MED
medical equipment

## What's needed for a new referral:

- Demographics
- Detailed Written Order Signed/Dated by physician
- Most recent Face-To-Face note discussing the item the patient is needing as well as the diagnosis

Hospital Bed (semi)

In addition to the reasonable and medically necessary criteria contained in this LCD, there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

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For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

A fixed height hospital bed (E0250, E0251, E0290, E0291, and E0328) is covered if one or more of the following criteria (1-4) are met:

1. The beneficiary has a medical condition which 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, or
2. The beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
3. The beneficiary 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, or
4. The beneficiary requires traction equipment, which can only be attached to a hospital bed.

iable height hospital bed (E0255, E0256, E0292, and E0293) is covered if the beneficiary meets one of the criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

A semi-electric hospital bed (E0260, E0261, E0294, E0295, and E0329) is covered if the beneficiary meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

A heavy duty extra wide hospital bed (E0301, E0303) is covered if the beneficiary meets one of the criteria for a fixed height hospital bed and the beneficiary's weight is more than 350 pounds, but does not exceed 600 pounds.

An extra heavy-duty hospital bed (E0302, E0304) is covered if the beneficiary meets one of the criteria for a hospital bed and the beneficiary's weight exceeds 600 pounds.

A total electric hospital bed (E0265, E0266, E0296, and E0297) is not covered; the height adjustment feature is a convenience feature. Total electric beds will be denied as not reasonable and necessary.

For any of the above hospital beds (plus those coded E1399 - see Policy Article Coding Guidelines), if documentation does not justify the medical need of the type of bed billed, payment will be denied as not reasonable and necessary.

If the beneficiary does not meet any of the coverage criteria for any type of hospital bed it will be denied as not reasonable and necessary.

ACCESSORIES:

MED X
medical equipment

DETAILED PHYSICIANS ORDER
DURABLE MEDICAL EQUIPMENT

Patient: _____ Date of Order: _____ HT: ____ WT: _____

Address: _____ DOB: _____ Length of Need: 99

_____ Diagnosis Codes: _____

**Equipment Needed:**

____ E1038 Transport chair (weight <= 300 lbs.)
____ K0001 Standard Manual Wheelchair
____ K0003 Lightweight Manual Wheelchair
____ K0004 High Strength Lightweight Manual Wheelchair
____ K0006 HD Manual Wheelchair (weight > 250 lbs.)
____ K0007 Extra HD Manual Wheelchair (weight > 300 lbs.)

Additional Accessories for K0001 – K0007 wheelchairs
Non Standard Seat Width
____ E2201 (>=20"-<24") ____ E2202 (24"-27")
____ Seat Cushion – Please specify:
E2601, E2602, E2603*, E2604*, E2622*, E2623*
____ Back Cushion – Please specify:
E2611, E2612
____ Heel Loops/ Standard leg rests (E0951) ___Right ____ Left
____ Elevating Leg rests (K0195) ___Right ___ Left
____ Articulating Leg rests (K0053)
____ Anti-Tippers (E0971) ___ Right ___ Left
____ Brake extensions (E0961) ___ Right ___ Left
____ Height adjustable arms (E0973) ___ Right ___ Left
____ Arm Trough (E2209)* ___ Right ___ Left
____ Amputee support (E1020)* ___ Right ___ Left
____ Swing away Hardware (E1028) ___ Right ___ Left
____ 1 arm drive attachment (E0958) ___ Right ___ Left
____ Lap tray (E0950)
____ Oxygen tank holder (E2208)
*Verify covered diagnosis*

____ E0260 Semi-electric hospital bed w/ mattress
____ E0261 Semi-electric hospital bed w/o mattress
____ E0265 Full electric hospital bed (ABN required)
____ E0303 HD hospital bed extra wide (350-600 lbs)
____ E0143 Standard Walker (No wheels)
____ E0143 Wheeled walker
____ E0143 Wheeled walker with seat (Rollator)
____ E0156 Walker Seat for Rollator
____ E0100 Cane-Standard Aluminum
____ E0105 Quad Cane (sm or lg)

____ **If other please specify:**

_____
_____
_____
_____
_____
_____

Physicians
Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Physicians
Signature: _____
(