
(b) Some examples of when a home pulse oximeter may be covered include the following:~~-~~¶
(A) When weaning a ~~client~~Member from home oxygen or a ventilator;~~-~~¶
(B) When a change in the ~~client~~Member'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~~Member on mechanical ventilation at home;~~-~~¶
(E) To monitor a ~~client~~Member with a tracheostomy at home;~~-~~¶
(F) To periodically re-assess the need for long-term oxygen in the home;~~-~~¶
(G) Infants with chronic lung disease (e.g., bronchopulmonary dysplasia);~~-~~¶
(H) Premature infants on active therapy for apnea;~~-~~¶
(I) When a ~~client~~Member exhibits a certain unstable illness and has compromised or potentially compromised respiratory status or airways;~~-~~¶
(J) When evidence-based clinical practice guidelines support the need;~~-~~¶
(c) Home pulse oximetry for indications other than those listed above may be covered on a case-by-case basis upon medical review by the Division's Policy Unit;~~-~~¶
(d) The durable medical equipment prosthetics, orthotics and supplies (DMEPOS) ~~p~~Provider is responsible to ensure the following services for home pulse oximetry are provided:~~-~~¶
(A) For purchase or rental of a pulse oximeter for home use:~~-~~¶
(i) Training ~~client~~Member or caregiver on the use and care of the equipment and developing an emergency plan, such as dialing immediate emergency services, are performed at the time of delivery or prior to equipment usage; and~~-~~¶
(ii) A follow-up telephone call or home visit is conducted within the first 30 days of equipment setup to ensure ~~client~~Member's continuation and proper use of the equipment;~~-~~¶
(B) For rental of a pulse oximeter for home use:~~-~~¶
(i) 24-hour/7 day a week respiratory therapist on-call availability for troubleshooting, exchanging of malfunctioning equipment, etc.; and~~-~~¶
(ii) The allowable rental fee includes all equipment, supplies, services, including all probes, routine maintenance, and necessary training for the effective use of the pulse oximeter;~~-~~¶
(e) The Division may cover replacement probes for a ~~client~~Member-owned covered oximeter as ordered by the treating ~~p~~Practitioner for continued use:~~-~~¶
(A) The Division shall reimburse for the least costly alternative for payment of probes, whether disposable or reusable, which meets the medical need of the ~~client;~~ Member;¶
(B) A reusable probe must be used when it is the least costly alternative, rather than a disposable probe, unless the ~~client~~Member's medical records clearly substantiate why a reusable probe is contraindicated;~~-~~¶
(C) Disposable probes (oxisensors) may be reused on the same ~~client~~Member 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~~Member with chronic, stable cardiopulmonary condition).~~-~~¶
(2) Documentation Requirements:~~-~~¶
(a) Submit the following documentation for ~~p~~Prior ~~a~~Authorization (PA) review:~~-~~¶
(A) An order from the treating ~~p~~Practitioner that clearly specifies the ~~m~~Medical ~~a~~Appropriateness for home pulse oximetry testing;~~-~~¶
(B) Documentation of signs/symptoms/medical condition exhibited by the ~~client~~Member, 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~~Member-owned oximeter, documentation of which type of probes are prescribed and why the probes requested are the least costly alternative;~~-~~¶
(E) Other medical records that corroborate conditions for coverage are met as specified in this rule;~~-~~¶
(b) History and physical exam and progress notes must be available for review by the Division, upon request.~~-~~¶
(3) Procedure Codes:~~-~~¶
(a) A4606 - Oxygen probe for use with ~~client~~Member-owned oximeter device, replacement;~~-~~¶
(b) E0445 - Oximeter device for measuring blood oxygen levels non-invasively;~~-~~¶
(A) For adults, PA is required;~~-~~¶
(B) The Division will purchase or rent on a monthly basis;~~-~~¶
(C) The Division will repair a ~~client~~Member-owned, covered pulse oximeter when cost effective;~~-~~¶
(D) Item considered purchased after seven (7) months of rent;~~-~~¶
(E) Quantity (units) is one on a given ~~d~~Date of ~~s~~Service.~~-~~¶
(4) Refer to Coverage Table OAR 410-122-0203-1.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0202

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

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

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness:~~-~~¶
(a) The Division may cover the initial three (3) month trial period of a positive airway pressure (PAP) device for treatment of obstructive sleep apnea (OSA)/when the ~~client~~Member meets the conditions of coverage in OAR 410-122-0080 and when all the following guidelines and criteria are met:~~-~~¶
(A) The ~~client~~Member has a face-to-face clinical evaluation by the treating ~~p~~Practitioner prior to a sleep test to assess the ~~client~~Member for obstructive sleep apnea;~~-~~¶
(B) The ~~client~~Member has a home sleep test or a polysomnogram performed in a facility-based laboratory to test for obstructive sleep apnea and the type of sleep test performed meets all CMS requirements for a valid sleep test and in accordance with OHA Prioritized List of Health Services Diagnostic Testing for Obstructive Sleep Apnea (OSA) Guideline Note;~~-~~¶
(C) The ~~client~~Member demonstrates a positive diagnosis of OSA, as defined in the OHA Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note; and~~-~~¶
(D) The ~~client~~Member or their caregiver has received instruction from the supplier in the proper use and care of the PAP device equipment and accessories.~~-~~¶
(b) Prior Authorization (PA) is not required for PAP device (E0601) rental and the purchase of prescribed accessories during the initial three (3) month trial period. The DMEPOS ~~p~~Provider is responsible to ensure all requirements in this rule are met.~~-~~¶
(c) A Bi-level Positive Airway Pressure (BiPAP) device without backup rate (E0470) may be covered for treatment of OSA when the following criteria are met:~~-~~¶
(A) Criteria in (1)(a)(A)-(D) of this rule; and~~-~~¶
(B) A Continuous Positive Airway Pressure (CPAP) or Automatic Positive Airway Pressure (APAP) device (E0601) has been tried and proven ineffective or there is documentation of medical contraindication to E0601 devices as determined by the treating ~~p~~Practitioner. Ineffective use is defined as documented failure to meet therapeutic goals using a CPAP/APAP device during the titration period of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure settings);~~-~~¶
(C) If a CPAP/APAP device is tried and found ineffective during the initial facility-based titration or three (3) month home trial, substitution of a BiPAP does not require a new face-to-face clinical evaluation or sleep test;~~-~~¶
(D) If a CPAP/APAP device has been used for more than three (3) months and the ~~client~~Member is switched to a BiPAP, a clinical re-evaluation must occur, but a new sleep test is not required. A new three (3) month trial shall begin for use of the BIPAP.~~-~~¶
(d) PA is not required for BiPAP device (E0470) rental and purchase of prescribed accessories during the initial three (3) month trial period. The DMEPOS ~~p~~Provider is responsible to ensure all requirements in this rule are met.~~-~~¶
(2) Continued Coverage of PAP device (PA Required):~~-~~¶
(a) Purchase or ongoing rental of a PAP device (E0601 or E0470) beyond the three-month trial period may be covered when the conditions of coverage have been met per the OHA Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note. The DMEPOS ~~p~~Provider must submit the following documentation, with request for authorization, prior to the fourth (4th) ~~d~~Date of ~~s~~Service:~~-~~¶
(A) A face-to-face re-evaluation visit conducted by the treating ~~p~~Practitioner no sooner than the ~~thirty-first (~~31st~~)~~ day but no later than the ~~ninety-first (~~91st~~)~~ day after initiating therapy that supports ~~client~~Member's clinical benefit, compliance, and demonstrates symptoms of OSA are improved; and~~-~~¶
(B) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage. PAP compliance report data can be documented by the treating ~~p~~Practitioner in the clinical re-evaluation. Adherence to therapy is defined as use of PAP four (4) hours or more per night on ~~seventy~~70 percent ~~(70%)~~ of nights during a consecutive ~~thirty (~~30~~)~~ day period anytime during the first three months of initial usage;~~-~~¶
(C) If the clinical re-evaluation by the treating practitioner does not occur until after the ~~ninety-first (~~91st~~)~~ day but the re-evaluation demonstrates the ~~client~~Member is compliant, as defined in this rule, and benefiting from PAP therapy at the time of their re-evaluation, the ~~p~~Provider shall submit a PA request for continued coverage. The

request for authorization shall include the following documentation:¶
(i) The clinical re-evaluation with the treating ~~p~~Practitioner that demonstrates the ~~client~~Member is compliant, as defined in this rule, and benefiting from the PAP therapy at the time of the re-evaluation; and¶
(ii) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage, at the time of the ~~client~~Member's re-evaluation. PAP compliance report data can be documented by the treating ~~p~~Practitioner in the clinical re-evaluation. Adherence to therapy is defined as use of PAP four (4) hours or more per night on ~~seventy~~70 percent ~~(70%)~~ of nights during a consecutive ~~thirty (~~30~~)~~ day period prior to ~~client~~Member's re-evaluation.¶
(D) If there is a break in billing of ~~sixty (~~60~~)~~ days or more between the end of the trial period and the request to purchase or continue renting the PAP device, the ~~p~~Provider shall also supply current objective evidence of adherence to use of the PAP device from the date the ~~p~~Prior ~~a~~Authorization request to resume coverage is submitted;¶
(i) Adherence to therapy is defined as use of PAP four (4) hours or more per night on ~~seventy~~70 percent ~~(70%)~~ of nights during a consecutive ~~thirty (~~30~~)~~ day period;¶
(ii) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the ~~thirteenth (~~13th~~)~~ consecutive month;¶
(b) If objective data does not support compliance and efficacy, extending the trial period beyond the third month may be approved on a case-by-case basis by the appropriate authorizing unit. To ask for an exception, the DMEPOS ~~p~~Provider must submit the following documentation with the ~~p~~Prior ~~a~~Authorization request:¶
(A) Documentation of a face-to-face visit with the treating ~~p~~Practitioner clearly specifying a treatment plan with measurable goals to improve adherence to treatment; and¶
(B) Objective evidence of PAP use, including a PAP summary report through direct download of usage;¶
(C) The trial period may extend up to a maximum of two (2) months to allow the ~~client~~Member to achieve compliance, as defined in this rule, and therapeutic benefit;¶
(D) Purchase or ongoing rental of a PAP device (E0601 or E0470) beyond the two (2) month extended trial period may be covered when the conditions for continued coverage have been met. Submit the following documentation with request for ~~p~~Prior ~~a~~Authorization:¶
(i) A face-to-face clinical re-evaluation conducted by the treating ~~p~~Practitioner which documents the following:¶
(I) ~~Client~~Member is compliant and benefiting from PAP therapy; and¶
(II) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage;¶
(ii) Adherence to therapy is defined as use of PAP four (4) hours or more per night on ~~seventy~~70 percent ~~(70%)~~ of nights during a consecutive ~~thirty (~~30~~)~~ day period anytime during the two (2) month extended rental period.¶
(E) If there is a break in billing of ~~sixty (~~60~~)~~ days or more between the end of the extended trial period and the request to purchase or continue renting the PAP device, the ~~p~~Provider shall also supply current objective evidence of adherence to use of the PAP device from the date the ~~p~~Prior ~~a~~Authorization request to resume coverage is submitted;¶
(i) Adherence to therapy is defined as use of PAP four (4) hours or more per night on ~~seventy~~70 percent ~~(70%)~~ of nights during a consecutive ~~thirty (~~30~~)~~ day period;¶
(ii) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the ~~thirteenth (~~13th~~)~~ consecutive month.¶
(c) ~~Client~~Members who fail their PAP trial, may be eligible to re-qualify for a PAP device trial but must have both:¶
(A) Face-to-face clinical re-evaluation by the treating ~~p~~Practitioner to determine etiology of the failure to respond to PAP therapy; and¶
(B) Repeat sleep test in a facility-based setting if deemed necessary by the treating practitioner. This may be a repeat diagnostic titration or split night study in accordance with the OHA Prioritized List of Health Services Diagnostic Testing for Obstructive Sleep Apnea (OSA) Guideline Note.¶
(d) For a ~~client~~Member using a PAP device prior to Oregon Health Plan (OHP) enrollment, continuing coverage for the device and related accessories may be authorized on a case-by-case basis upon submission and review of the following required documentation:¶
(A) Record of initial delivery date when the PAP equipment was dispensed; and¶
(B) Documentation from the ~~client~~Member's treating ~~p~~Practitioner to support the diagnosis of OSA and that coverage criteria in this rule are met in accordance with the OHA Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note; and¶
(C) A facility-based polysomnogram report or home sleep test that meets all CMS requirements for a valid sleep test in accordance with the OHA Prioritized List of Health Services Diagnostic Testing for Obstructive Sleep Apnea (OSA) Guideline Note; and¶
(D) Objective evidence of ~~client~~Member's ongoing adherence to PAP therapy at the time the ~~p~~Prior ~~a~~Authorization for continued coverage is requested. Adherence to therapy is defined as use of PAP four (4) hours or more per

night on ~~seventy~~70 percent ~~(70%)~~ of nights during a consecutive ~~thirty (~~30~~)~~ day period.~~-~~¶
(e) The continued rental of PAP equipment and the purchase of related accessories shall not be reimbursed, under any circumstance, when ~~client~~Member is not using the equipment or non-compliant with its use;~~-~~¶
(A) It is the ~~p~~Provider's responsibility to monitor appropriate and effective use of the device as ordered by the treating ~~p~~Practitioner; and~~-~~¶
(B) When the equipment is not being used as prescribed or ~~m~~Member is non-compliant with its use, it is the ~~p~~Provider's responsibility to stop billing for the continued rental of the equipment and the purchase of related accessories and supplies.~~-~~¶
(3) Accessories:~~-~~¶
(a) Either a non-heated (E0561) or heated (E0562) humidifier is covered and reimbursed separately when ordered by the treating ~~p~~Practitioner for use with a covered PAP device (E0470, E0601). No PA is required;~~-~~¶
(b) Accessories are separately reimbursable at the time of initial issue and when replaced. For replacement of accessories beyond initial issue:~~-~~¶
(A) Suppliers are required to verify the PAP or BiPAP device is still in use;~~-~~¶
(B) Regardless of utilization, a supplier must not dispense more than a three (3) month quantity of accessories;~~-~~¶
(C) Automatic shipments on a pre-determined basis, even if authorized by the ~~client~~Member or designee, are not allowed. An order refill does not have to be approved by the ordering ~~p~~Practitioner. However, a ~~client~~Member or their caregiver must request specific ongoing PAP supplies and accessories, subject to rule limitations and requirements, before they are dispensed. The DMEPOS ~~p~~Provider shall not automatically dispense a quantity of supplies and accessories on a predetermined regular basis, even if the ~~client~~Member has "authorized" this in advance;~~-~~¶
(c) The following represents the usual maximum number of accessories expected to be ~~m~~Medically ~~a~~Appropriate:~~-~~¶
(A) A4604 - 1 per 3 months;~~-~~¶
(B) A7027 - 1 per 3 months;~~-~~¶
(C) A7028 - 2 per month;~~-~~¶
(D) A7029 - 2 per month;~~-~~¶
(E) A7030 - 1 per 3 months;~~-~~¶
(F) A7031 - 1 per month;~~-~~¶
(G) A7032 - 2 per month;~~-~~¶
(H) A7033 - 2 per month;~~-~~¶
(I) A7034 - 1 per 3 months;~~-~~¶
(J) A7035 - 1 per 6 months;~~-~~¶
(K) A7036 - 1 per 6 months;~~-~~¶
(L) A7037 - 1 per 3 months;~~-~~¶
(M) A7038 - 2 per month;~~-~~¶
(N) A7039 - 1 per 6 months;~~-~~¶
(O) A7046 - 1 per 6 months.~~-~~¶
(4) Replacement of PAP Device:~~-~~¶
(a) For PAP devices initially covered through the Oregon Health Plan, a replacement PAP may be covered on a case-by-case basis in accordance with OAR 410-122-0184. The DMEPOS ~~p~~Provider must submit the following documentation with the PA request:~~-~~¶
(A) An order for the replacement PAP device from the treating ~~p~~Practitioner; and~~-~~¶
(B) A face-to-face clinical evaluation by the treating ~~p~~Practitioner that documents the present medical need for replacement and confirms the beneficiary continues to use and benefit from the PAP device.~~-~~¶
(b) For PAP devices not initially covered through the Oregon Health Plan, a replacement PAP may be covered on a case-by-case basis in accordance with OAR 410-122-0184. The DMEPOS ~~p~~Provider must submit records to support the ~~client~~Member meets criteria in paragraphs (1)(a)(A)-(D) of this rule and the following documentation with the PA request:~~-~~¶
(A) An order for the replacement PAP device from the treating ~~p~~Practitioner;~~-~~¶
(B) A face-to-face clinical evaluation by the treating ~~p~~Practitioner that documents the present medical need for replacement and confirms the beneficiary continues to use and benefit from the PAP device; and~~-~~¶
(C) Name of prior DMEPOS ~~p~~Provider and the date the PAP device was initially issued.~~-~~¶
(5) Prior ~~a~~Authorization is obtained from the same authorizing authority as specified in OAR 410-122-0040. PA is required for the following:~~-~~¶
(a) All subsequent rentals or purchase of a PAP device starting with the fourth (4th) month ~~d~~Date of ~~s~~Service;~~-~~¶
(b) Quantities of PAP accessories that exceed their usual maximum number as defined in (3)(c)(A-O);~~-~~¶
(c) A replacement PAP device.~~-~~¶
(6) Mandibular advancement devices (oral appliances) may be covered for those for whom CPAP fails or is contraindicated. A face-to-face clinical evaluation with the treating ~~p~~Practitioner is required to document the

presence of either condition and the ~~m~~Medical ~~n~~Necessity for the device. If a custom fabricated device is prescribed, the ~~p~~Practitioner's evaluation must also include why a less costly prefabricated device will not meet the ~~client~~Member's needs. No PA is required.~~-~~¶
(7) Reimbursement:~~-~~¶
(a) Rental charges apply toward purchase;~~-~~¶
(b) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the ~~thirteenth (~~13th~~)~~ consecutive month;~~-~~¶
(c) Equipment is considered purchased either upon completion of the capped rental period, after the Division fee schedule purchase price is met, or when the actual charge from the ~~p~~Provider is met, whichever is less;~~-~~¶
(d) Accessories are separately reimbursable at the time of initial issue.~~-~~¶
(8) Documentation Requirements:~~-~~¶
(a) For services requiring PA, submit documentation that supports coverage criteria and guidelines in this rule are met;~~-~~¶
(b) Medical records and documentation to support the ~~client~~Member meets criteria and conditions of coverage in this rule must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) ~~p~~Provider and made available to the Division on request.~~-~~¶
(9) For children and youth 18 years old or younger: the Division may cover a positive airway pressure (PAP) device for treatment of obstructive sleep apnea (OSA) when the criteria and conditions of coverage in the OHA Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note are met.~~-~~¶
(10) A Respiratory Assist Device (RAD) with backup rate (E0471) is not medically indicated for the treatment of obstructive sleep apnea. Coverage, coding, and documentation requirements are addressed in OAR 410-122-0205 Respiratory Assist Devices.~~-~~¶
(11) Table 122-0202 - PAP Devices.
Statutory/Other Authority: ORS 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0202.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341169

AMEND: 410-122-0203

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0203
Oxygen and Oxygen Equipment ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness: The Division may cover home oxygen therapy services. Refer to Table 122-0203-1 and the following guidelines:~~-~~¶
(a) For children under age 21 when the treating ~~p~~Practitioner has determined oxygen services to be ~~m~~Medically ~~a~~Appropriate; or~~-~~¶
(b) For adults aged 21 years of age and older who are fully dual-eligible ~~client~~Members (Medicare ~~client~~Members who are also eligible for Medicaid/Oregon Health Plan (OHP); See definition in General Rules, OAR 410-120-0000), the Division may cover oxygen services as follows:~~-~~¶
(A) If Medicare paid on the claim for the oxygen equipment, the Division may provide reimbursement;~~-~~¶
(B) If Medicare denied payment on the claim for the oxygen equipment, the Division shall/not provide reimbursement in accordance with Medicare rules and regulations;~~-~~¶
(C) Refer to Table 122-0203-2 for additional details on Medicare's reimbursement limitation of 36 monthly rental payments;~~-~~¶
(c) For adults 21 years of age and older who are not eligible for Medicare (only eligible for Medicaid/OHP), Prior Authorization (PA) is required and all of the following conditions must be met:~~-~~¶
(A) The treating ~~p~~Practitioner has ordered and evaluated the results of a qualifying blood gas study performed at the time of need; and~~-~~¶
(B) The ~~client~~Member's blood gas study meets the criteria stated below; and~~-~~¶
(C) The qualifying blood gas study was performed by a treating ~~p~~Practitioner or by a qualified ~~p~~Provider or supplier of ~~l~~Laboratory ~~s~~Services; and~~-~~¶
(D) The provision of oxygen and oxygen equipment shall/improve the ~~client~~Member's condition.~~-~~¶
(d) Group I criteria include any of the following:~~-~~¶
(A) An arterial partial pressure of oxygen (PO2) at or below 55 mm Hg or an arterial oxygen saturation (e.g. peripheral pulse oximetry reading) at or below 88 percent taken at rest (awake) while breathing room air; or~~-~~¶
(B) An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation (e.g. peripheral pulse oximetry reading) at or below 88 percent, taken during sleep for a ~~client~~Member who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation (e.g. peripheral pulse oximetry) at or above 89 percent while awake. In this instance, oxygen and oxygen equipment is only necessary during sleep; or~~-~~¶
(C) A decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation (e.g. peripheral pulse oximetry reading) more than five (5) percent from baseline saturation, taken during sleep and associated with symptoms of hypoxemia such as /impairment of cognitive processes and nocturnal restlessness or insomnia (not all-inclusive).In this instance, oxygen and oxygen equipment is only necessary during sleep; or~~-~~¶
(D) An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation (e.g. peripheral pulse oximetry reading) at or below 88 percent, taken during exercise for a ~~client~~Member who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation (e.g. peripheral pulse oximetry reading) at or above 89 percent during the day while at rest. In this instance, portable oxygen and oxygen equipment is only necessary while awake and during exercise;~~-~~¶
(e) Group II criteria: An arterial PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent; and any of the following: /~~-~~¶
(A) Dependent edema suggesting congestive heart failure; or~~-~~¶
(B) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure; gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or~~-~~¶
(C) Erythrocythemia with a hematocrit greater than 56 percent;~~-~~¶
(f) Group III criteria: Initial coverage of home oxygen therapy and oxygen equipment is necessary for ~~client~~Members in Group III, if all of the following conditions are met:~~-~~¶
(A) Absence of hypoxemia defined in Group I and Group II above, and~~-~~¶
(B) A covered medical condition with distinct physiologic, cognitive, and/or functional symptoms documented in high-quality, peer-reviewed literature to be improved by oxygen therapy;~~-~~¶
(g) 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;-¶
(h) If an ABG test at rest/awake is nonqualifying, but an exercise or sleep oximetry test on the same day is qualifying, the oximetry test result shall/determine coverage;-¶
(i) Oxygen therapy and related services, equipment or supplies are not considered ~~m~~Medically ~~a~~Appropriate or ~~m~~Medically ~~n~~Necessary for any of the following:-¶
(A) Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments;-¶
(B) Dyspnea without cor pulmonale or evidence of hypoxemia;-¶
(C) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO2 shall/improve the oxygenation of tissues with impaired circulation;-¶
(D) Terminal illnesses that do not affect the ability to breathe;-¶
(E) Emergency or stand-by oxygen systems for ~~client~~Members who are not regularly using oxygen since these services are precautionary and not therapeutic in nature;-¶
(F) Topical hyperbaric oxygen chambers (A4575);-¶
(G) When furnished by an airline (responsibility of the ~~client~~Member);-¶
(H) When provided/used outside the United States and its territories.-¶
(2) Testing Specifications:-¶
(a) The term blood gas study in this policy refers to both arterial blood gas (ABG) studies and pulse oximetry:-¶
(A) An ABG is the direct measurement of the PO2 on a sample of arterial blood. The PO2 is reported as mm Hg.-¶
(B) An oximetry test is the indirect measurement of arterial oxygen saturation (e.g. peripheral pulse oximetry reading) using a sensor on the ear or finger. The saturation is reported as a percent;-¶
(C) An overnight oximetry is a stand-alone pulse oximetry continuously recorded overnight. It does not include oximetry results done as part of other overnight testing such as polysomnography or home sleep testing;-¶
(b) The qualifying blood gas study must be one that complies with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B;-¶
(c) All oxygen qualification testing must be performed by a qualified ~~p~~Practitioner or other medical professional qualified to conduct oximetry:-¶
(A) A DMEPOS ~~p~~Provider is not considered a qualified ~~p~~Provider or a qualified laboratory for purposes of this policy;-¶
(B) Division shall not accept blood gas studies either performed or paid for by a DMEPOS ~~p~~Provider;-¶
(C) This prohibition does not extend to blood gas studies performed by a ~~h~~Hospital certified to do such tests;-¶
(d) When oxygen is covered based on an oximetry study obtained during exercise, there must be documentation of three oximetry studies performed within the same testing session in the ~~client~~Member's medical record:-¶
(A) Testing at rest without oxygen;-¶
(B) Testing during exercise without oxygen; and-¶
(C) Testing during exercise with oxygen applied, to demonstrate the improvement of the hypoxemia;-¶
(e) All three tests must be performed in person by a treating ~~p~~Practitioner or other medical professional qualified to conduct exercise oximetry testing;-¶
(f) Only the qualifying test value (i.e., testing during exercise without oxygen) is used for qualification. All three (3) tests must be available upon request by the Division;-¶
(g) The qualifying blood gas study may be performed while the ~~client~~Member is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria.-¶
(3) Obstructive Sleep Apnea (OSA), Polysomnography and Home Sleep Tests:-¶
(a) Home oxygen therapy and oxygen equipment with a PAP device is covered when criteria for both Oxygen and Oxygen Equipment and Positive Airway Pressure (PAP) devices for the treatment of Obstructive Sleep Apnea are met; and-¶
(b) For ~~client~~Members with OSA, it is required that the OSA be appropriately and sufficiently treated before oxygen saturation results obtained during sleep testing are considered qualifying for oxygen therapy and oxygen equipment. This means that the OSA must be sufficiently treated such that the underlying condition resulting in hypoxemia is unmasked. This must be demonstrated before the oxygen saturation results are obtained during polysomnography are considered qualifying for oxygen therapy and oxygen equipment; and-¶
(c) For ~~client~~Members with OSA, a qualifying oxygen saturation test may only occur during a titration polysomnographic study (either split night or stand-alone). The titration PSG is one in which all of the following criteria are met:-¶
(A) The titration is conducted over a minimum of two (2) hours; and-¶
(B) During titration:-¶

(i) The AHI/RDI is reduced to less than or equal to an average of ~~ten (~~10~~)~~ events per hour; or-¶
(ii) If the initial AHI/RDI was less than an average of ~~ten (~~10~~)~~ events per hour, the titration demonstrates further reduction in the AHI/RDI; and-¶
(C) Nocturnal oximetry conducted for the purpose of oxygen therapy qualification may only be performed after optimal PAP settings have been determined and the ~~client~~Member is using the PAP device at those settings; and-¶
(D) The nocturnal oximetry conducted during the PSG demonstrates an oxygen saturation of less than or equal to 88 percent;-¶
(d) Overnight oximetry performed as part of home sleep testing or as part of any other home testing is not considered eligible to be used for qualification for reimbursement of home oxygen and oxygen equipment.-¶
(4) Portable Oxygen Systems:-¶
(a) A portable oxygen system may be covered if the ~~client~~Member is mobile within the home for Groups I and II, and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen is not covered;-¶
(b) If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system. See exception in section (6) below;-¶
(c) If a portable oxygen system is covered, the DMEPOS ~~p~~Provider must provide whatever quantity of oxygen the ~~client~~Member uses; the reimbursement is the same, regardless of the quantity of oxygen dispensed.-¶
(5) Liter flow greater than four (4) LPM:-¶
(a) If initial oxygen coverage criteria for Group 1, II, and III have been met, the Division shall pay a higher allowance for a stationary system for a flow rate of greater than four (4) LPM only when:-¶
(A) Basic oxygen coverage criteria have been met; and-¶
(B) A blood gas study performed while the ~~client~~Member is on four (4) LPM meets Group I or II criteria;-¶
(b) Payment is limited to the standard fee schedule allowance if a flow rate greater than four (4) LPM is billed and the coverage criteria for the higher allowance are not met.-¶
(6) Documentation Requirements: The DMEPOS ~~p~~Provider shall maintain and provide record of the face-to-face encounter and written order/prescription in addition to the qualifying documentation which supports conditions of coverage and testing requirements as specified in this rule are met;-¶
(a) The written order for home oxygen must be completed, signed, and dated by the treating ~~p~~Practitioner, not the DMEPOS ~~p~~Provider, prior to delivery. The DMEPOS ~~p~~Provider may use a written confirmation of other details of the oxygen order, or the treating ~~p~~Practitioner can enter the other details directly, such as the means of oxygen delivery (cannula, mask, etc.) and the specifics of varying oxygen flow rates and/or non-continuous use of oxygen./There must be a treating ~~p~~Practitioner's signed and dated order for each item billed. Items billed before a signed and dated order has been received by the DMEPOS ~~p~~Provider must be submitted with an EY modifier added to each affected Healthcare Common Procedure Coding System (HCPCS) code;-¶
(b) The following special instructions apply to replacement equipment:-¶
(A) Initial date should be the date that the replacement equipment is initially needed. This is generally understood to be the date of delivery of the oxygen equipment;-¶
(B) A treating ~~p~~Practitioner's order is needed to reaffirm the ~~m~~Medical ~~n~~Necessity of the item for replacement of an item;-¶
(C) Claims for the initial rental month (and only the initial rental month) must have the RA modifier (Replacement of DME item) added to the HCPCS code for the equipment when there is replacement due to reasonable useful lifetime or replacement due to damage, theft, or loss;-¶
(D) Claims for the initial rental month must include a narrative explanation of the reason why the equipment was replaced and supporting documentation must be maintained in the DMEPOS ~~p~~Provider's files;-¶
(c) In the following situations, a new order must be obtained and kept on file by the DMEPOS ~~p~~Provider; however, a repeat blood gas study is not required:-¶
(A) Prescribed maximum flow rate changes but remains within one of the following:-¶
(i) Less than 1 LPM;-¶
(ii) 1-4 LPM;-¶
(iii) Greater than 4 LPM;-¶
(B) Change from one type of stationary system to another (i.e., concentrator, liquid, gaseous);-¶
(C) Change from one type of portable system to another (i.e., gaseous or liquid tanks, portable concentrator, transfilling system).-¶
(d) Documentation for continued coverage and payment of oxygen and oxygen equipment after initial coverage must include evidence in the medical record documenting:-¶
(A) Group I: While there is no formal requirement for re-evaluation and retesting, ~~p~~Providers shall ensure that once qualified for home oxygen therapy, the oxygen therapy and oxygen equipment remain reasonable and necessary;-¶
(B) Group II:-¶
(i) Evaluation and documentation of a repeat qualifying blood gas test by the treating ~~p~~Practitioner between the

61st/and 90th/days after initiation of therapy; and,¶
(ii) A new written order by the treating ~~p~~Practitioner.¶
(C) Group III:¶
(i) Evaluation and documentation of a repeat qualifying blood gas test by the treating practitioner between the 61st/and 90th/days after initiation of therapy; and,¶
(ii) A new written order by the treating ~~p~~Practitioner.¶
(e) Reimbursement ends unless continued payment and documentation coverage requirements in this rule are met. This documentation must be kept on file with the DMEPOS ~~p~~Provider and available to the Division upon request.¶
(7) Oxygen contents:¶
(a) The Division allowance for rented oxygen systems includes oxygen contents necessary for one (1) month;¶
(b) Stationary oxygen contents (E0441, E0442) are separately payable only when the coverage criteria for home oxygen have been met and they are used with a ~~client~~Member-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~~Member owns a concentrator and rents or owns a portable system; or¶
(B) The ~~client~~Member 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 ~~client~~Members.¶
(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 ~~p~~Provider must provide any accessory ordered by the ~~p~~Practitioner;¶
(c) Accessories are not separately payable.¶
(9) Billing for miscellaneous oxygen items:¶
(a) Only rented oxygen systems (E0424, E0431, E0434, E0439, E1390RR, E1405 RR, E1406RR, E1392RR) are considered for coverage;¶
(b) For gaseous or liquid oxygen systems or contents, report one unit of service for one (1) month rental. Do not report in cubic feet or pounds;¶
(c) Use the appropriate modifier if the prescribed flow rate is less than one (1) LPM (QE) or greater than four (4) LPM (QF or QG). Division only accepts these modifiers with stationary gaseous (E0424) or liquid (E0439) systems or with an oxygen concentrator (E1390, E1391). Do not use these modifiers with codes for portable systems or oxygen contents;¶
(d) Use Code E1391 (oxygen concentrator, dual delivery port) in situations in which two (2) ~~client~~Members are both using the same concentrator. In this situation, this code must only be requested for one (1) of the ~~client~~Members;¶
(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 ~~client~~Members using lightweight oxygen concentrators that can function as both the ~~client~~Member'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 two (2) LPM order equivalency;¶
(g) The Medicare Pricing, Data Analysis and Coding (PDAC) contractor assists DMEPOS ~~p~~Providers and manufacturers in determining which HCPCS code shall be used to describe DMEPOS items. Refer to the product classification list on the PDAC contractor website for appropriate Healthcare Common Procedure Coding System

(HCPCS) codes.¶
(10) Table 122-0203-1, Oxygen and Oxygen Equipment.¶
(11) Table 122-0203-2, Oxygen Contents.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0203.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341170

AMEND: 410-122-0204

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0204
Nebulizer ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~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 ~~p~~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 (A7007, A7017), related compressor (E0565 or E0572), and water or saline (A4217 or A7018) may be covered when it is ~~m~~Medically ~~a~~Appropriate to deliver humidity to a ~~client~~Member with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent;¶
(ii) Combination code E0585 shall be covered for the same indications as in (1)(a)(B)(i);¶
(iii) An E0565 or E0572 compressor and filtered nebulizer (A7006) may be covered when it is ~~m~~Medically ~~n~~Necessary and ~~a~~Appropriate to administer pentamidine to a ~~client~~Member with HIV, pneumocystosis, or complications of organ transplants;¶
(C) Small volume ultrasonic nebulizer:~~¶~~
~~(i) A~~ a small volume ultrasonic nebulizer (E0574) and related accessories may be covered when it is ~~m~~Medically ~~n~~Necessary and ~~a~~Appropriate to administer treprostinil inhalation solution (J7686) to a ~~client~~Member with pulmonary hypertension only;¶
(D) Controlled dose inhalation drug delivery system:~~¶~~
~~(i) A~~ a controlled dose inhalation drug delivery system (K0730) may be covered when it is ~~m~~Medically ~~n~~Necessary and ~~a~~Appropriate to administer iloprost (Q4074) to ~~client~~Members with pulmonary hypertension only;¶
(E) Large volume ultrasonic nebulizer:~~¶~~
~~(i) A~~ a large volume ultrasonic nebulizer (E0575) offers no proven clinical advantage over a pneumatic compressor and nebulizer and will be reviewed on a case-by-case basis to determine if ~~m~~Medically ~~n~~Necessary and ~~a~~Appropriate for use;¶
(F) The Division shall consider other uses of compressors/generators individually on a case-by-case basis to determine their ~~m~~Medical ~~a~~Appropriateness;¶
(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 ~~client~~Members 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 prefilled disposable large volume nebulizer (A7008) is considered a convenience item. A non-disposable unfilled nebulizer (A7007, A7017, or E0585) filled with water or saline (A4217 or A7018) by the ~~client~~Member 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 used in conjunction with ultrasonic nebulizers coded E0574 shall be billed on separate claim lines. The dome and mouthpiece shall be billed with code A7016. Other accessories shall be billed with code A9999. When code A9999 is used, the claim must clearly describe the type and quantity of accessories provided;¶
(F) Accessories are separately payable if the related aerosol compressor and the individual accessories are ~~m~~Medically ~~a~~Appropriate. The following table lists each covered compressor/generator and its covered accessories. Other compressor/generator/accessory combinations are not covered;¶
(G) Compressor/Generator (Related Accessories): E0565 (A4619, A7006, A7010,-A7012, A7013, A7014, A7015, A7017, A7525, E1372); E0570 (A7003, A7004, A7005, A7006, A7013, A7015, A7525);-E0572 (A7006, A7007, A7014, A7017); E0574 (A7013, A7014, A7016); E0585 (A4619, A7006, A7010,-A7012, A7013, A7014, A7015, A7525); K0730 (A7005);¶

(H) This array of accessories represents all possible combinations, but it may not be appropriate to bill any or all of them for one device;¶
(I) Table 122-0204-1 lists the usual maximum frequency of replacement for accessories. The Division shall not cover claims for more than the usual maximum replacement amount unless the request has been prior approved by the Division before dispensing. The ~~p~~Provider shall submit requests for more than the usual maximum replacement amount to the Division for review.¶
(2) Coding guidelines:¶
(a) Accessories:¶
(A) Codes 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 A7016 describes the dome and mouthpiece containing the aerosolization mechanism for an ultrasonic/electronic nebulizer system;¶
(E) 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;¶
(F) Code A7007 or A7017 is billed for a durable, bottle type nebulizer when it is used with an E0572 compressor or a separately billed E0565 compressor;¶
(G) Code A7007 or 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~~Member-owned oxygen system.¶
(b) Equipment:¶
(A) In this policy,~~-~~nebulization of inhalation solutions is accomplished by two types of devices. Pneumatic compressor nebulizers achieve nebulization of liquid by means of air flow. Ultrasonic or electronic nebulizers produce nebulization of liquid by means of a vibrating mechanism;¶
(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 may be AC powered; DC powered or both;¶
(D) 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;¶
(E) Code E0574 describes an ultrasonic/electronic generator used with a small volume chamber for medication delivery. Aerosolization of the inhalation solution occurs in a nebulization chamber by means of a vibrating mechanism such as (not all inclusive) a vibrating disk, pizo-electric device, or vibrating mesh;¶
(F) Code E0575 describes a large volume ultrasonic nebulizer system that is used for medication and humidification delivery, and which is capable of continuous operation;¶
(G) Code K0730 describes a controlled dose inhalation drug delivery system. Aerosol is delivered in pulses during the inspiration. The duration of each pulse is adapted according to the breathing pattern.¶
(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~~Member's medical records corroborating the ~~m~~Medical ~~a~~Appropriateness of the current use;¶
(c) When a compressor/generator is dispensed for other uses, supporting documentation that justifies the ~~m~~Medical ~~a~~Appropriateness shall be on file with the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) ~~p~~Provider;¶
(d) The DMEPOS ~~p~~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.¶
~~[ED. NOTE: Table referenced is available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0205

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0205
Respiratory Assist Devices ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness: The Division may cover the initial three (3) month trial period of a respiratory assist device (RAD) for ~~client~~Members who are diagnosed with one of the following clinical disorders: Restrictive Thoracic Disorders, Severe Chronic Obstructive Pulmonary Disease (COPD), Central Sleep Apnea (CSA), Complex Sleep Apnea (CompSA), or Hypoventilation Syndrome; and when the criteria for each specific clinical disorder and the following guidelines are met:~~-~~¶
(2) As referenced in this policy, non-invasive positive pressure respiratory assistance (NPPRA) is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy).~~-~~¶
(3) Indications and Coverage - General:~~-~~¶
(a) The "treating ~~p~~Practitioner" must be one who is qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of respiratory assist devices (RAD);~~-~~¶
(b) For the purpose of this policy, polysomnographic studies must be performed in a sleep study laboratory, and not in the home or in a mobile facility. The sleep study laboratory must comply with all applicable state and federal regulatory requirements;~~-~~¶
(c) For the purpose of this policy, arterial blood gas, sleep oximetry and polysomnographic studies may not be performed by a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) ~~p~~Provider. For purposes of this policy's coverage and payment guidelines, a DMEPOS ~~p~~Provider is not considered a qualified ~~p~~Provider or supplier of these tests;~~-~~¶
(4) Indications and Coverage - Coverage criteria for RAD devices per diagnosed condition:~~-~~¶
(a) Restrictive Thoracic Disorders:~~-~~¶
(A) A bilevel device without backup rate (E0470) or a respiratory assist device with a backup rate (E0471) is covered when criteria i-iii are met:~~-~~¶
(i) There is documentation in the ~~client~~Member's medical record of a neuromuscular disease (for example, amyotrophic lateral sclerosis (ALS), or a severe thoracic cage abnormality (for example, post thoracoplasty for TB);¶
(ii) One of the following:~~-~~¶
(I) An arterial blood gas PaCO2, done while awake and breathing the ~~client~~Member's prescribed FIO2 is greater than or equal to 45 mm Hg~~.~~; or~~-~~¶
(II) Sleep oximetry demonstrates oxygen saturation less than or equal to 88 percent for greater than or equal to five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours), done while breathing the ~~client~~Member's prescribed recommended FIO2~~.~~; or~~-~~¶
(III) For a neuromuscular disease (only), either maximal inspiratory pressure is less than 60 cm H~~@~~2O or forced vital capacity is less than 50 percent predicted;~~-~~¶
(iii) Chronic obstructive pulmonary disease does not contribute significantly to the ~~client~~Member's pulmonary limitation.~~-~~¶
(B) If all of the above criteria are met, either an E0470 or an E0471 device will be covered for the first three months of therapy.~~-~~¶
(b) Severe COPD:~~-~~¶
(A) An E0470 device is covered if criteria i - iii are met:~~-~~¶
(i) An arterial blood gas PaCO2, done while awake and breathing the ~~client~~Member's prescribed FIO2, is greater than or equal to 52 mm Hg.~~-~~¶
(ii) Sleep oximetry demonstrates oxygen saturation less than or equal to 88 percent for greater than or equal to a cumulative five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours), done while breathing oxygen at two (2) LPM or the ~~client~~Member's prescribed FIO2 (whichever is higher).~~-~~¶
(iii) Prior to initiating therapy, sleep apnea and treatment with a continuous positive airway pressure device (CPAP) has been considered and ruled out. (Note: Formal sleep testing is not required if there is sufficient information in the medical record to demonstrate that the beneficiary does not suffer from some form of sleep apnea (Obstructive Sleep Apnea (OSA), CSA and/or CompSA) as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation).~~-~~¶

(B) For severe COPD ~~client~~Members who qualified for an E0470 device, an E0471 started any time after a period of initial use of an E0470 device is covered if both criteria i and ii are met:~~-~~¶
(i) An arterial blood gas PaCO2, done while awake and breathing the ~~client~~Member's prescribed FIO2, shows that the ~~client~~Member's PaCO2 worsens greater than or equal to seven (7) mm Hg compared to the original result from criterion (4)(b)(A)(i), (above).~~-~~¶
(ii) A facility-based PSG demonstrates oxygen saturation less than or equal to 88 percent for greater than or equal to a cumulative five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours) while using an E0470 device that is not caused by obstructive upper airway events - i.e., AHI less than five (5).~~-~~¶
(C) For severe COPD ~~client~~Members who qualified for an E0470 device, an E0471 device will be covered if, at a time no sooner than 61 days after initial issue of the E0470 device, both of the following criteria i and ii are met:~~-~~¶
(i) An arterial blood gas PaCO2 is done while awake and breathing the ~~client~~Member's prescribed FIO2, still remains greater than or equal to 52 mm Hg.~~-~~¶
(ii) Sleep oximetry while breathing with the E0470 device, demonstrates oxygen saturation less than or equal to 88 percent for greater than or equal to a cumulative five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours), done while breathing oxygen at two (2) LPM or the ~~client~~Member's prescribed FIO2 [whichever is higher].~~-~~¶
(c) Central Sleep Apnea or Complex Sleep Apnea~~-~~¶
(A) An E0470 or E0471 device is covered when, prior to initiating therapy, a complete facility-based, attended PSG is performed documenting the following (i and ii):~~-~~¶
(i) Diagnosis of CSA or CompSA; and~~-~~¶
(ii) Significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the ~~client~~Member's prescribed FIO2.¶
(B) If all of the above criteria are met, either an E0470 or an E0471 device will be covered for the first three (3) months of therapy.~~-~~¶
(d) Hypoventilation Syndrome~~-~~¶
(A) An E0470 device is covered if both criteria i and ii and either criteria iii or iv are met:~~-~~¶
(i) Initial arterial blood gas PaCO2, done while awake and breathing the ~~client~~Member's prescribed FIO2, is greater than or equal to 45 mm Hg;~~-~~¶
(ii) Spirometry shows an FEV1/FVC greater than or equal to 70 percent;~~-~~¶
(iii) Arterial blood gas PaCO2, done during sleep or immediately upon awakening, and breathing the ~~client~~Member's prescribed FIO2, shows the ~~client~~Member's PaCO2 worsened greater than or equal to seven (7) mm Hg compared to the original result in criterion (4)(b)(A)(i) (above);~~-~~¶
(iv) Facility-based PSG or HST demonstrates oxygen saturation less than or equal to 88 percent for greater than or equal to five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours) that is not caused by obstructive upper airway events - i.e., AHI less than five (5).~~-~~¶
(B) An E0471 device is covered for a ~~client~~Member with hypoventilation syndrome if both criteria i, ii, and either criteria iii or iv are met:~~-~~¶
(i) A covered E0470 device is being used;~~-~~¶
(ii) Spirometry shows an FEV1/FVC greater than or equal to 70 percent;~~-~~¶
(iii) Arterial blood gas PaCO2, done while awake, and breathing the ~~client~~Member's prescribed FIO2, shows that the ~~client~~Member's PaCO2 worsens greater than or equal to seven (7) mm Hg compared to the arterial blood gas (ABG) result performed to qualify the ~~client~~Member for the E0470 device;~~-~~¶
(iv) Facility-based PSG or HST demonstrates oxygen saturation less than or equal 88 percent for greater than or equal to five (5) minutes of nocturnal recording time (minimum recording time of two (2) hours) that is not caused by obstructive upper airway events - i.e., AHI less than five (5) while using an E0470 device.~~-~~¶
(5) Continued Coverage: Prior ~~a~~Authorization (PA) is required for ongoing rental of a RAD device beyond the third (3rd) month and may be covered when the conditions for continued coverage in this rule are met. Submit the following documentation with request for authorization prior to the (4th) fourth month ~~d~~Date of ~~s~~Service:~~-~~¶
(a) Evaluation completed by the prescribing practitioner no sooner than ~~sixty-one (~~61~~)~~ days after initiating use of the RAD device, stating the ~~client~~member is compliantly using the RAD device an average of four (4) hours per twenty-four (24) hour period and the ~~client~~Member is benefiting from its use; and~~-~~¶
(b) Objective evidence of adherence to use of the RAD device, including a summary of RAD compliance report through a direct download of usage.~~-~~¶
(6) Accessories:~~-~~¶
(a) Either a non-heated (E0561) or heated (E0562) humidifier is covered and reimbursed separately when ordered by the treating ~~p~~Practitioner for use with a covered RAD device. No PA is required;~~-~~¶
(b) For replacement of accessories beyond initial issue:~~-~~¶
(A) Suppliers are required to verify the RAD device is still in use;~~-~~¶
(B) Regardless of utilization, a supplier must not dispense more than a three (3) month quantity of accessories;~~-~~¶

(C) Automatic shipments on a pre-determined basis, even if authorized by the ~~client~~Member or designee, are not allowed. An order refill does not have to be approved by the ordering ~~p~~Practitioner. However, a ~~client~~Member or their caregiver must request specific ongoing PAP supplies and accessories, subject to rule limitations and requirements, before they are dispensed. The DMEPOS ~~p~~Provider shall not automatically dispense a quantity of supplies and accessories on a predetermined regular basis, even if the ~~client~~Member has "authorized" this in advance;~~-~~¶
(c) The following represents the usual maximum number of accessories expected to be ~~m~~Medically ~~a~~Appropriate:~~-~~¶
(A) A4604 - 1 per 3 months;~~-~~¶
(B) A7027 - 1 per 3 months;~~-~~¶
(C) A7028 - 2 per month;~~-~~¶
(D) A7029 - 2 per month;~~-~~¶
(E) A7030 - 1 per 3 months;~~-~~¶
(F) A7031 - 1 per month;~~-~~¶
(G) A7032 - 2 per month;~~-~~¶
(H) A7033 - 2 per month;~~-~~¶
(I) A7034 - 1 per 3 months;~~-~~¶
(J) A7035 - 1 per 6 months;~~-~~¶
(K) A7036 - 1 per 6 months;~~-~~¶
(L) A7037 - 1 per 3 months;~~-~~¶
(M) A7038 - 2 per month;~~-~~¶
(N) A7039 - 1 per 6 months;~~-~~¶
(O) A7046 - 1 per 6 months.~~-~~¶
(7) Reimbursement:~~-~~¶
(a) Rental charges apply toward purchase;~~-~~¶
(b) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the ~~thirteenth (~~13th~~)~~ consecutive month;~~-~~¶
(c) Equipment is considered purchased upon completion of the capped rental period, after the Division fee schedule purchase price is met, or when the actual charge from the ~~p~~Provider is met, whichever is less;~~-~~¶
(d) When the RAD is not being used as prescribed or ~~client~~Member is non-compliant with its use, the DMEPOS ~~p~~Provider shall stop billing for the continued rental of the equipment and the purchase of related accessories and supplies.~~-~~¶
(8) Documentation:~~-~~¶
(a) The following documentation must be submitted with the request for PA and the original kept on file with the DMEPOS ~~p~~Provider:~~-~~¶
(A) An order for all equipment and accessories including the ~~client~~Member's diagnosis, an ICD-10-CM code signed and dated by the treating ~~p~~Practitioner;~~-~~¶
(B) Summary of events from the polysomnogram;~~-~~¶
(C) Arterial blood gas results, if required under the indications and coverage section;~~-~~¶
(D) Sleep oximetry results, if required under the indications and coverage section;~~-~~¶
(E) Treating ~~p~~Practitioner statement regarding medical symptoms characteristic of sleep-associated hypoventilation, including, but not limited to daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, and dyspnea;~~-~~¶
(F) Other treatments that have been tried and failed. To be submitted in addition to the above at the fourth (4th) month review;~~-~~¶
(b) ~~Client~~Members currently using BiPapS and BiPap ST are not subject to the new criteria.~~-~~¶
(9) Table 122-0205-1, Procedure Codes.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0205.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341174

AMEND: 410-122-0206

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0206
Intermittent Positive Pressure Breathing ¶

E0500, IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source the Division will rent. Covered if ~~m~~Medically ~~a~~Appropriate for the following indications:¶
(1) ~~Client~~Members at risk of respiratory failure because of decreased respiratory function secondary to kyphoscoliosis or neuromuscular disorders.¶
(2) ~~Client~~Members with severe bronchospasm or exacerbated chronic obstructive pulmonary disease (COPD) who fail to respond to standard therapy.¶
(3) The management of atelectasis that has not improved with simple therapy.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0208

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0208
Suction Pumps ¶

(1) Indications and Limitations of Coverage:¶
(a) Use of a home model respiratory suction pump may be covered for a ~~client~~Member who has difficulty raising and clearing secretions secondary to:¶
(A) Cancer or surgery of the throat or mouth; or¶
(B) Dysfunction of the swallowing muscles; or¶
(C) Unconsciousness or obtunded state; or¶
(D) Tracheostomy; or¶
(E) Neuromuscular conditions;¶
(b) When a respiratory suction pump (E0600) is covered, tracheal suction catheters are separately payable supplies. In most cases, in the home setting, sterile catheters are ~~m~~Medically ~~a~~Appropriate only for tracheostomy suctioning. Three suction catheters per day are covered for ~~m~~Medically ~~a~~Appropriate tracheostomy suctioning, unless additional documentation is provided. When a tracheal suction catheter is used in the oropharynx, which is not sterile, the catheter can be reused if properly cleansed ~~and/~~or disinfected. In this situation, the ~~m~~Medical ~~a~~Appropriateness for more than three catheters per week requires additional documentation;¶
(c) Sterile saline solution (A4216, A4217) may be covered and separately payable when used to clear a suction catheter after tracheostomy suctioning. It is not usually ~~m~~Medically ~~a~~Appropriate for oropharyngeal suctioning. Saline used for tracheal lavage is not covered;¶
(d) Supplies (A4628) are covered and are separately payable when they are ~~m~~Medically ~~a~~Appropriate and used with a ~~m~~Medically ~~a~~Appropriate suction pump (E0600) in a covered setting;¶
(e) When a suction pump (E0600) is used for tracheal suctioning, other supplies (e.g., cups, basins, gloves, solutions, etc.) are included in the tracheal care kit code, A4625-(see OAR 410-122-0209 for details). When a suction pump is used for oropharyngeal suctioning, these other supplies are not ~~m~~Medically ~~a~~Appropriate;¶
(f) The suction device must be appropriate for home use without technical or professional supervision. Those using the suction apparatus must be sufficiently trained to adequately, appropriately and safely use the device.¶
(2) A ~~client~~Member's medical record must reflect the need for the supplies dispensed and billed. The medical record must be kept on file by the durable medical equipment (DME) ~~p~~Provider and made available to the Division ~~of Medical Assistance Programs (Division)~~ upon request.¶
(3) A portable or stationary home model respiratory suction pump (E0600) is an electric aspirator designed for oropharyngeal and tracheal suction.¶
(4) A portable or stationary home model gastric suction pump (E2000) is an electric aspirator designed to remove gastrointestinal secretions.¶
(5) A tracheal suction catheter is a long, flexible catheter.¶
(6) An oropharyngeal catheter is a short, rigid (usually) plastic catheter of durable construction.¶
(7) Code E0600 must not be used for a suction pump used with gastrointestinal tubes.¶
(8) Code E2000 must be used for a suction pump used with gastrointestinal tubes.¶
(9) Providers should contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor for guidance on the correct coding of these items.¶
(10) When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, there must be clear documentation in the ~~client~~Member's medical records corroborating the ~~m~~Medical ~~a~~Appropriateness for the higher utilization. The Division may request copies of the ~~client~~Member's medical records that corroborate the order and any additional documentation that pertains to the ~~m~~Medical ~~a~~Appropriateness of items and quantities billed.¶
(11) Table 122-0208, Suction Pumps.¶
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0208.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341176

AMEND: 410-122-0209

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0209
Tracheostomy Care Supplies ¶

(1) Indications and Coverage: For a ~~client~~Member following an open surgical tracheostomy that has been open or is expected to remain open for at least three months:¶
(a) Standard tracheostomy supplies, including tracheostomy tubes (A7520, A7521), do not require ~~p~~Prior ~~a~~Authorization;¶
(b) Custom/Specialized tracheostomy tubes must be a device that requires the manufacturer to complete substantive customization or modification for a specific individual's medical need;¶
(c) Custom/Specialized tracheostomy tubes require ~~p~~Prior ~~a~~Authorization and shall be approved with clinical documentation supporting the ~~m~~Medical ~~a~~Appropriateness and a statement from the prescribing ~~p~~Practitioner explaining why a standard or off-the-shelf tracheostomy tube will not meet the ~~client~~Member's medical needs.¶
(2) Documentation:¶
(a) A prescription for tracheal equipment that is signed by the prescribing ~~p~~Practitioner shall be kept on file by the DMEPOS ~~p~~Provider. The prescribing ~~p~~Practitioner's records shall contain information that supports the ~~m~~Medical ~~a~~Appropriateness of the item ordered;¶
(b) Custom/Specialized tracheostomy tubes require an assessment every six months indicating a standard tracheostomy tube does not currently meet the medical needs of the ~~client~~Member. Documentation shall be submitted to the Division at the time of request.¶
(3) Billing:¶
(a) Custom/Specialized tracheostomy tubes shall be billed using the correct HCPCS code and modifier 22;¶
(b) Custom/Specialized tracheostomy tubes shall be reimbursed following the payment methodology outlined in OAR 410-122-0186 for manually priced items.¶
(4) Procedure Codes - Table 122-0209.~~¶~~
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0209.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341177

AMEND: 410-122-0210

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0210
Ventilators ¶

(1) Indications and limitations of coverage:¶
(a) Mechanical ventilatory support may be provided to a ~~client~~Member 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 ~~m~~Medical ~~a~~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~~Member 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~~Member is ready for discharge and has been on a ventilator more than ~~ten (~~10~~)~~ days;¶
(b) E0465, E0466 or E0472 may be covered if:¶
(A) A ~~client~~Member has no respiratory drive either due to paralysis of the diaphragm or a central brain dysfunction; or¶
(B) A ~~client~~Member has a stable, chronic condition with no orders to wean from the ventilator; or¶
(C) A ~~client~~Member 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~~Member has uncompromised lung disease;¶
(c) E0465 or E0466 may be covered if supporting documentation indicates:¶
(A) A ~~client~~Member has chronic lung disease where volume ventilation may further damage lung tissue; or¶
(B) A ~~client~~Member has a compromised airway or musculature and has respiratory drive and a desire to breathe; or¶
(C) A ~~client~~Member shall eventually be weaned from the ventilator; or¶
(D) A ~~client~~Member 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~~Member;¶
(b) For example (not all-inclusive), a secondary ventilator may be covered when:¶
(A) A ~~client~~Member 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~~Member 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~~Member. Therefore, ventilators are reimbursed on a monthly rental payment for as long as the equipment is ~~m~~Medically ~~a~~Appropriate;¶
(b) Payment includes:¶
(A) The durable medical equipment (DME) ~~p~~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 ~~p~~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~~Member 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 ~~a~~Authorization (PA):¶
(a) PA is not required when E0465, E0466 or E0472 is dispensed as the primary ventilator. The ~~p~~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 ~~d~~Date of ~~s~~Service and before submitting claims. See Oregon Administrative Rule (OAR) 410-120-0000 (General Rules);¶
(B) Payment authorization shall 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~~Member's medical records, kept on file with the DME ~~p~~Provider and made available to the Division on request. Table 122-0210¶
~~[ED. NOTE: Tables referenced are available from the agency.].~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0210.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341178

AMEND: 410-122-0211

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0211
Cough Stimulating Device ¶

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

Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0220

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0220
Pacemaker Monitor ¶

(1) E0610 - Pacemaker monitor, self-contained, checks battery depletion, includes audible and visible check systems:¶
(a) The Division will purchase;¶
(b) Also covered for payment by the Division when ~~client~~the Member is a resident of a ~~n~~Nursing ~~f~~Facility.¶
(2) E0615 - Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems:¶
(a) The Division will purchase;¶
(b) Also covered for payment by the Division when ~~client~~the Member is a resident of a ~~n~~Nursing ~~f~~Facility.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0250

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0250
Breast Pumps ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness:~~-~~¶
(a) In accordance with OHA Prioritized List of Health Services Breastfeeding Support and Supplies Guideline Note, the Division may cover a breast pump and supplies for postpartum ~~women~~individuals when a pump is necessary to establish or maintain milk production in order to maximize availability of breast milk to the baby;~~-~~¶
(b) For cases in which there is a medical indication for breast pumps, the pumps shall be supplied whenever possible within 24~~-~~hours to allow for continued milk production;~~-~~¶
(c) The ~~client~~Member or caregiver shall receive instruction from the supplier in the proper use and care of the breast pump within 48~~-~~hours of receiving the equipment;~~-~~¶
(d) The rental of a hospital grade breast pump (E0604) may be covered for up to three (3) months when prescribed for use in the home;~~-~~¶
(e) A breast pump shall not be provided until a need is determined following birth;~~-~~¶
(f) A breast pump shall not be provided if it is known that mother is using a substance that is contraindicated while breastfeeding and does not plan to stop its use;~~-~~¶
(g) Replacement supplies may be covered when ~~m~~Medically ~~n~~Necessary and for the continued operation of the breast pump (E0602, E0603, E0604);~~-~~¶
(A) Reimbursement of ~~m~~Medically ~~n~~Necessary replacement supplies are limited to replacement tubing, replacement adapter, replacement cap for breast pump bottle, replacement breast shield and protector, replacement polycarbonate bottle, replacement locking ring, replacement valve, and a disposable collection and storage bag for breast milk (any size, any type);~~-~~¶
(B) The following represents the usual number of supplies expected to be ~~m~~Medically ~~a~~Appropriate; however, the quantity and frequency of replacement supplies shall be determined by the treating ~~p~~Practitioner:~~-~~¶
(i) A4281 - 2 units per year;~~-~~¶
(ii) A4282 - 2 units per year;~~-~~¶
(iii) A4283 - 2 units per year;~~-~~¶
(iv) A4284 - 2 sets per year;~~-~~¶
(v) A4285 - 2 units per year;~~-~~¶
(vi) A4286 - 2 units per year;~~-~~¶
(vii) A4287 - 186 units per month;~~-~~¶
(viii) A4288 - 2 units per year.~~-~~¶
(2) Prior Authorization (PA): A PA is obtained from the same authorizing authority as specified in OAR 410-122-0040. PA is required for the following:~~-~~¶
(a) Replacement of the breast pump due to loss, theft, or irreparable damage in accordance with OAR 410-122-0184;~~-~~¶
(b) Replacement supplies not identified in this rule;~~-~~¶
(c) Rental of a hospital grade breast pump (E0604) beyond the third month;~~-~~¶
(3) The following services are not considered ~~m~~Medically ~~n~~Necessary:~~-~~¶
(a) Accessories not necessary for the operation of a breast pump (for example, travel bags, nursing bras, bra pads, breast feeding pillows, etc.);~~-~~¶
(b) An electric breast pump for the comfort and convenience of the ~~mother;~~ breast-feeding parent;¶
(c) Purchase of heavy-duty hospital grade breast pumps;~~-~~¶
(d) Replacement parts covered under the manufacturer's ~~and/~~or supplier's warranty.~~-~~¶
(4) Reimbursement:~~-~~¶
(a) Reimbursement for the purchase of a single-user electric breast pump (E0603) includes all parts and supplies necessary for the operation of the electric pump;~~/-~~¶
(b) Reimbursement for the purchase of a manual breast pump (E0602) includes all parts and supplies necessary for the operation of the manual pump;~~-~~¶
(c) Reimbursement for the first month's rental of a hospital grade breast pump (E0604) includes all parts and supplies necessary for the operation of the hospital grade pump;~~-~~¶
(d) Replacement supplies, other than breast shields, are not reimbursable at the time of purchase or rental;~~-~~¶

(e) Rental charges apply to purchase;¶
(f) Reimbursement is limited to the purchase of one (1) breast pump per pregnancy;¶
(5) Documentation:¶
(a) For services requiring ~~p~~Prior ~~a~~Authorization, submit documentation that supports coverage criteria in this rule are met;¶
(b) Medical records and documentation to support the ~~client~~Member meets criteria and conditions of coverage in this rule must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) ~~p~~Provider and made available to the Division on request.¶
(6) Procedure Codes:¶
(a) E0602 - Breast pump, manual, any type - purchase only;¶
(b) E0603 - Breast pump, electric (AC and/or DC), any type - purchase only;¶
(c) E0604 - Breast pump, hospital grade, electric (AC and/or DC), any type - rental only;¶
(d) A4281 - Tubing for breast pump, replacement;¶
(e) A4282 - Adapter for breast pump, replacement;¶
(f) A4283 - Cap for breast pump bottle, replacement;¶
(g) A4284 - Breast shield and splash protector for use with breast pump, replacement;¶
(h) A4285 - Polycarbonate bottle for use with breast pump, replacement;¶
(i) A4286 - Locking ring for breast pump, replacement;¶
(j) A4287 - Disposable collection and storage bag for breast milk, any size, any type;¶
(k) A4288 - Valve for breast pump, replacement.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0260

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0260
Home Uterine Monitoring ¶

(1) Home uterine monitoring (S9001) requires ~~p~~Prior ~~a~~Authorization (PA) and may be approved for the following conditions:¶
(a) Pre-term labor with one or more of the following complications:¶
(A) Incompetent cervix;¶
(B) Cervical cerclage;¶
(C) Polyhydramnios;¶
(D) Anomalies of the uterus;¶
(E) History of cone biopsy;¶
(F) Cervical dilation or effacement;¶
(G) Unknown etiology.¶
(b) History of pre-term labor and delivery;¶
(c) Multiple gestation.¶
(2) Uterine monitoring will only be approved for the above conditions between the 24th and through the completion of the 36th week of pregnancy.¶
(3) The Division will provide coverage for rental only. The allowable rental fee for the uterine monitor includes all equipment, supplies, services, and nursing visits necessary for the effective use of the monitor. This does not include medications or prescribing ~~p~~Practitioner's professional services.¶
(4) The ~~client~~Member must have landline telephone or reasonable access to one. The Division will not be responsible for providing the landline telephone or landline access.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0300

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0300
Light Therapy ¶

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

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0300.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341188

AMEND: 410-122-0320

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0320
Manual Wheelchair Base ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness:~~-~~¶
(a) The Division may cover a manual wheelchair when conditions of coverage in OAR 410-122-0080 and all of the following criteria are met:~~-~~¶
(A) The ~~client~~Member 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~~Member from accomplishing an MRADL entirely;~~-~~¶
(ii) Places the ~~client~~Member at reasonably determined heightened risk of morbidity or mortality secondary to attempts to perform an MRADL; or~~-~~¶
(iii) Prevents the ~~client~~Member from completing an MRADL within a reasonable time frame.~~-~~¶
(B) An appropriately fitted cane or walker cannot sufficiently resolve the ~~client~~Member's mobility limitation;~~-~~¶
(C) If the ~~client~~Member shall be using the wheelchair in the home, the home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for use of the manual wheelchair that is being requested;~~-~~¶
(D) Use of a manual wheelchair shall significantly improve the ~~client~~Member's ability to participate in their MRADLs. For ~~client~~Members with severe cognitive or physical impairments, participation in MRADLs may require the assistance of a caregiver;~~-~~¶
(E) The ~~client~~Member is willing to use the requested manual wheelchair on a regular basis;~~-~~¶
(F) The ~~client~~Member 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 subsection (1)(a) of this rule are met:~~-~~¶
(A) When the wheelchair can be reasonably expected to improve the ~~client~~Member's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits, and the ~~client~~Member 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 may be reasonably expected to significantly improve the ~~client~~Member'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~~Member'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~~Member 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~~Member's current wheelchair is no longer ~~m~~Medically ~~a~~Appropriate, or repair and modifications to the wheelchair exceed replacement cost;~~-~~¶
(C) When a covered, ~~client~~Member-owned wheelchair is in need of repair, the Division may pay for one (1) month's rental of a wheelchair in accordance with OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing.~~-~~¶
(c) The Division may not reimburse for another wheelchair if the ~~client~~Member has a ~~m~~Medically ~~a~~Appropriate wheelchair, regardless of payer;~~-~~¶
(d) If the ~~client~~Member shall be using the wheelchair in the home, the home must be able to accommodate and allow for the effective use of the requested wheelchair. The Division does not reimburse for adapting living quarters;~~-~~¶
(e) The Division may not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, awnings,

additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves;¶
(f) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair, as well as support services such as delivery, set-up, pick-up and delivery for repairs/modifications, education, ongoing assistance with the use of the wheelchair; and if provided, emergency services;¶
(g) The Division may cover an adult tilt-in-space wheelchair (E1161) when a client Member meets all of the following conditions (A-I):¶
(A) A standard base with a reclining back option will not meet the client Member's needs;¶
(B) Requires assistance with transfers;¶
(C) The client Member's plan of care addresses the need to change position at frequent intervals, and the client Member is not left in the tilt position most of the time; and¶
(D) Has one of the following:¶
(i) High risk of skin breakdown;¶
(ii) Poor postural control, especially of the head and trunk;¶
(iii) Hyper/hypotonia;¶
(iv) Need for frequent changes in position and has poor upright sitting.¶
(E) The client Member must have a specialty evaluation, conducted within six (6) months prior to the start of services, that was performed by a licensed/certified medical professional, such as a PT or OT, or treating p Practitioner who has specific training and experience in rehabilitation wheelchair evaluations and documents the m Medical n Necessity for the wheelchair and its special features, including a description of the client Member's mobility needs within the home and community. The PT, OT, or treating p Practitioner billing or rendering services must not have a financial relationship with the DMEPOS p Provider;¶
(F) Tilt-n-space wheelchairs must be supplied by a DMEPOS p 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; Member;¶
(G) The ATP must be employed by the p 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 p Provider;¶
(H) Documentation must be complete and detailed enough so a third party shall be able to understand the nature of the p Provider's ATP involvement, if any, in the evaluation;¶
(I) The ATP may not conduct the p Provider evaluation at the time of delivery of the wheelchair to the client Member's residence;¶
(h) One month's rental for a manual adult tilt-in-space wheelchair (E1161) may be covered for a client Member residing in a n Nursing f Facility when all of the following conditions are met:¶
(A) The anticipated n Nursing f Facility length of stay is thirty (30) days or less;¶
(B) The conditions of coverage for a manual tilt-in-space wheelchair as described in section paragraphs (1)-(g)-(A)-(I) are met;¶
(C)The client Member is expected to have an ongoing need for this same wheelchair after discharge from the n Nursing f 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 Member 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: Member:¶
(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: Member:¶
(i) Self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; or¶
(ii) Requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair and spends at least two (2) hours per day in the wheelchair.¶
(B) If the expected duration of need is less than three (3) months (e.g., postoperative recovery), a high-strength lightweight wheelchair is rarely m Medically a Appropriate.¶
(l) The Division may cover an ultra-lightweight wheelchair (K0005) when criteria (A) or (B) are met and (C) and (D) are met:¶
(A) The client Member must be a full-time manual wheelchair user; or¶
(B) The client Member must require individualized fitting and adjustments for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a K0001, K0002, K0003 or K0004 manual wheelchair; and¶

(C) The ~~client~~Member must have a specialty evaluation, conducted within six (6) months prior to the start of services, that was performed by a licensed/certified medical professional, such as a PT or OT, or treating ~~p~~Practitioner who has specific training and experience in rehabilitation wheelchair evaluations and documents the ~~m~~Medical ~~n~~Necessity for the wheelchair and its special features, including a description of the ~~client~~Member's mobility needs within the home and community. The PT, OT, or treating ~~p~~Practitioner billing or rendering services must not have a financial relationship with the DMEPOS ~~p~~Provider. Documentation may include what types of activities the ~~client~~Member frequently encounters and whether the ~~client~~Member is fully independent in the use of the wheelchair. Describe the features of the K0005 base that are needed compared to the K0004 base; and~~-~~¶
(D) The wheelchair must be supplied by a DMEPOS ~~p~~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;~~ Member;¶
(m) The Division may cover a heavy-duty wheelchair (K0006) when a ~~client~~Member weighs more than 250 pounds or has severe spasticity;~~-~~¶
(n) The Division may cover an extra heavy-duty wheelchair (K0007) when a ~~client~~Member weighs more than 300 pounds;~~-~~¶
(o) For a ~~client~~Member residing in a ~~n~~Nursing ~~f~~Facility, an extra heavy-duty wheelchair (K0007) may only be covered when a ~~client~~Member weighs more than 350 pounds;~~-~~¶
(p) For more information on coverage criteria regarding repairs and maintenance, see 410-122-0184 Repairs, Maintenance, Replacement and Delivery;~~-~~¶
(q) The wheelchair requested must be the most appropriate and least costly alternative that shall meet the ~~client~~Member's medical and functional needs.~~-~~¶
(2) Coding Guidelines:~~-~~¶
(a) Adult manual wheelchairs (K0001-K0007, K0009, E1161) have a seat width and a seat depth of 15" or greater; ¶
(b) For codes K0001-K0007 and K0009, the wheels must be large enough and positioned so that the user can self-propel the wheelchair;~~-~~¶
(c) In addition, specific codes are defined by the following characteristics:~~-~~¶
(A) Adult tilt-in-space wheelchair (E1161):~~-~~¶
(i) Ability to tilt the frame of the wheelchair greater than or equal to 20 degrees from horizontal while maintaining the same back-to-seat angle; and~~-~~¶
(ii) Lifetime warranty on side frames and cross-braces;~~-~~¶
(iii) Wheelchairs with less than 20 degrees of tilt must not be coded based upon the tilt feature. The appropriate base product must be coded as K0001-K0007. Coding as E1161 or K0108 is inappropriate coding.~~-~~¶
(B) Standard wheelchair (K0001):~~-~~¶
(i) Weight: Greater than 36 pounds;~~-~~¶
(ii) Seat height: 19" or greater; and~~-~~¶
(iii) Weight capacity: 250 pounds or less.~~-~~¶
(C) Standard hemi (low seat) wheelchair (K0002):~~-~~¶
(i) Weight: Greater than 36 pounds;~~-~~¶
(ii) Seat height: Less than 19"; and~~-~~¶
(iii) Weight capacity: 250 pounds or less.~~-~~¶
(D) Lightweight wheelchair (K0003):~~-~~¶
(i) Weight: 34-36 pounds; and~~-~~¶
(ii) Weight capacity: 250 pounds or less.~~-~~¶
(E) High strength, lightweight wheelchair (K0004):~~-~~¶
(i) Weight: Less than 34 pounds; and~~-~~¶
(ii) Lifetime warranty on side frames and cross-braces.~~-~~¶
(F) Ultra-lightweight wheelchair (K0005):~~-~~¶
(i) Weight: Less than 30 pounds;~~-~~¶
(ii) Adjustable rear axle position; and~~-~~¶
(iii) Lifetime warranty on side frames and cross-braces.~~-~~¶
(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 ~~m~~Medically ~~a~~Appropriate to meet the needs of a particular ~~client~~Member, 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~~Member, submit the code for the wheelchair base used and submit the modification with code K0108 (wheelchair component or accessory, not otherwise specified);¶
(h) Manual wheelchair bases (K0001-K0007, K0009) include construction of any type material, including but not limited to, titanium, carbon, or any other lightweight high strength material. Providers shall not bill for construction materials. Billing for construction material is considered incorrect coding and unbundling.¶
(3) Documentation requirements:¶
(a) Functional mobility evaluation:¶
(A) Providers must submit medical documentation that supports conditions of coverage in this rule are met for purchase and modifications of all covered, ~~client~~Member-owned manual wheelchairs except for K0001, K0002, or K0003 (unless modifications are required);¶
(B) Information must include but is not limited to:¶
(i) The ~~p~~Practitioner's face-to-face examination in accordance with OAR 410-122-0090. The face-to-face examination must occur no more than six (6) months prior to the start of services;¶
(ii) Medical justification needs assessment, order, and specifications for the wheelchair completed by a ~~p~~Physical ~~t~~Therapist (PT), ~~o~~Occupational ~~t~~Therapist (OT), or treating ~~p~~Practitioner. The person billing or rendering services who provides this information must have no direct or indirect financial relationship, agreement, or contract with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) ~~p~~Provider requesting authorization;¶
(iii) ~~Client~~Member identification and complex rehab technology supplier identification information that may be completed by the DMEPOS ~~p~~Provider; and¶
(iv) Signature and date by the treating ~~p~~Practitioner and the PT or OT.¶
(C) If the information on this form includes all the elements of an order, the ~~p~~Provider may submit the completed form in lieu of an order.¶
(b) Additional documentation:¶
(A) Information from a PT, OT, treating ~~p~~Practitioner that specifically indicates:¶
(i) A brief description of the ~~client~~Member's impairment in functional mobility that establishes that they have a mobility limitation and how it interferes with the performance of or participation in activities of daily living;¶
(ii) Why an appropriately fitted cane or walker cannot sufficiently resolve the ~~client~~Member's mobility limitation.¶
(B) Pertinent information from a PT, OT, or treating ~~p~~Practitioner about the following elements that support coverage criteria are met for a manual wheelchair; only relevant elements need to be addressed:¶
(i) Symptoms;¶
(ii) Related diagnoses;¶
(iii) History:¶
(I) How long the condition has been present;¶
(II) Clinical progression;¶
(III) Interventions that have been tried and the results;¶
(IV) Past use of walker, manual wheelchair, power-operated vehicle (POV), or power wheelchair and the results.¶
(iv) Physical exam:¶
(I) Weight;¶
(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;¶
(III) Presence of abnormal tone or deformity of arms, legs, or trunk;¶
(IV) Neck, trunk, and pelvic posture and flexibility;¶
(V) Sitting and standing balance.¶
(v) Functional assessment indicating any problems with performing the following activities including the need to use a cane, walker, or the assistance of another individual:¶
(I) Transferring between a bed, chair, and a manual wheelchair or power mobility device;¶
(II) Walking around their home or community including information on distance walked, speed, and balance.¶
(C) Documentation from a PT, OT, or treating ~~p~~Practitioner that clearly distinguishes the ~~client~~Member'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~~Member-owned equipment (including serial numbers), as well as any other equipment being used or available to meet the ~~client~~Member's medical needs, including how long it has been used by the ~~client~~Member and why it cannot be grown (expanded) or modified, if applicable;¶

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

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0320.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341190

AMEND: 410-122-0325

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0325
Power Wheelchair Base ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness:~~-~~¶
(a) The Division may cover a power wheelchair (PWC) when conditions of coverage in OAR 410-122-0080 and all the following criteria are met:~~-~~¶
(A) The ~~client~~Member 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~~Member from accomplishing an MRADL entirely; or~~-~~¶
(ii) Places the ~~client~~Member at reasonably determined heightened risk of morbidity or mortality secondary to attempts to perform an MRADL; or~~-~~¶
(iii) Prevents the ~~client~~Member from completing an MRADL within a reasonable time frame.~~-~~¶
(B) An appropriately fitted cane or walker cannot sufficiently resolve the ~~client~~Member's mobility limitation;~~-~~¶
(C) The ~~client~~Member 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~~Member shall be using the PWC in the home, the home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the PWC that is being requested;~~-~~¶
(E) Use of a PWC shall significantly improve the ~~client~~Member's ability to participate in MRADLs. For ~~client~~Members with severe cognitive and physical impairments, participation in MRADLs may require the assistance of a caregiver;~~-~~¶
(F) The presence of a caregiver does not preclude coverage of a PWC if the ~~client~~Member is willing and able to safely operate the PWC;~~-~~¶
(G) The ~~client~~Member is willing to use the requested PWC on a regular basis;~~-~~¶
(H) There is objective evidence that demonstrates that the ~~client~~Member cannot use a power-operated vehicle (POV);~~-~~¶
(I) The ~~client~~Member has sufficient mental and physical capabilities to safely operate the PWC;~~-~~¶
(J) If the ~~client~~Member 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~~Member with their MRADLs shall be considered in determining coverage;~~-~~¶
(K) The ~~client~~Member's weight is less than or equal to the weight capacity of the PWC requested.~~-~~¶
(b) Only when conditions of coverage as specified in subsection (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~~Member's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits, and the ~~client~~Member 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~~Member'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~~Member'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~~Member 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~~Member's current wheelchair is no longer ~~m~~Medically ~~a~~Appropriate, or repair and modifications to the wheelchair exceed replacement costs;~~-~~¶
(C) When a covered ~~client~~Member-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 ~~p~~Practitioner must conduct a face-to-face examination of the ~~client~~Member within six (6) months prior to writing the order and that visit with the treating ~~p~~Practitioner starts the six (6) month timeline;¶
(A) The treating ~~p~~Practitioner's face-to-face examination of the ~~client~~Member can be performed during a ~~h~~Hospital or ~~n~~Nursing ~~f~~Facility stay; however, the visit must be conducted within six (6) months prior to writing the order;¶
(B) The ~~p~~Practitioner may refer the ~~client~~Member to a licensed/certified medical professional, such as a ~~p~~Physical ~~t~~Therapist (PT) or ~~o~~Occupational ~~t~~Therapist (OT), to provide the assessment for the wheelchair. This individual must not be an employee of the DMEPOS ~~p~~Provider or have any direct or indirect financial relationship, agreement, or contract with the DMEPOS ~~p~~Provider. When the DMEPOS ~~p~~Provider is owned by a ~~h~~Hospital, a PT/OT working in the inpatient or outpatient ~~h~~Hospital setting may perform part of the face-to-face examination:¶
(i) If the ~~client~~Member was referred to the PT/OT before being seen by the ~~p~~Practitioner, then once the ~~p~~Practitioner has received and reviewed the written report of this examination, the ~~p~~Practitioner must see the ~~client~~Member and perform any additional examination that is needed. The ~~p~~Practitioner's report of the visit shall state concurrence or any disagreement with the PT/OT examination and must occur within the six (6) month timeframe;¶
(ii) If the ~~p~~Practitioner examined the ~~client~~Member before referring the ~~client~~Member to a PT/OT, then again in-person after receiving the report of the PT/OT examination, it is also acceptable for the ~~p~~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 ~~p~~Practitioner must send a copy of the note from his initial visit to evaluate the ~~client~~Member plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS ~~p~~Provider;¶
(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~~Member has a ~~m~~Medically ~~a~~Appropriate wheelchair, regardless of payer;¶
(e) If the ~~client~~Member 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 ~~p~~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;~~ Member;¶
(g) The ATP must be employed by the provider in a full-time, part-time, or contracted capacity as is acceptable by state law. The ATP, if part-time or contracted, must be under the direct control of the ~~p~~Provider;¶
(h) Documentation must be complete and detailed enough so a third party shall be able to understand the nature of the ~~p~~Provider's ATP involvement, if any, in the licensed/certified medical professional (LCMP) specialty evaluation;¶
(i) The ATP may not conduct the ~~p~~Provider evaluation at the time of delivery of the power mobility device to the ~~client~~Member'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 delivery, set-up, pick-up and delivery for repairs/modifications, education, ongoing assistance with use of the wheelchair, and if provided, also includes support services such as emergency services;¶
(k) The delivery of the PWC must be within 120 days following approval of the PA request by the Division;¶
(l) A PWC may not be ordered by a ~~p~~Podiatrist;¶
(2) The Division does not consider the following services ~~m~~Medically ~~n~~Necessary or ~~m~~Medically ~~a~~Appropriate:¶
(a) A PWC for ~~client~~Members who are able to independently self-propel an optimally configured manual wheelchair;¶
(b) A PWC with a captain's chair for a ~~client~~Member who needs a separate wheelchair seat and/or back cushion;¶
(c) Items or upgrades that primarily allow performance of leisure or recreational activities including but not limited to backup wheelchairs, backpacks, accessory bags, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves;¶
(3) Coding Guidelines:¶
(a) Specific types of PWCs:¶
(A) A Group 1 PWC (K0813-K0816) or a Group 2 PWC (K0820-K0829) may be covered when all of the coverage criteria for a PWC are met and the wheelchair is appropriate for the ~~client~~Member's weight and physical dimensions;¶

(B) A Group 2 PWC with a seat elevation system (K0830-K0831) may be covered when all of the coverage criteria for a PWC are met, and criteria for a power seat elevation system are met in accordance with OAR 410-122-0340;¶
(i) When billing a heavy duty or very heavy-duty power wheelchair described by HCPCS codes K0824, K0825, K0826, K0827, K0828, and K0829 that could include a seat elevation system, that system, if included, shall be billed separately under HCPCS code K0108 by using HCPCS codes K0824 - K0829 plus K0108;¶
(ii) K0108 may also be applied to Group 2 noncomplex heavy-duty bases (K0824, K0825, K0826, K0827, K0828, and K0829) and Group 5 power driven wheelchair bases. For example, a K0825 wheelchair with an accessory seat elevation system shall be billed using K0108.¶
(C) A Group 2 Single Power Option PWC (K0835 - K0840) may be covered when the coverage criteria for a PWC are met; and if¶
(i) One of the following criteria I or II is met, and the following criteria in (ii) are met:¶
(I) The ~~client~~Member requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); or¶
(II) The ~~client~~Member meets the coverage criteria for a power tilt or recline seating system and the system is being used on the wheelchair;¶
(ii) All of the following criteria I and II are met:¶
(I) The ~~client~~Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, ~~n~~Nurse ~~p~~Practitioner, or ~~p~~Practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the ~~m~~Medical ~~a~~Appropriateness for the wheelchair and its special features (see Documentation Requirements in section (3) of this rule). The PT, OT, ~~n~~Nurse ~~p~~Practitioner, or ~~p~~Practitioner billing or rendering services must have no financial relationship with the DMEPOS ~~p~~Provider; and¶
(II) 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.~~ Member.¶
(D) A Group 2 Multiple Power Option PWC (K0841, K0842, K0843) may be covered when the coverage criteria for a PWC are met, and if:¶
(i) One of the following criteria I or II is met, and the following criteria in (ii) are met: /¶
(I) The ~~client~~Member meets the coverage criteria for a power tilt or recline seating system and the system is being used on the wheelchair; or¶
(II) The ~~client~~Member uses a ventilator that is mounted on the wheelchair;¶
(ii) All of the following criteria I and II are met:¶
(I) The ~~client~~Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT, OT, or ~~p~~Practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the ~~m~~Medical ~~a~~Appropriateness for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or ~~p~~Practitioner billing or rendering services must have no financial relationship with the DMEPOS ~~p~~Provider; and¶
(II) 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.~~ Member.¶
(E) A Group 3 PWC with no power options (K0848-K0855) may be covered when:¶
(i) The coverage criteria for a PWC are met; and¶
(ii) The ~~client~~Member's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and¶
(iii) The ~~client~~Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or ~~p~~Practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the ~~m~~Medical ~~n~~Necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or ~~p~~Practitioner billing or rendering services must have no financial relationship with the DMEPOS ~~p~~Provider; 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;~~ Member;¶
(F) A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) may be covered when:¶
(i) The Group 3 criteria in section (2)(a)(D) (i-ii) are met; and¶
(ii) The Group 2 Single Power Option in section (2)(a)(B) or Multiple Power Options section (2)(a)(C) (respectively) are met.¶
(G) Requests for Group 4 PWCs shall be reviewed on a case-by-case basis. ~~Client~~Member 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~~Member's medical needs.~~-~~¶
(H) Requests for power wheelchairs not otherwise classified (K0898) shall be reviewed on a case-by-case basis. ~~Client~~Member specific clinical documentation must be submitted that supports the individual's medical need and demonstrates that there is no equally effective, less costly PWC that meets the ~~client~~Member's medical needs.~~-~~¶
(I) A power assist system (E0986) for a manual wheelchair may be covered if all of the following criteria are met:~~-~~¶
(i) The ~~client~~Member meets criteria for a power wheelchair but does not require a fully-powered wheelchair; and~~-~~¶
(ii) The ~~client~~Member has demonstrated ability to self-propel in a manual wheelchair or a history of self-propelling for at least one year; and~~-~~¶
(iii) The ~~client~~Member has had a specialty evaluation that was performed by a licensed/certified medical professional, such as ~~p~~Physical ~~t~~Therapist (PT) or ~~o~~Occupational ~~t~~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;~~ Member;¶
(v) E0986 is all-inclusive. All components, e.g., drive wheels, batteries, chargers, controls, mounting hardware, etc, for a manual wheelchair conversion are included in this code.~~-~~¶
(b) PWC Basic Equipment Package: Each PWC code is required to include the following items on initial issue (i.e., no separate billing/payment at the time of initial issue, unless otherwise noted):~~-~~¶
(A) Lap belt or safety belt;~~-~~¶
(B) Battery charger, single mode;~~-~~¶
(C) Complete set of tires and casters, any type;~~-~~¶
(D) Legrests: There is no separate billing or payment if fixed, swing away, or detachable non-elevating leg rests with or without calf pad are provided. Elevating legrests may be billed separately;~~-~~¶
(E) Footrests/foot platform: There is no separate billing or payment if fixed, swingaway or detachable footrests or a foot platform without angle adjustment are provided. There is no separate billing for angle adjustable footplates with Group 1 or 2 power wheelchairs. Angle adjustable footplates may be billed separately with Group 3, 4 or 5 power wheelchairs;~~-~~¶
(F) K0040 may be billed separately with K0848 through K0864;~~-~~¶
(G) Armrests: There is no separate billing or payment if fixed, swingaway, or detachable non-adjustable armrests with arm pad are provided. Adjustable height armrests may be billed separately;~~-~~¶
(H) Upholstery for seat and back of proper strength and type for patient weight capacity of the power wheelchair;¶
(I) Weight specific components (braces, bars, upholstery, brackets, motors, gears) as required by patient weight capacity;~~-~~¶
(J) Controller and Input Device: There is no separate billing or payment if a non-expandable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a non-standard joystick (i.e., non-proportional or mini, compact or short throw proportional), or other alternative control device may be billed separately.~~-~~¶
(c) If a ~~client~~Member 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);~~-~~¶
(4) Prior Authorization (PA): All codes in this rule require PA and may be purchased, rented, and repaired. Submit all of the following documentation with the PA request:~~-~~¶
(a) A copy of the written report of the face-to-face examination of the ~~client~~Member by the ~~p~~Practitioner:~~-~~¶
(A) This report must include information related to the following:~~-~~¶
(i) This ~~client~~Member'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~~Member's mobility limitation;~~-~~¶
(iii) Why a manual wheelchair cannot sufficiently resolve the ~~client~~Member's mobility limitation;~~-~~¶
(iv) Why a POV/scooter cannot sufficiently resolve the ~~client~~Member's mobility limitation;~~-~~¶
(v) The ~~client~~Member's physical and mental abilities to operate a PWC safely:~~-~~¶
(I) Besides a mobility limitation, if other conditions exist that limit a ~~client~~Member's ability to participate in activities of daily living (ADLs), how these conditions shall be ameliorated or compensated by use of the wheelchair;~~-~~¶
(II) How these other conditions shall be ameliorated or compensated sufficiently such that the provision of a PWC shall be reasonably expected to significantly improve the ~~client~~Member's ability to perform or obtain assistance to

participate in MRADLs.¶
(B) The face-to-face examination shall provide pertinent information about the following elements. Only relevant elements need to be addressed:¶
(i) Symptoms;¶
(ii) Related diagnoses;¶
(iii) History:¶
(I) How long the condition has been present;¶
(II) Clinical progression;¶
(III) Interventions that have been tried and the results;¶
(IV) Past use of walker, manual wheelchair, POV, or PWC and the results.¶
(iv) Physical exam:¶
(I) Weight;¶
(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;¶
(III) Presence of abnormal tone or deformity of arms, legs, or trunk;¶
(IV) Neck, trunk, and pelvic posture and flexibility;¶
(V) Sitting and standing balance.¶
(v) Functional assessment indicating any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:¶
(I) Transferring between a bed, chair, and power mobility device;¶
(II) Walking around their home or community including information on distance walked, speed, and balance.¶
(C) The examination must clearly distinguish the ~~client~~Member's abilities and needs within the home and community.¶
(b) The ~~p~~Practitioner's written order received by the DMEPOS ~~p~~Provider within 45 days (date stamp or equivalent must be used to document receipt date) after the practitioner's face-to-face examination. The order must include all of the following elements:¶
(A) ~~Client~~Member'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 ~~p~~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 ~~p~~Provider. This subsequent order must be signed and dated by the treating ~~p~~Practitioner, received by the DMEPOS ~~p~~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 ~~d~~Diagnosis ~~c~~Codes that relate specifically to the need for the PWC;¶
(E) Length of need;¶
(F) Practitioner's signature;¶
(G) Date of ~~p~~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~~Member-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the ~~client~~Member's medical needs, including how long it has been used by the ~~client~~Member and why it cannot be grown (expanded) or modified, if applicable;¶
(e) If the ~~client~~Member shall be using the PWC in the home, the DMEPOS ~~p~~Provider or ~~p~~Practitioner must perform an on-site, written evaluation of the ~~client~~Member's living quarters, prior to delivery of the PWC. This assessment must support that the ~~client~~Member'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 ~~p~~Provider and signed and dated by the ~~p~~Practitioner that includes:¶
(i) The specific base (HCPCS code and manufacturer name/model) and all options and accessories (including HCPCS codes), whether PA is required or not, that shall be billed separately;¶
(ii) The DMEPOS ~~p~~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 ~~p~~Provider must enter "not applicable";¶
(iv)The DMEPOS ~~p~~Provider must receive the signed and dated detailed product description from the ~~p~~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 ~~p~~Provider must keep the above documentation on file;~~-~~¶
(i) Documentation that the coverage criteria have been met must be present in the ~~client~~Member's medical records and made available to the Division upon request.~~-~~¶
(5) Reimbursement:~~-~~¶
(a) Codes specified in this rule shall not be reimbursed for ~~clients~~Member residing in ~~n~~Nursing ~~f~~Facilities;~~-~~¶
(b) Reimbursement on standard Group 1 and Group 2 wheelchairs without power option (K0813-K0816, K0820-K0829) shall only be made on a monthly rental basis;~~-~~¶
(c) Rented equipment is considered purchased after ~~thirteen (~~13~~)~~ continuous months of rent or the Division fee schedule purchase price or the actual charge from the ~~p~~Provider is met, whichever is less.~~-~~¶
(6) Documentation:~~-~~¶
(a) For services requiring ~~p~~Prior ~~a~~Authorization, submit documentation that supports coverage criteria in this rule are met;~~-~~¶
(b) Documentation that the coverage criteria have been met must be present in the ~~client~~Member's medical record. This documentation and any additional medical information from the DMEPOS ~~p~~Provider must be made available to the Division upon request.~~-~~¶
(7) Procedure codes:~~-~~¶
(a) The Medicare Pricing, Data Analysis and Coding (PDAC) contractor assists DMEPOS ~~p~~Providers and manufacturers in determining which codes shall be used to describe DMEPOS items. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information;~~-~~¶
(b) Refer to the product classification list on the PDAC contractor website for appropriate HCPCS codes.~~-~~¶
(c) Refer to Table 122-0325.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0325.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341191

AMEND: 410-122-0330

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0330
Power-Operated Vehicle ¶

(1) Indications and limitations of coverage and medical appropriateness:-¶
(a) The Division may cover a power-operated vehicle (POV) when conditions of coverage in OAR 410-122-0080 and all of the following criteria are met:-¶
(A) The ~~client~~Member 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~~Member from accomplishing an MRADL entirely; or-¶
(ii) Places the ~~client~~Member at reasonably determined heightened risk of morbidity or mortality secondary to attempts to perform an MRADL; or-¶
(iii) Prevents the ~~client~~Member from completing an MRADL within a reasonable time frame.-¶
(B) An appropriately fitted cane or walker cannot resolve the ~~client~~Member's mobility limitation;-¶
(C) The ~~client~~Member does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair to perform MRADLs during a typical day:-¶
(i) Assessment of upper extremity function shall consider limitations of strength, endurance, range of motion, or coordination, presence of pain, and deformity or absence of one or both upper extremities;-¶
(ii) An optimally-configured manual wheelchair features an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.-¶
(D) The ~~client~~Member has sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV;-¶
(E) If the ~~client~~Member shall be using the POV in the home, the ~~client~~Member'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~~Member is able to:-¶
(i) Safely transfer to and from the POV;-¶
(ii) Operate the tiller steering system, and-¶
(iii) Maintain postural stability and position while operating the POV.-¶
(G) Use of a POV shall significantly improve the ~~client~~Member's ability to participate in their MRADLs;-¶
(H) The ~~client~~Member 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 ~~p~~Practitioner or ~~n~~Nurse ~~p~~Practitioner must conduct a face-to-face examination of the ~~client~~Member within six (6) months before writing the order, and that visit with the treating practitioner starts the six (6) month timeline;-¶
(A) The treating ~~p~~Practitioner's face-to-face examination can be performed during a ~~h~~Hospital or ~~n~~Nursing ~~f~~Facility stay; however, the visit must be conducted within six (6) months prior to writing the order;-¶
(B) The ~~p~~Practitioner may refer the ~~client~~Member to a licensed/certified medical professional, such as a ~~p~~Physical ~~t~~Therapist (PT) or ~~o~~Occupational ~~t~~Therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS ~~p~~Provider or have any direct or indirect financial relationship, agreement, or contract with the DMEPOS ~~p~~Provider. When the DMEPOS ~~p~~Provider is owned by a ~~h~~Hospital, a PT/OT working in the inpatient or outpatient ~~h~~Hospital setting may perform part of the face-to-face examination:-¶
(i) If the ~~client~~Member was referred to the PT/OT before being seen by the ~~p~~Practitioner, then once the ~~p~~Practitioner has received and reviewed the written report of this examination, the ~~p~~Practitioner must see the ~~client~~Member and perform any additional examination that is needed. The ~~p~~Practitioner's report of the visit shall state concurrence or any disagreement with the PT/OT examination and must occur within the six (6) month timeframe;¶
(ii) If the ~~p~~Practitioner examined the ~~client~~Member before referring the ~~client~~Member to a PT/OT, then again in person after receiving the report of the PT/OT examination, it is also acceptable for the ~~p~~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 ~~p~~Practitioner must send a copy of the note from ~~his~~their initial visit to evaluate the ~~client~~Member plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS ~~p~~Provider;~~-~~¶
(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.~~-~~¶
(2) The Division does not consider the following services ~~m~~Medically ~~n~~Necessary or ~~m~~Medically ~~a~~Appropriate:~~-~~¶
(a) POV for ~~client~~Member s who are able to ambulate with the help of assistive equipment or independently able to self-propel an optimally-configured manual wheelchair;~~-~~¶
(b) A POV used to replace private or public transportation such as an automobile, bus, or taxi;~~-~~¶
(c) If a POV is covered, a manual or power wheelchair provided at the same time or subsequently shall be considered for denial as not ~~m~~Medically ~~a~~Appropriate;~~-~~¶
(3) Coding guidelines:~~-~~¶
(a) Group 1 POVs (K0800 - K0802) are typically used only inside the home;~~-~~¶
(b) Group 2 POVs (K0806 -K0808) have added capabilities not needed for in home use. ~~Client~~Member 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~~Member'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 ~~p~~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.~~-~~¶
(4) Prior Authorization (PA): Submit all of the following documentation with the PA request:~~-~~¶
(a) A copy of the written report of the face-to-face examination of the ~~client~~Member by the ~~p~~Practitioner:¶
(A) The report must include information related to the following:~~-~~¶
(i) The ~~client~~Member'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~~Member's mobility limitations;~~-~~¶
(iii) Why a manual wheelchair cannot sufficiently resolve the ~~client~~Member's mobility limitations;~~-~~¶
(iv) The ~~client~~Member's physical and mental abilities to operate a POV (scooter):~~-~~¶
(I) Besides a mobility limitation, if other conditions exist that limit a ~~client~~Member's ability to participate in MRADLs, how these conditions shall be ameliorated or compensated;~~-~~¶
(II) How these other conditions shall be ameliorated or compensated sufficiently such that the additional provision of //POV shall be reasonably expected to significantly improve the ~~client~~Member'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 ~~p~~Practitioner's written order, received by the DMEPOS ~~p~~Provider within ~~thirty (~~30~~)~~ days after the ~~p~~Practitioner's face-to-face examination that includes all of the following elements:~~-~~¶
(A) ~~Client~~Member'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 ~~p~~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 ~~p~~Provider. This subsequent order must be signed and dated by the treating ~~p~~Practitioner, received by the DMEPOS ~~p~~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 ~~d~~Diagnosis ~~c~~Code that relates specifically to the need for the POV;~~-~~¶
(D) Length of need;~~-~~¶
(E) Practitioner's signature;~~-~~¶
(F) Date of ~~p~~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~~Member -owned equipment (including serial numbers) as well as any other equipment being used or available to meet the ~~client~~Member'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~~Member's living quarters performed by the DMEPOS ~~p~~Provider. This assessment must support that the ~~client~~Member'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 ~~p~~Provider;~~-~~¶
(5) Reimbursement:~~-~~¶
(a) Codes specified in this rule shall not be reimbursed for ~~client~~Member s residing in nursing facilities;~~-~~¶
(b) If a ~~client~~Member has a medically appropriate POV regardless of payer, the Division shall not reimburse for another POV;~~-~~¶
(c) The cost of the POV includes all options and accessories that are provided at the time of initial purchase, including but not limited to batteries, battery chargers, weight appropriate upholstery and seating system, tiller steering, non-expandable controller with proportional response to input, complete set of tires, and all accessories needed for safe operation;~~-~~¶
(d) Reimbursement for the POV includes all labor charges involved in the assembly of the POV and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education, and on-going assistance with use of the POV;~~-~~¶
(e) If a ~~client~~Member -owned POV meets coverage criteria, ~~m~~Medically ~~a~~Appropriate replacement items including but not limited to batteries may be covered;~~-~~¶
(f) The Division may cover a new POV when a ~~client~~Member's existing POV is no longer ~~m~~Medically ~~a~~Appropriate or repair and modifications to the POV exceed replacement costs;~~-~~¶
(g) The Division shall cover one month's rental of a POV if a ~~client~~Member -owned POV is being repaired;~~-~~¶
(h) The Division shall purchase, rent, and repair;~~-~~¶
(A) Rental charges apply toward purchase;~~-~~¶
(B) Item is considered purchased when the Division fee schedule purchase price or the actual charge from the ~~p~~Provider is met, whichever is less.~~-~~¶
(6) Documentation:~~-~~¶
(a) For services requiring ~~p~~Prior ~~a~~Authorization, submit documentation that supports coverage criteria in this rule are met;~~-~~¶
(b) Documentation that the coverage criteria have been met must be present in the ~~client~~Member's medical record. This documentation and any additional medical information from the DMEPOS ~~p~~Provider must be made available to the Division upon request.~~-~~¶
(7) 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
Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0360

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0360
Canes and Crutches ¶

(1) Indications and Coverage: When prescribed by a ~~p~~Practitioner for a ~~client~~Member with a condition causing impaired ambulation and there is a potential for ambulation.¶
(2) A white cane for a visually impaired ~~client~~Member is considered to be a self-help item and is not covered by the Division.¶
(3) Table 122-0360.¶
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0360.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341196

AMEND: 410-122-0365

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0365
Standing and Positioning Aids ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness: Standing frame systems, prone standers, supine standers or boards, and accessories may be covered by the Division when conditions of coverage in OAR 410-122-0080 and the following criteria are met:~~-~~¶
(a) The ~~client~~Member 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~~Member is at high risk for lower extremity contractures that cannot be appropriately managed by other treatment modalities (i.e., stretching, active therapy, home programs, etc.)~~-~~¶
(c) The ~~client~~Member has been sequentially evaluated by a ~~p~~Physical or ~~o~~Occupational ~~t~~Therapist to make certain the ~~client~~Member can tolerate a standing or upright position and obtain medical benefit; and,~~-~~¶
(d) The ~~client~~Member is following a home therapy program for the stander established by a ~~p~~Physical or ~~o~~Occupational ~~t~~Therapist; and~~-~~¶
(e) The home is able to accommodate the equipment; and~~-~~¶
(f) The weight of the ~~client~~Member does not exceed manufacturer's weight capacity; and~~-~~¶
(g) The ~~client~~Member has demonstrated an ability to utilize the standing aid independently or with assistance from a caregiver; and~~-~~¶
(h) The ~~client~~Member has demonstrated compliance with other programs; and~~-~~¶
(i) The ~~client~~Member has demonstrated a successful clinical evaluation or trial period in a monitored setting; and~~-~~¶
(j) The ~~client~~Member 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~~Member shall be sequentially evaluated by a ~~p~~Physical or ~~o~~Occupational ~~t~~Therapist to make certain the client can tolerate and obtain medical benefit; and~~-~~¶
(b) The ~~client~~Member shall be following a therapy program initially established by a ~~p~~Physical or ~~o~~Occupational ~~t~~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:~~ Member:¶
(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~~Member is over 5'11" tall; and~~-~~¶
(B) The ~~client~~Member has no trunk control and needs additional support; or~~-~~¶
(C) The ~~client~~Member has more involved need for assistance with balance, stability, or positioning;~~-~~¶
(c) Hip guides may be covered when a ~~client:~~ Member:¶
(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:~~ Member:¶
(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:~~ Member:¶
(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:~~ Member:¶
(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:~~ Member:¶
(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:~~ Member:¶
(A) Has increased tone that pulls arms backward so hands cannot come to midline; or¶
(B) Has poor tone, strength, or control that causes arms to hang out to side and backward causing pain and risking injury; or¶
(C) Has needs for posture;¶
(j) A tray may be covered when proper positioning cannot be accomplished with other accessories;¶
(k) Abductors may be covered to reduce tone for proper alignment and weight bearing;¶
(l) Sandals (shoe holders) may be covered when a ~~client:~~ Member:¶
(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~~Member has one aid that meets medical needs, regardless of who obtained it, the Division may not provide another aid of same or similar function.¶
(5) Gait Belts (E0700) shall be covered when:¶
(a) The ~~client~~Member weighs 60 lbs. or more; and¶
(b) The care provider is trained in the proper use; and¶
(c) The ~~client~~Member can walk independently but needs:¶
(A) A minor correction of ambulation; or¶
(B) Minimal or standby assistance to walk alone; or¶
(C) Requires assistance with transfer;¶
(6) For services requiring ~~p~~Prior ~~a~~Authorization (PA), submit the following documentation to support coverage criteria in this rule are met:¶
(a) Documentation of ~~m~~Medical ~~a~~Appropriateness, which has been reviewed and signed by the prescribing ~~p~~Practitioner;¶
(b) The care plan outlining positioning and treatment regimen and all DME currently available for use by the ~~client;~~ Member;¶
(c) The ~~p~~Practitioner's order;¶
(d) Each item requested shall be itemized with description of product, make, model number, and manufacturers' suggested retail price (MSRP);¶
(e) The Positioner Justification form (DMAP 3155) or reasonable facsimile with recommendation for most appropriate equipment completed by the prescribing ~~p~~Practitioner or the evaluating PT or OT;¶
(7) Providers shall use the appropriate HCPCS code assigned to the standing system base (e.g., E0637, E0638, E0641, and E0642).¶
(8) Providers shall use E1399 for standing frame accessories when billing separately from the base. PA is required when the billed charge for the accessory is greater than $150.¶
(9) PDAC coding verification is not required on standing frame equipment and accessories as this is statutorily excluded from Medicare coverage and as such does not have an assigned HCPCS code.¶
(10) Documentation and medical records to support the ~~client~~Member meets all criteria and conditions of coverage in this rule must be kept on file with the DMEPOS ~~p~~Provider and shall be made available to the Division upon request.¶
(11) Table 122-0365.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0365.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:

https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341197

AMEND: 410-122-0375

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

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 ~~p~~Practitioner for a ~~client~~Member 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 ~~client~~Members 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 ~~client~~Members 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~~Member, documentation must support why a standard folding wheeled walker, E0143, was not provided as the least costly ~~m~~Medically ~~a~~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~~Member 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: See attached Table 122-0375-1¶
(~~L~~l) Providers 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 ~~p~~Practitioner, kept on file by the DMEPOS ~~p~~Provider, and made available to the Division upon request. The treating ~~p~~Practitioner's records must contain information that supports the ~~m~~Medical ~~a~~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.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0375.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341198

AMEND: 410-122-0380

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0380
Hospital Beds ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness: The Division may cover a hospital bed when conditions of coverage in OAR 410-122-0080 and the following criteria are met:~~-~~¶
(a) A fixed height hospital bed (E0250, E0251, E0290, E0291, E0328) when the ~~client~~Member meets at least one (1) of the following criteria:~~-~~¶
(A) Has a medical condition that requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed;~~-~~¶
(B) Requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain;~~-~~¶
(C) Requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges shall have been considered and ruled out;~~-~~¶
(D) Requires traction equipment that can only be attached to a hospital bed;~~-~~¶
(b) A variable height hospital bed (E0255, E0256, E0292 and E0293) when all of the following criteria are met:~~-~~¶
(A) Criteria for a fixed height hospital bed are met;~~-~~¶
(B) A bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position is required;~~-~~¶
(c) A semi-electric hospital bed (E0260, E0261, E0294, E0295, and E0329) when all of the following criteria are met:~~-~~¶
(A) Criteria for a fixed height hospital bed are met;~~-~~¶
(B) Frequent changes or an immediate need for a change in body position are required;~~-~~¶
(C) The ~~client~~Member or caregiver is capable of safely and effectively operating the bed controls;~~-~~¶
(d) A heavy duty extra wide hospital bed (E0301, E0303) when all of the following criteria are met:~~-~~¶
(A) Criteria for a fixed height hospital bed are met;~~-~~¶
(B) The ~~client~~Member weighs more than 350 pounds but less than 600 pounds;~~-~~¶
(C) The ~~client~~Member or caregiver is capable of safely and effectively operating the bed controls;~~-~~¶
(e) An extra heavy duty hospital bed (E0302, E0304) when all of the following are met:~~-~~¶
(A) Criteria for one of the hospital beds described in (1)(a)-(d) are met;~~-~~¶
(B) The ~~client~~Member weighs more than 600 pounds;~~-~~¶
(C) The ~~client~~Member or caregiver is capable of safely and effectively operating the bed controls;~~-~~¶
(D) When provided for a ~~n~~Nursing ~~f~~Facility ~~client~~Member, the bed shall be rated for institutional use;~~-~~¶
(f) Total electric hospital beds (E0265, E0266, E0296, E0297, and E0329) are reviewed on a case-by-case basis to determine if the ~~client~~Member's documentation supports the height adjustment feature is ~~m~~Medically ~~n~~Necessary and ~~m~~Medically ~~a~~Appropriate for the treatment of the ~~client~~Member's condition;~~-~~¶
(g) No ~~p~~Prior ~~a~~Authorization (PA) is required for the initial two (2) months rental of a hospital bed unless otherwise specified in this rule (2)(b) and (d). The DMEPOS ~~p~~Provider is responsible to ensure all requirements in this rule are met.~~-~~¶
(2) PA Required: PA is obtained from the same authorizing authority as specified in OAR 410-122-0040 and required for the following services:~~-~~¶
(a) Initial purchase or subsequent rentals of a hospital bed starting with the third (3rd) month ~~d~~Date of ~~s~~Service;~~-~~¶
(b) Total electric hospital beds starting with the first (1st) month rental or upon initial purchase;~~-~~¶
(c) Replacement of a hospital bed during the five (5) year reasonable useful lifetime due to loss, theft, or irreparable damage;~~-~~¶
(d) Enclosed safety beds starting with the first (1st) month rental or upon initial purchase. Refer to the Division's policy for criteria and coverage guidelines: https://www.oregon.gov/oha/HSD/OHP/Announcements/Safety-Bed-Policy1124.pdf.~~-~~¶
(3) Documentation requirements:~~-~~¶
(a) For services requiring ~~p~~Prior ~~a~~Authorization, submit documentation that supports coverage criteria specified in this rule are met, including:~~-~~¶
(A) For all hospital beds:~~-~~¶
(i) Primary ~~d~~Diagnosis ~~c~~Code for the condition necessitating the need for a hospital bed;~~-~~¶

(ii) The type of bed currently used by the ~~client~~Member and why it doesn't meet the medical needs of the ~~client;~~ Member;¶
(B) For semi-electric beds: Why a variable height bed cannot meet the medical needs of the ~~client;~~ Member;¶
(C) For heavy duty and extra heavy-duty beds: The ~~client~~Member's height and weight.~~-~~¶
(b) Documentation and medical records to support the ~~client~~Member meets all criteria and conditions of coverage in this rule must be kept on file with the DMEPOS ~~p~~Provider and shall be made available to the Division upon request.~~-~~¶
(4) Table 122-0380 - Hospital Beds.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0380.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341199

AMEND: 410-122-0400

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0400
Pressure Reducing Support Surfaces ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness:¶
(a) Group 1 (A4640, E0181-E0182, E0184-E0189, and E0196-E0199):¶
(A) The Division may cover a Group 1 support surface when the ~~client~~Member meets:¶
(i) Criterion (I), or;¶
(ii) Criteria (II) or (III) and at least one of criteria (IV)-(VII):¶
(I) Completely immobile - i.e., ~~client~~Member cannot make changes in body position without assistance;¶
(II) Limited mobility - i.e., ~~client~~Member 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) ~~p~~Provider must provide a support surface in which the ~~client~~Member 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~~Member 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~~Member 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~~Member, if appropriate, and caregiver on the prevention and/or management of pressure ulcers; regular assessment by a nurse, ~~p~~Physician, or other licensed healthcare ~~p~~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~~Member circumstances may be weighed. Undermining and/or tunneling, anatomic location on the body and the size of the ~~client~~Member 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~~Member has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a ~~h~~Hospital or ~~n~~Nursing ~~f~~Facility (discharge within the past 30 days);¶
(B) The DMEPOS ~~p~~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~~Member residing in a ~~n~~Nursing ~~f~~Facility, subject to service limitations of Division rules, only when the following requirements are met:¶
(A) The ~~client~~Member 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 shall be tested with the ~~client~~Member 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~~Member and interventions/regimen necessary to assist the ~~client~~Member to achieve optimal health potential. Developing the plan of care includes establishing measurable ~~client~~Member 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 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~~Member lift, reduce pressure and prevent bottoming out;¶
(J) Alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0181, E0182, and A4640;¶
(K) Code A4640 or E0182 may only be billed when they are provided as replacement components for a ~~client~~Member-owned 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),-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:¶
(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;¶
(ii) Inflated cell height of the air cells through which air is being circulated is five inches or greater;¶
(iii) 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;¶
(iv) A surface designed to reduce friction and shear; and¶
(v) 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 3.5 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 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~~Member 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 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~~Member's ~~p~~Practitioner or home care nurse (by the RN resident care manager for a ~~client~~Member in a ~~n~~Nursing ~~f~~Facility), which generally includes the following:~~-~~¶
(I) Education of the ~~client~~Member, if appropriate, and caregiver on the prevention and/or management of pressure ulcers;¶
(II) Regular assessment by a nurse, ~~p~~Physician, or other licensed healthcare ~~p~~Practitioner;¶
(III) Appropriate turning and positioning including the number of hours per 24-period that the ~~client~~Member 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 ~~p~~Practitioner (by a registered dietitian for a ~~client~~Member in a ~~n~~Nursing ~~f~~Facility) within the last 90 days;¶
(VII) ~~Client~~Member'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~~Member:¶
(i) An order for each item requested, signed and dated by the attending ~~p~~Practitioner;¶
(ii) A plan of care which has been established by the ~~client~~Member's ~~p~~Practitioner or home care nurse (by the RN resident care manager for a ~~client~~Member in a ~~n~~Nursing ~~f~~Facility), which generally includes the following:¶
(I) Education of the ~~client~~Member, if appropriate, and caregiver on the prevention of pressure ulcers;¶
(II) Regular assessment by a nurse, ~~p~~Physician, or other licensed healthcare ~~p~~Practitioner¶
(III) Appropriate turning and positioning including the number of hours per 24-period that the ~~client~~Member 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 ~~p~~Practitioner;¶
(ii) Operative report;¶
(iii) Hospital discharge summary;¶
(iv) Plan of care;¶
(~~F~~D) Required documentation may not be completed by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) ~~p~~Provider or anyone in a financial relationship of any kind with the DMEPOS ~~p~~Provider;¶
(~~G~~E) 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~~F) Medical records must be kept on file by the DMEPOS ~~p~~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~~Member or a Group 2 surface following a myocutaneous flap or skin graft:¶
(i) Progress notes from the attending ~~p~~Practitioner;¶
(ii) Description of all pressure ulcers, including progress towards healing, by a licensed healthcare ~~p~~Practitioner (by the RN resident care manager for a ~~client~~Member in a ~~n~~Nursing ~~f~~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~~Member:¶
(i) Progress notes from the attending 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 ~~p~~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.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0400.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341200

AMEND: 410-122-0420

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0420
Hospital Bed Accessories ¶

(1) Table 122-0420, Hospital Bed Accessories Procedure codes - Trapeze Bars:¶
(a) Indications and coverage: Trapeze bars are indicated when a ~~client~~Member needs this device to sit up because of respiratory condition, to change body position for other medical reasons, or to get in or out of bed;¶
(b) The Division may consider coverage for bariatric trapeze bars only coded as E1399 (durable medical equipment, miscellaneous) for a ~~client~~Member residing in a ~~n~~Nursing ~~f~~Facility), subject to service limitations of Division rules, only when the following requirements are met:¶
(A) The ~~client~~Member meets the conditions of coverage as specified in this rule; and¶
(B) The bariatric trapeze bar has been assigned code E1399 by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor;¶
(C) Supporting documentation has been submitted to the appropriate authorizing authority for ~~p~~Prior ~~a~~Authorization;¶
(c) Documentation of ~~m~~Medical ~~a~~Appropriateness which has been reviewed and signed by the prescribing ~~p~~Practitioner must be kept on file by the DME ~~p~~Provider;¶
(2) See Table 122-0420 for procedure codes.~~¶~~
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0420.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341201

AMEND: 410-122-0475

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0475
Therapeutic Shoes for Diabetics ¶

(1) Indications and Coverage:¶
(a) For each ~~client~~Member, 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 ~~p~~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 ~~p~~Practitioner managing the ~~client~~Member's systemic diabetic condition, a podiatrist or other qualified ~~p~~Practitioner knowledgeable in the fitting of the therapeutic shoes and inserts may prescribe the particular type of footwear necessary.¶
(2) Documentation:¶
(a) The ~~p~~Practitioner who is managing the individual's systemic diabetic condition documents that the ~~client~~Member 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~~Member is being treated under a comprehensive plan of care for ~~his or he~~their diabetes and that the ~~or she~~y need~~s~~ therapeutic shoes;¶
(b) Documentation of the above criteria may be completed by the prescribing ~~p~~Practitioner or supplier but shall be reviewed for accuracy and signed and dated by the certifying ~~p~~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.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0475.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341202

AMEND: 410-122-0510

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

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 ~~m~~Medical ~~a~~Appropriateness:¶
(a) Non-spinal Electrical Osteogenesis Stimulator:¶
(~~a~~A) The Division may cover a non-spinal electrical osteogenesis stimulator (E0747) when any of the following criteria are met:¶
(~~A~~B) 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¶
(~~B~~C) Failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery; or¶
(~~C~~D) Congenital pseudarthrosis;¶
(i) 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 practitioner stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;¶
(ii) 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 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 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) Additional medical records may be requested by the Division;¶

(c) The ~~client~~Member's medical records shall reflect the need for the stimulator requested. The ~~client~~Member's medical records include, but are not limited to, the ~~p~~Practitioner's office records, ~~h~~Hospital records, nursing home records, ~~h~~Home ~~h~~Health ~~a~~Agency records, records from other healthcare professionals, and test/diagnostic reports.¶
(5) Table 122-0510.¶
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0510.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341203

AMEND: 410-122-0515

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

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

Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness: The Division may cover a neuromuscular electrical stimulator (NMES) that uses electrodes to transmit an electrical impulse to the skin over selected muscle groups. There are two (2) broad categories of NMES:~~-~~¶
(1) One type of NMES is for treatment of muscle atrophy;~~-~~¶
(a) In this category, the NMES device stimulates the muscle when the ~~client~~Member is in a resting state to treat muscle atrophy;~~-~~¶
(b) The Division shall cover this type of NMES to treat muscle atrophy specific to disuse atrophy where nerve supply to the muscle is intact (including brain, spinal cord and peripheral nerves) and to treat other non-neurological reasons for disuse atrophy. Some examples would be casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins).~~-~~¶
(2) The second type of NMES is commonly referred to as functional electrical stimulation (FES). FES devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.~~-~~¶
(a) In this category, the FES device is used to enhance functional activity of neurologically impaired ~~client~~Members. FES devices used to improve the ability to walk in ~~client~~Members with spinal cord injury (SCI) shall be covered;~~-~~¶
(b) The Division shall/only cover FES for SCI ~~clients~~Member for walking, who meet the following criteria:~~-~~¶
(A) ~~Client~~Member has completed at least ~~thirty-two (32) p~~32 Physical ~~t~~Therapy sessions, directly performed one-on-one with the ~~p~~Physical ~~t~~Therapist with the device over a trial period of three (3) months, with the specific goal of using the 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 ~~h~~Hospitals; outpatient ~~h~~Hospitals; comprehensive outpatient rehabilitation facilities; and outpatient rehabilitation facilities;~~-~~¶
(C) The ~~p~~Practitioner treating the ~~client~~Member for SCI will use this trial period to properly evaluate the person's ability to use the FES frequently and for the long term; and~~-~~¶
(D) The ~~client~~Member meets all of the following characteristics:~~-~~¶
(i) Intact lower motor units (L1 and below) (both muscle and peripheral nerve);~~-~~¶
(ii) Muscle and joint stability for weight bearing at upper and lower extremities that demonstrates balance and control to maintain an upright support posture independently;~~-~~¶
(iii) Demonstrated brisk muscle contraction to NMES and sensory perception of electrical stimulation sufficient for muscle contraction;~~-~~¶
(iv) High motivation, commitment and cognitive ability to use FES devices for walking;~~-~~¶
(v) Can transfer independently and demonstrates independent standing tolerance for at least three (3) minutes;~~-~~¶
(vi) Demonstrated hand and finger function to manipulate controls;~~-~~¶
(vii) At least six (6) month post recovery spinal cord injury and restorative surgery;~~-~~¶
(viii) Hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and~~-~~¶
(ix) Demonstrated willingness to use the device long-term.~~-~~¶
(3) FES for walking is contraindicated for a SCI ~~client~~Member 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; or~~-~~¶
(e) Autonomic dysflexia;~~-~~¶
(4) The requested system or device shall either be approved, registered, or listed as a medical device with the Food and Drug Administration (FDA) and otherwise generally considered to be safe and effective for the intended purpose.~~-~~¶
(5) Documentation requirements:~~-~~¶
(a) Submit the following documentation for ~~p~~Prior ~~a~~Authorization (PA) review:~~-~~¶
(A) An order from the treating practitioner;~~-~~¶
(B) Documentation of signs/symptoms/medical condition exhibited by the ~~client~~Member that clearly specifies the ~~m~~Medical ~~a~~Appropriateness and ~~m~~Medical ~~n~~Necessity for the device;~~-~~¶
(C) Medical records that corroborate conditions for coverage are met as specified in this rule.~~-~~¶

(b) Documentation and medical records to support the ~~client~~Member meets all criteria and conditions of coverage in this rule must be kept on file with the DMEPOS ~~p~~Provider and shall be made available to the Division upon request.¶
(6) Procedure codes:¶
(a) The Medicare Pricing, Data Analysis and Coding contractor is responsible for assisting DMEPOS providers and manufacturers in determining which HCPCS code shall be used to describe DMEPOS items;¶
(b) Refer to the product classification list on the Medicare Pricing, Data Analysis and Coding (PDAC) contractor website for appropriate Healthcare Common Procedure Coding System (HCPCS) codes.¶
(c) NMES:¶
(A) E0745, Neuromuscular stimulator, electronic shock unit - Division shall rent - Purchased after no more than 10 months of rental - PA required.¶
(B) A4595, Electrical stimulator supplies, two (2) lead, per month, (e.g. TENS, NMES) - Includes all supplies necessary for the effective use of the device - Division shall/purchase;¶
(d) FES:¶
(A) E0764, Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program; - Division shall rent - Purchased after no more than 10 months of rental - PA required.¶
(B) E0770 - Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified - Division shall rent - Purchased after no more than 10 months of rental - PA required.¶
(C) A4595, Electrical stimulator supplies, two (2) lead, per month/one (1) unit (e.g. FES, NMES) - Includes all supplies necessary for the effective use of the device. Not reimbursable with initial purchase. If ~~m~~Medically ~~n~~Necessary, a maximum of two (2) units per month (4 leads) is allowed.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0520

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0520
Glucose Monitors and Diabetic Supplies ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness:¶
(a) The Division may cover home blood glucose monitors and related diabetic supplies for ~~client~~Members with diabetes who can self-monitor blood glucose (SMBG) or be monitored with assistance;¶
(b) Coverage of home blood glucose monitors is limited to ~~client~~Members meeting all of the following conditions:¶
(A) The ~~client~~Member has diabetes that is being treated by a ~~p~~Practitioner; and¶
(B) The glucose monitor and related accessories and supplies have been ordered by a ~~p~~Practitioner who is treating the ~~client~~Member's diabetes; and¶
(C) The ~~client~~Member 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~~Member or caregiver is capable of using the test results to assure the ~~client~~Member'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 ~~client~~Members who meet the basic coverage criteria (1)(b)(A)-(E) of this rule and the following:¶
(A) For code E2100, the treating ~~p~~Practitioner certifies that the ~~client~~Member 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 ~~p~~Practitioner certifies that the ~~client~~Member 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~~Member 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~~Member according to the following limitations:¶
(i) For ~~client~~Members 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 ~~client~~Members 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 ~~a~~Acute change in glycemic control or active diabetic medication adjustment;¶
(iii) For ~~client~~Members 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 ~~client~~Members 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 ~~p~~Prior ~~a~~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 ~~p~~Practitioner has seen the ~~client~~Member 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~~Member's medical record the specific reason for the additional supplies for that particular ~~client~~Member; and¶
(III) If refills of quantities of supplies that exceed utilization guidelines are dispensed, there shall be documentation in the ~~p~~Practitioner's records (e.g., a specific narrative statement that adequately specifies the frequency at which the ~~client~~Member is actually testing or a copy of the ~~client~~Member's log) that the ~~client~~Member is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the ~~client~~Member 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~~Member's expected utilization. Providers shall stay attuned to atypical utilization patterns on behalf of their ~~client~~Members and verify with the ordering ~~p~~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 ~~a~~Authorization (PA) shall be obtained prior to dispensing amounts in excess of these utilization limits;¶
(f) Providers may contact the treating ~~p~~Practitioner to renew an order; however, the request for renewal may only be made with the ~~client~~Member's continued monthly use of testing supplies and only with the ~~client~~Member's or caregiver's request to the ~~p~~Provider for order renewal;¶
(g) An order refill does not have to be approved by the ordering ~~p~~Practitioner; however, a ~~client~~Member or their caregiver shall specifically request refills of glucose monitor supplies before they are dispensed. The ~~p~~Provider may not automatically dispense a quantity of supplies on a predetermined regular basis, even if the ~~client~~Member 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 not covered as they are not ~~m~~Medically ~~n~~Necessary or ~~m~~Medically ~~a~~Appropriate:¶
(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;¶
(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;¶
(J) Urine test or reagent strips or tablets.¶
(2) Guidelines:¶
(a) Insulin-treated means that the ~~client~~Member is receiving insulin injections to treat their diabetes. Insulin does not exist in an oral form and therefore ~~client~~Members 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 ~~p~~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 ~~p~~Prior ~~a~~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 ~~p~~Practitioner's signature;¶
(D) The date of the treating ~~p~~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~~Member with impaired visual acuity, submit documentation that includes a narrative statement from the ~~p~~Practitioner which indicates the ~~client~~Member's specific numerical visual acuity (e.g., 20/400) and that this result represents "best corrected" vision;¶
(e) For E2101 ~~client~~Members with impaired manual dexterity, submit documentation that includes a narrative statement from the ~~p~~Practitioner which indicates an explanation of the ~~client~~Member'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 ~~m~~Medical ~~a~~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) ~~p~~Provider and made available to the Division on request;¶
(h) The appropriate ~~d~~Diagnosis ~~c~~Code describing the condition that necessitates glucose testing shall be included on each claim for the monitor, accessories, and supplies;¶
(i) Diabetic supply ~~p~~Providers are not prohibited from creating data collection forms in order to gather ~~m~~Medically ~~a~~Appropriate information; however, the Division shall not rely solely on those forms to prove the ~~m~~Medical ~~a~~Appropriateness of services provided;¶
(j) A ~~client~~Member'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 ~~p~~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 ~~p~~Provider shall obtain PA. After PA the ~~p~~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) shall require PA from the Division. Diabetic supply ~~p~~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.¶
(5) Procedure Codes: Table 122-0520 - Diabetic Supplies.~~¶~~
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0520.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341205

AMEND: 410-122-0525

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0525
External Insulin Infusion Pump ¶

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

records corroborate all criteria in this rule are met;¶
(c) The DMEPOS ~~p~~Provider shall keep medical records on file and make them available to the Division upon request.¶
(4) Table 122-0525.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0525.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341206

AMEND: 410-122-0540

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0540
Ostomy Supplies ¶

(1) Indications and Limitations of Coverage and Medical Appropriateness: The Division may cover ostomy supplies for a ~~client~~Member 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~~Member 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);~~-~~¶
(C) Stoma absorptive cover (A5083); or¶
(D) Gauze pads (A6216);¶
(c) For a ~~client~~Member 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~~Member is limited to a three month supply;¶
(e) The following services are not covered:¶
(A) Ostomy clamps;¶
(B) Ostomy supplies when a ~~client~~Member 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 ~~p~~Prior ~~a~~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) ~~p~~Provider and made available to the Division on request;¶
(c) A ~~client~~Member'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~~Member 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.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0540.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341207

AMEND: 410-122-0560

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0560
Urological and Bowel Supplies ¶

(1) Indications and Limitations of Coverage and Medical Appropriateness:-¶
(a) The Division may cover the following urinary catheters, external urinary collection devices, and ~~m~~Medically appropriate related supplies when used to drain or collect urine for a ~~client~~Member who has permanent urinary incontinence or permanent urinary retention;-¶
(b) Indwelling Catheters (A4311-A4316, A4338-A4346):-¶
(A) No more than one (1) catheter per month for routine catheter maintenance;-¶
(B) Non-routine catheter changes when documentation substantiates ~~m~~Medical ~~a~~Appropriateness, such as for the following indications:-¶
(i) Catheter is accidentally removed (e.g., pulled out by ~~client~~Member);-¶
(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 ~~a~~Acute event is prevented by a scheduled change frequency of more than once (1) per month;-¶
(C) A specialty indwelling catheter (A4340) or an all-silicone catheter (A4344, A4312, or A4315) when documentation in the ~~client~~Member's medical record supports the ~~m~~Medical ~~a~~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 ~~m~~Medically ~~a~~Appropriate;-¶
(c) Catheter Insertion Tray (A4310-A4316, A4353, and A4354):-¶
(A) Only one (1) insertion tray per episode of indwelling catheter insertion;-¶
(B) One (1) intermittent catheter with insertion supplies (A4353) per episode of ~~m~~Medically ~~a~~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 ~~m~~Medically ~~a~~Appropriate non-routine changes when the documentation substantiates the ~~m~~Medical ~~a~~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 ~~client~~Members 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 ~~m~~Medically ~~a~~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 ~~m~~Medically ~~a~~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 ~~m~~Medical ~~a~~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 ~~m~~Medically ~~a~~Appropriate continuous bladder irrigation include a three-way Foley catheter (A4313, A4316, and A4346), irrigation tubing set (A4355), and sterile water/saline (A4217):-¶
(i) The Division may cover one (1) irrigation tubing set per day for continuous catheter irrigation;-¶
(ii) Continuous irrigation is considered a temporary measure and may only be covered for up to 14 days;-¶

(g) Intermittent Catheterization: Intermittent catheter supplies when basic coverage criteria are met and the ~~client~~Member or caregiver can perform the procedure:~~-~~¶
(A) For each episode of covered catheterization, one (1) catheter (A4351, A4352) and an individual packet of lubricant (A4332); or~~-~~¶
(B) One (1) sterile intermittent catheter kit (A4353) when the ~~client~~Member requires catheterization and meets one of the following criteria (i-iv):~~-~~¶
(i) The ~~client~~Member is immunosuppressed. Examples of immunosuppressed ~~client~~Members include (but are not limited) ~~client~~Members who are:~~-~~¶
(I) On a regimen of immunosuppressive drugs post-transplant;~~-~~¶
(II) On cancer chemotherapy;~~-~~¶
(III) Has AIDS;~~-~~¶
(IV) Has a drug-induced state such as chronic oral corticosteroid use;~~-~~¶
(ii) The ~~client~~Member has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization;~~-~~¶
(iii) The ~~client~~Member is a pregnant, spinal cord-injured ~~fem~~individual~~e~~ with neurogenic bladder (for duration of pregnancy only);~~-~~¶
(iv) The ~~client~~Member 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~~Member's medical records of concurrent presence of one or more of the following signs, symptoms or laboratory findings:~~-~~¶
(I) Fever (oral temperature greater than 38□ C [100.4□ F]);~~-~~¶
(II) Systemic leukocytosis;~~-~~¶
(III) Change in urinary urgency, frequency, or incontinence;~~-~~¶
(IV) Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation);~~-~~¶
(V) Physical signs of prostatitis, epididymitis, orchitis;~~-~~¶
(VI) Increased muscle spasms;~~-~~¶
(VII) Pyuria (greater than five white blood cells [WBCs] per high-powered field);~~-~~¶
(C) The kit code (A4353) must be used for billing even if the components are packaged separately rather than together as a kit;~~-~~¶
(h) Coude (Curved) Tip Catheters:~~-~~¶
(A) Use of a Coude (curved) tip catheter (A4352) in female ~~client~~Members is rarely ~~m~~Medically ~~a~~Appropriate;~~-~~¶
(B) For any ~~client~~Member, when a Coude tip catheter is dispensed and billed, there must be specific documentation in the ~~client~~Member'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 ~~client~~Members 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 ~~m~~Medical ~~a~~Appropriateness;~~-~~¶
(D) Male external catheters (condom-type) or female external urinary collection devices are not covered for ~~client~~Members 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 ~~m~~Medical ~~a~~Appropriateness for such a catheter;~~-~~¶
(F) Coverage of female external urinary collection devices is limited to one metal cup (A4327) per week or one (1) pouch (A4328) per day;~~-~~¶
(j) Anal Irrigation System and Catheter:~~-~~¶
(A) Refer to the OHA Prioritized List of Health Services Anal Irrigation Systems Guideline Note for coverage guidelines;~~-~~¶
(B) Utilization and frequency are determined by the treating ~~p~~Practitioner. The following represents the usual maximum number of kits and catheters expected to be ~~m~~Medically ~~a~~Appropriate:~~-~~¶
(i) A4459 - 1 unit (one unit = one kit) every three~~e~~ (3) months;~~-~~¶
(ii) A4453 - 31 units (one unit = one catheter) per month;~~-~~¶
(k) Miscellaneous Supplies:~~-~~¶
(A) Appliance cleaner (A5131): One (1) unit of service (16 oz) per month when used to clean the inside of certain urinary collecting appliances (A5102, A5105, A5112);~~-~~¶
(B) One (1) external urethral clamp or compression device (A4356) every three (3) months or sooner if the rubber/foam casing deteriorates;~~-~~¶
(C) Adhesive catheter anchoring devices (A4333, three per week) and catheter leg straps (A4334, one (1) per

month) for indwelling urethral catheters;-¶
(D) A catheter/tube anchoring device (A5200) separately payable when it is used to anchor a covered suprapubic tube or nephrostomy tube;-¶
(E) Non-Sterile Gloves (A4927): four (4) units are allowed per month, one (1) unit = 100 each (50 pairs);-¶
(I) 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 ~~client~~Members;-¶
(M) Syringes, trays, sterile saline, or water used for routine irrigation;-¶
(N) Disposable external urethral clamp or compression device, with pad and/or pouch, each.-¶
(2) Guidelines:-¶
(a) Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within three (3) months. A determination that there is no possibility that the ~~client~~Member's condition may improve sometime in the future is not required. If the medical records, including the judgment of the attending treating practitioner, indicate the condition is of long and indefinite duration (ordinarily at least three (3) months), the test of permanence is considered met;-¶
(b) A urinary intermittent catheter with insertion supplies (A4353) is a kit, which includes a catheter, lubricant, gloves, antiseptic solution, applicators, drape, and a tray or bag in a sterile package intended for single use;-¶
(c) Adhesive strips or tape used with male external catheters are included in the allowance for the code and are not separately payable;-¶
(d) Catheter insertion trays (A4310-A4316, A4353, and A4354) that contain component parts of the urinary collection system, (e.g., drainage bags and tubing) are inclusive sets and payment for additional component parts may be allowed only per the stated criteria in each section of the policy;-¶
(e) Extension tubing (A4331) may be covered for use with a latex urinary leg bag (A5112) and is included in the allowance for codes A4314, A4315, A4316, A4354, A4357, A4358, and A5105 and A4331 cannot be separately billed with these codes;-¶
(f) Use A4333 when used to anchor an indwelling urethral catheter;-¶
(g) Use code A5105 when billing for a urinary suspensory with leg bag;-¶
(h) Replacement leg straps (A5113, A5114) are used with a urinary leg bag (A4358, A5105, or A5112). These codes are not used for a leg strap for an indwelling catheter;-¶
(i) A4326 is a male external catheter with an integrated collection chamber that does not require the use of an additional leg bag.-¶
(3) Documentation Requirements:-¶
(a) For services requiring ~~p~~Prior ~~a~~Authorization (PA), submit documentation which supports coverage criteria as specified in this rule are met;-¶
(b) Intermittent Catheterization:-¶
(A) The ~~p~~Practitioner's order must indicate the actual number of times intermittent catheterization is performed per day;-¶
(B) The ~~client~~Member'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 ~~m~~Medical ~~a~~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) ~~p~~Provider and made available to the Division on request;-¶
(e) A ~~client~~Member'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.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0560.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341208

AMEND: 410-122-0580

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0580
Bath Supplies ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness: The Division may cover bath supplies when the ~~client~~Member meets the conditions of coverage in OAR 410-122-0080 and when the following guidelines are met:~~-~~¶
(a) A rehab shower/commode chair may be covered when all of the following criteria are met:~~-~~¶
(A) ~~Client~~Member is unable to use a standard shower chair/bench due to a neurological or musculoskeletal condition;~~-~~¶
(B) ~~Client~~Member has positioning, trunk stability or neck support needs that a standard shower chair/bench cannot provide;~~-~~¶
(C) The home (shower) can accommodate a rehab shower/commode chair;~~-~~¶
(D) Less costly alternatives have been considered or tried and ruled out;~~-~~¶
(E) The rehab shower/commode chair meets the following specifications and standard features as a minimum:~~-~~¶
(i) Constructed specifically for use as a rehab shower/commode chair (corrosive resistant);~~-~~¶
(ii) Swing-away or detachable arms;~~-~~¶
(iii) Removable commode pan holder and pan;~~-~~¶
(iv) Adjustable removable footrests;~~-~~¶
(v) Wheel lock system;~~-~~¶
(F) The rehab shower/commode chair must be supplied by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) ~~p~~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;~~ Member;¶
(G) Verification of the healthcare common procedure coding system (HCPCS) code assignment by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor is not required for a rehab shower/commode chair;~~-~~¶
(H) Use E1399 for a rehab shower/commode chair and accessories that are not included in the base for the rehab shower/commode chair. PDAC coding verification is not required for these items as they are statutorily excluded from coverage by Medicare and have no assigned HCPCS codes.~~-~~¶
(b) Custom/Specialized Pediatric Bath Chair:~~-~~¶
(A) Custom/Specialized pediatric bath chair requires fitting and/or adjustment to treat a specific medical need;~~-~~¶
(B) Custom/Specialized pediatric bath chairs require ~~p~~Prior ~~a~~Authorization (PA). Documentation must include the following:~~-~~¶
(i) The treating ~~p~~Practitioner's records supporting the ~~m~~Medical ~~a~~Appropriateness of the item ordered and explaining why a standard bath chair will not meet the individual's medical needs; and~~-~~¶
(ii) Documentation shall identify less costly alternatives and explain why a less costly alternative will fail to meet the individual's medical needs.~~-~~¶
(C) A custom/specialized pediatric bath chair shall be billed using the appropriate HCPCS code (E0240, E0245, or E0247) and modifier 22;~~-~~¶
(i) DMEPOS ~~p~~Providers shall refer to the product classification list on the PDAC contractor website for coding verification;~~-~~¶
~~(ii)~~ ¶
A pediatric custom/specialized bath chair billed using HCPCS code E0240, E0245, or E0247 and modifier 22 shall be reimbursed following the payment methodology outlined in OAR 410-122-0186 for manually priced items.~~-~~¶
(2) Documentation requirements:~~-~~¶
(a) The ~~p~~Practitioner's order and medical justification for the equipment must be kept on file by the DMEPOS ~~p~~Provider. The ~~client~~Member's medical records must contain information which supports the ~~m~~Medical ~~a~~Appropriateness of the item and accessories ordered;~~-~~¶
(b) For services requiring ~~p~~Prior ~~a~~Authorization, submit documentation which supports conditions of coverage in this rule are met.~~-~~¶
(3) Table 122-0580 Bath Supplies.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0580.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341209

AMEND: 410-122-0590

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

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~~Member would be bed confined.¶
(2) The areas within the ~~client~~Member's residence where the lift will be utilized must be able to accommodate and allow for the effective use of the lift. The Division does not reimburse for adapting the living quarters.¶
(3) A sling or seat for a ~~client~~Member 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~~Member weighs 450 pounds or more;¶
(6) Procedure codes:¶
(a) E0621 - Sling or seat, ~~client~~Member lift, canvas or nylon - Purchase - Prior ~~a~~Authorization (PA) required;¶
(b) E0630 - ~~Client~~Member lift, hydraulic with seat or sling (considered purchased after 10 months of rental) - Purchase, rent or repair - PA required;¶
(c) E0635 - ~~Client~~Member lift, electric, with seat or sling - Rent only. This item is a capped rental and becomes the property of the ~~client~~Member after 10 months of continuous rental or when the usual purchase price is reached, whichever is lesser. May be covered for a ~~n~~Nursing ~~f~~Facility ~~client~~Member - PA required.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0600

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0600
Toilet Supplies ¶

(1) The Division may consider coverage for commodes when:¶
(a) The ~~client~~Member is physically incapable of utilizing regular toilet facilities. This would occur when the ~~client~~Member 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~~Member 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~~Member residing in a ~~n~~Nursing ~~f~~Facility, subject to service limitations of Division rules, when all of the following requirements are met:¶
(A) The ~~client~~Member 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~~Member or if the ~~client~~Member has a body configuration that requires extra width.¶
(e) A commode with integrated seat lift mechanism (E0170, E0171) is covered if it is ~~m~~Medically ~~a~~Appropriate and ~~client~~Member meets criteria for a seat lift mechanism. A commode with seat lift mechanism is intended to allow the ~~client~~Member 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 ~~p~~Practitioner's order, the ~~client~~Member's height and weight and information supporting the ~~m~~Medical ~~a~~Appropriateness for the commode dispensed;¶
(b) For codes requiring ~~p~~Prior ~~a~~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.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0600.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341211

AMEND: 410-122-0630

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0630
Incontinent Supplies ¶

(1) The/Division may cover incontinent supplies for urinary or fecal incontinence in accordance with OHA Prioritized List of Health Services Fecal Incontinence Guideline Note and as follows:-¶
(a) Category I Incontinent Supplies: For up to 200 units (any code or product combination in this category) per month, unless documentation supports the ~~m~~Medical ~~a~~Appropriateness for a higher quantity. For quantities over this limit a ~~p~~Prior ~~a~~Authorization shall be required. When requesting multiple Category I product types (i.e., diapers and liners) that exceed the allowable, ~~p~~Prior ~~a~~Authorization and documentation as described in paragraph (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 ~~m~~Medical ~~a~~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 ~~m~~Medical ~~a~~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~~Member 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 ~~d~~Dates of ~~s~~Service or anticipated coverage period. For example, if a ~~p~~Provider bills and is paid for 12 units of T4536 on a given ~~d~~Date of ~~s~~Service, a ~~client~~Member 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 two (2) units per month of gloves).-¶
(2) Incontinent supplies are not covered:-¶
(a) For nocturnal enuresis; or-¶
(b) For children under the age of three (3).-¶
(3) A ~~p~~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~~Member's medical records shall support the ~~m~~Medical ~~a~~Appropriateness for the services provided or being requested by the medical equipment, prosthetics, orthotics and supplies (DMEPOS) ~~p~~Provider, including, but not limited to:-¶
(A) For all categories, the medical reason and condition causing the incontinence; and-¶
(B) When a ~~client~~Member 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 ~~client~~Members not residing in their home subsequent PA requests for incontinence product(s), the ~~p~~Provider shall submit a log with the PA request. This log shall be the most recent log for the ~~client~~Member documenting the number and frequency of incontinent product changes;-¶
(D) PA requests for multiple Category I incontinence product types for the same ~~client~~Member (i.e. doubling up) shall be accompanied by adequate explanation from the ~~client~~Member'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 ~~p~~Provider shall have documentation on file from the prescribing ~~p~~Practitioner supporting ~~m~~Medical ~~a~~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~~Member weight and measurements that support the use of the bariatric incontinence product (e.g., ~~client~~Member 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 ~~p~~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 each (50 pairs) equal one (1) unit.¶
(6) Table 122-0630-1, Incontinent Supplies¶
(7) Table 122-0630-2, Incontinent Supplies - Counting Units and Pieces
Statutory/Other Authority: ORS 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0630.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341212

AMEND: 410-122-0640

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0640
Eye Prostheses ¶

(1) Indications and coverage:¶
(a) An eye prosthesis is indicated for a ~~client~~Member (adult or child) with absence or shrinkage of an eye due to birth defect, trauma, or surgical removal;¶
(b) For ~~clients under age 21~~EPSDT Beneficiaries, the prescribing ~~p~~Practitioner shall determine and document ~~m~~Medical ~~a~~Appropriateness of the eye prosthesis and related services;¶
(c) For ~~clients age 21 and old~~adult Members, 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 ~~m~~Medical ~~a~~Appropriateness. An exception to this limitation is allowed when clinical documentation supports ~~m~~Medical ~~a~~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 ~~m~~Medical ~~a~~Appropriateness.¶
(2) Documentation requirements:¶
(a) An order for each item shall be signed and dated by the treating ~~p~~Physician, kept on file by the supplier, and made available upon request;¶
(b) Documentation of ~~m~~Medical ~~a~~Appropriateness that has been reviewed and signed by the prescribing ~~p~~Practitioner 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 ~~m~~Medical ~~a~~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.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0640.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341213

AMEND: 410-122-0655

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0655
External Breast Prostheses ¶

(1) Indications and Limitations of Coverage and Medical Appropriateness:¶
(a) The Division may cover an external breast prosthesis for a ~~client~~Member who has had a mastectomy;¶
(b) An external breast prosthesis garment, with mastectomy form (L8015) may be covered for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;¶
(c) An external breast prosthesis of a different type may be covered if there is a change in the ~~client~~Member's medical condition necessitating a different type of item;¶
(d) The Division will pay for only one breast prosthesis per side for the useful lifetime of the prosthesis;¶
(e) The Division will pay for a breast prosthesis for a ~~client~~Member residing in a nursing facility;¶
(f) Two prostheses, one per side, are allowed for a ~~client~~Member who has had bilateral mastectomies;¶
(g) More than one external breast prosthesis per side is not covered;¶
(h) An external breast prosthesis of the same type may be replaced if it is lost or is irreparably damaged (this does not include ordinary wear and tear);¶
(i) Replacement sooner than the useful lifetime because of ordinary wear and tear is not covered.¶
(2) Guidelines:¶
(a) Use code A4280 when billing for an adhesive skin support that attaches an external breast prosthesis directly to the chest wall;¶
(b) L8000 is limited to a maximum of four units every 12 months;¶
(c) Code L8015 describes a camisole type undergarment with polyester fill used post mastectomy;¶
(d) The right (RT) and left (LT) modifiers must be used with these codes. When the same code for two breast prostheses are billed for both breasts on the same date, the items (RT and LT) must be entered on the same line of the claim form using the RTLT modifier and two units of service;¶
(e) The useful lifetime expectancy for silicone breast prostheses is two years;¶
(f) For fabric, foam, or fiber filled breast prostheses, the useful lifetime expectancy is six months.¶
(3) Requirements:¶
(a) For services that do not require ~~p~~Prior ~~a~~Authorization (PA), the durable medical equipment, prosthetic, orthotic and supplies (DMEPOS) ~~p~~Provider must have documentation on file which supports conditions of coverage as specified in this rule are met;¶
(b) For services that require PA, the DMEPOS ~~p~~Provider must submit documentation for review which supports conditions of coverage as specified in this rule are met;¶
(c) Medical records must be made available to the Division on request.¶
(4) Table 122-0655 (Procedure Codes): The procedure codes in this table may be covered for purchase.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0655.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341214

AMEND: 410-122-0658

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0658
Gradient Compression Stockings/Sleeves ¶

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

~~p~~Provider and made available to the Division on request.~~¶~~
(4) Table 122-0658
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0658.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341215

AMEND: 410-122-0660

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0660
Orthotics and Prosthetics ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness:¶
(a) The 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 21~~EPSDT Beneficiaries, the prescribing practitioner shall determine and document medical appropriateness;¶
(e) The hospital is responsible for reimbursing the ~~p~~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 ~~p~~Provider travels to a ~~client~~Member's residence to evaluate the ~~client~~Member'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 ~~p~~Prior ~~a~~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) ~~p~~Provider and made available to the Division on request.¶
(3) Table 122-0660-1: Codes requiring PA.~~¶~~
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0660.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341216

AMEND: 410-122-0662

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0662
Ankle-Foot Orthoses and Knee-Ankle-Foot Orthoses ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness: The 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 ~~d~~Diagnosis ~~c~~Code by any other healthcare ~~p~~Provider, and in addition specifically for:¶
(a) AFOs not used during ambulation: A static AFO (L4396) may be covered when (A)-(E) are met:¶
(A) The ~~client~~Member has a plantar flexion contracture of the ankle (Internal Classification of Diseases (ICD)-10 ~~d~~Diagnosis ~~c~~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~~Member'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, or both;¶
(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 ~~n~~Nursing ~~f~~Facility) or caregiver (at home) is documented in the ~~client's~~Members 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 ~~f~~or 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~~Member 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~~Member has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury;¶
(v) The ~~client~~Member 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~~Member, 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 orthotic, 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~~Member's condition or irreparable accidental damage if the device is still ~~m~~Medically ~~a~~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~~Member residing in a ~~n~~Nursing ~~f~~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 ~~m~~Medical ~~a~~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~~Member 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~~Member 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 ~~m~~Medically ~~a~~Appropriate.¶
(3) Coding Guidelines:¶
(a) A prefabricated orthotic is one that is manufactured in quantity without a specific ~~client~~Member in mind. A prefabricated orthotic may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific ~~client~~Member (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~~Member 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~~Member 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~~Member who is nonambulatory;¶
(D) Has a soft interface.¶
(4) HCPCS Modifiers:¶
(a) EY - No ~~physician~~ Por other licensed health care ~~p~~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 ~~p~~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 ~~p~~Prior ~~a~~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) ~~p~~Provider;¶
(c) Prior to billing for each new or full replacement item, the DMEPOS ~~p~~Provider must first have received a completed written, signed and dated practitioner's order that includes:¶
(A) The treating ~~d~~Diagnosis ~~c~~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 ~~m~~Medical ~~a~~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 ~~m~~Medical ~~a~~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 ~~p~~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 ~~p~~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 ~~p~~Provider must include the ICD-10 ~~d~~Diagnosis ~~c~~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 ~~d~~Date of ~~s~~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~~Member's medical record supporting the ~~m~~Medical ~~a~~Appropriateness for the higher utilization;¶
(j) The ~~client~~Member's medical record must support the ~~m~~Medical ~~a~~Appropriateness for items and all additions billed to the Division and this documentation must be made available to the Division on request.¶

(6) Table 122-0662
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0662.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341217

AMEND: 410-122-0678

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

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

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness: The Division may cover some dynamic adjustable extension/flexion devices for a covered condition when all of the following conditions are met:~~-~~¶
(a) As an adjunct to ~~p~~Physical ~~t~~Therapy for ~~client~~Members 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 ~~p~~Physical ~~t~~Therapist;~~-~~¶
(b) As an adjunct to ~~p~~Physical ~~t~~Therapy in the ~~a~~Acute post-operative period for ~~client~~Members 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 ~~p~~Physical ~~t~~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 ~~d~~Diagnosis ~~c~~Code by any other healthcare ~~p~~Provider;~~-~~¶
(d) Reimbursement is limited to a maximum of four (4) months per episode;~~-~~¶
(e) Reimbursement is on a month-to-month rental basis only.~~-~~¶
(2) Documentation requirements:~~-~~¶
(a) Submit medical records that support the conditions of coverage, as specified in this rule, have been met, including the treatment plan from the ~~p~~Physical ~~t~~Therapist;~~-~~¶
(b) The treatment plan shall include:~~-~~¶
(A) Baseline measurements (pre-intervention measurements) of range of motion (ROM) limitations;~~-~~¶
(B) Weekly ROM measurements with documented 10 degree improvement.~~-~~¶
(3) Refer to Table 122-0678 - Dynamic Adjustable Extension/Flexion Devices for HCPCS codes.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0678.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341218

AMEND: 410-122-0680

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0680
Facial Prostheses ¶

(1) Indications and Coverage:¶
(a) Covered when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect;¶
(b) Adhesives, adhesive remover and tape used in conjunction with a facial prosthesis are covered. Other skin care products related to the prosthesis, including but not limited to cosmetics, skin cream, cleansers, etc., are not covered;¶
(c) The following services and items are included in the allowance for a facial prosthesis:¶
(A) Evaluation of the ~~client~~Member;¶
(B) Pre-operative planning;¶
(C) Cost of materials;¶
(D) Labor involved in the fabrication and fitting of the prosthesis;¶
(E) Modifications to the prosthesis made at the time of delivery of the prosthesis or within 90 days thereafter;¶
(F) Repair due to normal wear or tear within 90 days of delivery;¶
(G) Follow-up visits within 90 days of delivery of the prosthesis;¶
(d) Modifications to a prosthesis that occur more than 90 days after delivery of the prosthesis and that are required because of a change in the ~~client~~Member's condition are covered;¶
(e) Repairs are covered when there has been accidental damage or extensive wear to the prosthesis that can be repaired. If the expense for repairs exceeds the estimated expense for a replacement prosthesis, no payments can be made for the amount of the excess;¶
(f) Follow-up visits which occur more than 90 days after delivery and which do not involve modification or repair of the prosthesis are ~~n~~Non-~~c~~Covered ~~s~~Services;¶
(g) Replacement of a facial prosthesis is covered in cases of loss or irreparable damage or wear or when required because of a change in the ~~client~~Member's condition that cannot be accommodated by modification of the existing prosthesis;¶
(h) When a prosthesis is needed for adjacent facial regions, a single code must be used to bill for the item, whenever possible. For example, if a defect involves the nose and orbit, this should be billed using the hemi-facial prosthesis code and not separate codes for the orbit and nose. This would apply even if the prosthesis is fabricated in two separate parts.¶
(2) Documentation: The following must be submitted for ~~p~~Prior ~~a~~Authorization (PA):¶
(a) An order for the initial prosthesis ~~and/~~or related supplies which is signed and dated by the ordering prescribing practitioner must be kept on file by the prosthetist/supplier and submitted with request for PA;¶
(b) A separate prescribing ~~p~~Practitioner order is not required for subsequent modifications, repairs or replacement of a facial prosthesis;¶
(c) A new prescribing ~~p~~Practitioner order is required when different supplies are ordered;¶
(d) A photograph of the prosthesis and a photograph of the ~~client~~Member without the prosthesis must be retained in the supplier's record and must be submitted with the PA request;¶
(e) When code L8048 is used for a miscellaneous prosthesis or prosthetic component, the authorization request must be accompanied by a clear description and a drawing/copy of photograph of the item provided and the ~~m~~Medical ~~a~~Appropriateness;¶
(f) Requests for replacement, repair or modification of a facial prosthesis must include an explanation of the reason for the service;¶
(g) When replacement involves a new impression/moulage rather than use of a previous master model, the reason for the new impression/moulage must be clearly documented in the authorization request.¶
(3) Procedure Codes - Table 122-0680.~~¶~~
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0680.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341219

AMEND: 410-122-0700

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0700
Negative Pressure Wound Therapy Pumps ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~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 ~~n~~Nursing ~~f~~Facility:¶
(A) The ~~client~~Member 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~~Member'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~~Member;¶
(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~~Member's moisture and incontinence;¶
(iii) For neuropathic (for example, diabetic) ulcers:¶
(I) The ~~client~~Member 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 ~~p~~Practitioner considers it the best available treatment option;¶
(B) The ~~client~~Member 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 ~~m~~Medical ~~a~~Appropriateness for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the ~~client~~Member 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~~Member. A request for more than one NPWT pump per ~~client~~Member for the same time period is not covered;¶
(f) For the purposes of this rule, a licensed health care professional may be a ~~p~~Physician, ~~p~~Physician's associate (PA), registered nurse (RN), ~~l~~Licensed ~~p~~Practical ~~n~~Nurse (LPN), or ~~p~~Physical ~~t~~Therapist (PT). The ~~p~~Practitioner must be licensed to assess wounds ~~and/~~or administer wound care.¶
(2) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness - Continued Coverage: For wounds and ulcers described in subsection (1)(a) or (1)(b), for ~~client~~Members 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 ~~p~~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~~Member, whether or not by the ~~p~~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 ~~p~~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 ~~m~~Medical ~~a~~Appropriateness for the higher utilization.¶
(10) Table 122-0700.¶
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0700.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341220

AMEND: 410-122-0710

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0710
Adaptive Car Seats and Travel Vests
(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness: Adaptive car seats and travel vests provide safety during transportation in a vehicle for individuals of all ages with health care needs that cannot be met using conventional car seats.~~-~~¶
(2) An adaptive car seat or travel vest that meets Federal Motor Vehicle Safety Standard 213 may be covered by the Division for an individual with a significant health condition for which a conventional car seat harness or its positioning is unsafe or physically incompatible as documented by one or more of the following functional limitations (list not all-inclusive):~~-~~¶
(a) Inability to maintain an unsupported sitting position independently;~~-~~¶
(b) Significant head and trunk instability;~~-~~¶
(c) Significant hypotonicity, hypertonicity, spasticity, muscle spasm, contractures, seizure activity, or other physiological symptoms or events that result in uncontrollable movement and position changes and/or the inability to make positional correction;~~-~~¶
(d) Bony or other fragility for which a conventional car seat harness use or positioning is unsafe;~~-~~¶
(e) Fracture casting or post-surgical casting for which positioning in a conventional car seat is unsafe or physically incompatible;~~-~~¶
(f) Congenital or acquired condition for which conventional car seat harness use ~~and/~~or car seat positioning is incompatible (e.g. omphalocele, osteogenesis imperfecta, myelomeningocele, airway anomalies including tracheostomy, scoliosis or kyphosis); or~~-~~¶
(g) Neurodevelopmental condition that renders conventional car seat safety features unsafe or ineffective.~~-~~¶
(3) Prior Authorization (PA): The PA request must include the following documentation:~~-~~¶
(a) The prescribing ~~p~~Practitioner's clinical documentation supporting the individual's diagnosed medical condition(s) for an adaptive car seat or travel vest;~~-~~¶
(b) A signed and dated evaluation by a licensed ~~p~~Physical ~~t~~Therapist, a licensed occupational therapist, or a National Highway Traffic Safety Administration (NHTSA) certified Child Passenger Safety Technician (CPST/CPS Technician) that is co-signed by a licensed ~~p~~Practitioner with CPST-I certification in adaptive needs transportation, which includes detailed documentation of all of the following:~~-~~¶
(A) The individual's medical condition(s) for which the adaptive car seat or travel vest is needed;~~-~~¶
(B) Description of what equipment is currently being used to transport the individual in a vehicle and why it no longer meets their medical needs;~~/-~~¶
(C) Interventions and less costly alternatives that have been tried and why those interventions were not successful (e.g., conventional car seats, vests, harnesses);~~-~~¶
(D) Brand name and model number of the adaptive car seat or travel vest being requested (including each accessory);~~-~~¶
(E) Acknowledgement that the requested adaptive car seat or travel vest is appropriate for use in the vehicle used to transport the ~~client~~Member; and~~-~~¶
(F) ~~Client~~Member's current height and weight, and the weight capacity and growth potential of the adaptive car seat model or travel vest requested.~~-~~¶
(c) An order signed by the prescribing ~~p~~Practitioner supporting the adaptive car seat (and accessories) or travel vest requested; and~~-~~¶
(d) Manufacturer's suggested retail price (MSRP) for the brand and model number of the adaptive car seat (including each accessory) or travel vest requested.~~-~~¶
(4) The licensed ~~p~~Physical ~~t~~Therapist, licensed ~~o~~Occupational ~~t~~Therapist, CPS Technician (CPST), or licensed ~~p~~Practitioner performing the evaluation must have no financial relationship with the DMEPOS ~~p~~Provider.~~-~~¶
(5) Reimbursement:~~-~~¶
(a) HCPCS code E1399 shall be used for billing the adaptive car seats or travel vests and reimbursed in accordance with OAR 410-122-0186;~~-~~¶
(b) All accessories shall be billed using HCPCS E1399 and reimbursed in accordance with OAR 410-122-0186;~~-~~¶
(c) Certified CPS Technician visits for the initial equipment evaluation, installation and instructional training, and follow up visits to address a change in individual's growth or development, a change in individual's behavior, a change in vehicle/mode of transportation, or a change in medical need may be billed to the Division (Refer to (6) in

this rule for coding descriptions and details) only when records of those evaluations and visits are reviewed and co-signed by a licensed ~~p~~Practitioner with CPST-I certification in adaptive needs transportation.~~-~~¶
(6) Documentation:~~-~~¶
(a) For PA, submit documentation that supports coverage criteria and guidelines in this rule are met;~~/-~~¶
(b) Medical records and documentation to support the ~~client~~Member meets criteria and conditions of coverage in this rule must be kept on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) ~~p~~Provider and shall be made available to the Division upon request./~~-~~¶
(7) Procedure Codes and definitions:~~-~~¶
(a) E1399 - Durable medical equipment, miscellaneous (adaptive car seat, accessories, travel vest); - PA Required~~-~~¶
(b) 99204 - New patient office or other outpatient visit with moderate level of medical decision making, if using time, 45 minutes or more (Initial assessment and evaluation of ~~client~~Member and vehicle performed by certified CPST - provider type specialty 321);~~-~~¶
(c) 99213 - Established patient office or other outpatient visit with low level of decision making, if using time, 20 minutes or more (Follow up visit performed by certified CPST - provider type specialty 321);~~-~~¶
(d) 99214 - Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more (Follow up visit performed by certified CPST - provider type specialty 321);~~-~~¶
(e) 99215 - Established patient office or other outpatient visit with high level of medical decision making, if using time, 40 minutes or more to address a change in the ~~client~~Member's growth or development, a change in ~~client~~Member's behavior, a change in vehicle/mode of transportation, or a need to change from a conventional seat to an adaptive car seat or travel vest (Reevaluation/reassessment visit performed by a certified CPST - provider type specialty 321).~~-~~¶
(f) A CPST, also known as a CPS Technician, is defined as a professional who is currently NHTSA certified by Safe Kids Worldwide and Safe Travel for all Children (STAC) in Transporting Children with Special Healthcare Needs. A CPST must be trained in adaptive needs transportation and perform services in accordance with the National CPS Board's Child Passenger Safety Technician Code of Conduct.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0720

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-122-0720
Pediatric Wheelchairs ¶

(1) Indications and limitations of coverage and ~~m~~Medical ~~a~~Appropriateness:~~-~~¶
(a) For ~~clients under the age of 21:~~ EPSDT Beneficiaries: The EPSDT program covers all ~~m~~Medically ~~n~~Necessary and ~~m~~Medically ~~a~~Appropriate services needed to correct or ameliorate health conditions, or to improve the ~~client~~EPSDT Beneficiary's ability to grow, develop, or participate in school, regardless of placement on or inclusion in the Prioritized List of Health Services. Coverage for a pediatric wheelchair for ~~clients under age 21~~EPSDT Beneficiaries shall be based on an individual review for ~~m~~Medical ~~n~~Necessity and ~~m~~Medical ~~a~~Appropriateness, as defined in OAR 410-151-0001.¶
(b) For ~~clients age 21 and old~~adult Members - The Division may cover a pediatric wheelchair when all of the following criteria are met:~~-~~¶
(A) The ~~client~~Member 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~~Member from completing an MRADL entirely; or¶
(ii) Places the ~~client~~Member at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a MRADL; or~~-~~¶
(iii) Prevents the ~~client~~Member from completing an MRADL within a reasonable timeframe.¶
(B) An appropriately fitted cane or walker cannot sufficiently resolve the ~~client~~Member's mobility limitation;~~-~~¶
(C) If the ~~client~~Member will be using the wheelchair in the home, the ~~client~~Member'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~~Member's ability to participate in MRADLs. For ~~client~~Members with severe cognitive and physical impairments, participation in MRADLs may require the assistance of a caregiver;~~-~~¶
(E) The ~~client~~Member is willing to use the requested pediatric wheelchair on a regular basis;~~-~~¶
(F) The ~~client~~Member 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 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.~~-~~¶
(c) Only when conditions of coverage as specified in subsection (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~~Member's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits and the ~~client~~Member 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~~Member'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~~Member '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~~Member 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~~Member's current wheelchair is no longer ~~m~~Medically ~~a~~Appropriate or repair or modifications to the wheelchair exceed replacement cost;~~-~~¶
(C) When a covered, ~~client~~Member -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.~~-~~¶
(d) A pediatric tilt-in-space wheelchair (E1231- E1234) may be covered when a ~~client~~Member meets all of the

following conditions:¶
(A) A standard base with a reclining back option will not meet the ~~client~~Member's needs;¶
(B) Requires assistance for transfers;¶
(C) The plan of care addresses the need to change position at frequent intervals, and the ~~client~~Member 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) One month's rental for a manual pediatric tilt-in-space wheelchair (E1231-E1234) may be covered for a ~~client~~Member residing in a ~~n~~Nursing ~~f~~Facility when all of the following conditions are met:¶
(A) The anticipated ~~n~~Nursing ~~f~~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) (d) (A) (D) are met;¶
(C) The ~~client~~Member is expected to have an ongoing need for this same wheelchair after discharge from the ~~n~~Nursing ~~f~~Facility;¶
(D) Coverage is limited to one month's rental.¶
(f) The Division does not reimburse for another wheelchair if the ~~client~~Member has a ~~m~~Medically ~~a~~Appropriate wheelchair, regardless of payer;¶
(g) If the ~~client~~Member will be using the wheelchair in the home, the ~~client~~Member'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;¶
(h) 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;¶
(i) 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;¶
(j) Power mobility devices and related options and accessories must be supplied by a DMEPOS ~~p~~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;~~ Member;¶
(k) The ATP must be employed by a ~~p~~Provider in a full-time, part-time, or contracted capacity as is acceptable by state law. The ~~p~~Provider's ATP, if part-time or contracted, must be under the direct control of the ~~p~~Provider;¶
(l) Documentation must be complete and detailed enough so a third party would be able to understand the nature of the ~~p~~Provider's ATP involvement, if any, in the licensed/certified medical professional (LCMP) specialty evaluation;¶
(m) The ATP may not conduct the ~~p~~Provider evaluation at the time of delivery of the power mobility device to the ~~client~~Member's residence;¶
(n) A Group 5 (Pediatric) power wheelchair (PWC) with Single Power Option (K0890) or with Multiple Power Options (K0891) may be covered when the coverage criteria for a PWC in OAR 410-122-0325, Power Wheelchair Base, are met.¶
(~~n~~o) The delivery of a PWC must be within 120 days following completion of the face-to-face examination with the ~~p~~Physician;¶
(~~o~~p) A PWC may not be ordered by a podiatrist.¶
(~~p~~q) 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 ~~m~~Medically ~~a~~Appropriate to meet the needs of a particular ~~client~~Member, 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~~Member, 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) ~~p~~Providers must submit medical documentation that supports conditions of coverage in this rule are met for purchase and modifications of all covered, ~~client~~Member -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 ~~p~~Provider requesting authorization;~~-~~¶
(ii) ~~Client~~Member identification and rehab technology supplier identification information that may be completed by the DMEPOS ~~p~~Provider; and~~-~~¶
(iii) Signature and date by the treating ~~p~~Physician and PT or OT.~~-~~¶
(C) If the information on this form includes all the elements of an order, the ~~p~~Provider may submit the completed form in lieu of an order.¶
(b) Additional documentation:~~-~~¶
(A) Information from a PT, OT, or treating ~~p~~Physician that specifically indicates:~~-~~¶
(i) The ~~client~~Member'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~~Member's mobility limitations.~~-~~¶
(B) Pertinent information from a PT, OT, or treating ~~p~~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 ~~p~~Physician that clearly distinguishes the ~~client~~Member'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~~Member -owned equipment (including serial numbers), as well as any other equipment being used or available to meet the ~~client~~Member's medical needs, including how long it has been used by the ~~client~~Member and why it cannot be grown (expanded) or modified, if applicable;~~-~~¶
(F) If ~~client~~Member will be using the wheelchair in the home, the DMEPOS ~~p~~Provider or ~~p~~Practitioner must perform an on-site, written evaluation of the ~~client~~Member's living quarters, prior to delivery of the wheelchair. This assessment must support that the ~~client~~Member'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 ~~p~~Prior ~~a~~Authorization (PA) is required or not, that will be billed separately.~~-~~¶
(c) A written order by the treating ~~p~~Physician, identifying the specific type of pediatric wheelchair needed. If the order does not specify the type requested by the DMEPOS ~~p~~Provider on the authorization request, the ~~p~~Provider must obtain another written order that lists the specific pediatric wheelchair that is being ordered and any options and accessories requested. The DMEPOS ~~p~~Provider may enter the items on this order. This order must be signed and dated by the treating ~~p~~Physician, received by the DMEPOS ~~p~~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 ~~p~~Physician, identifying the specific type of manual wheelchair needed:~~-~~¶

(i) If the order does not specify the type of wheelchair requested by the DMEPOS ~~p~~Provider on the authorization request, the ~~p~~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 ~~p~~Provider may enter the items on this order;~~-~~¶
(iii) This order must be signed and dated by the treating ~~p~~Physician, received by the DMEPOS ~~p~~Provider, and submitted to the authorizing authority.~~-~~¶
(B) HCPCS codes;~~-~~¶
(C) If the ~~client~~Member will be using the wheelchair in the home, documentation from the DMEPOS ~~p~~Provider that supports that the ~~client~~Member'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 ~~p~~Provider; and~~-~~¶
(h) Documentation that the coverage criteria have been met must be present in the ~~client~~Member's medical records, and this documentation must be made available to the Division upon request.¶
(4) Table 410-122-0720 - Pediatric Wheelchairs.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

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

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0720.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=341222

AMEND: 410-122-0730

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

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

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

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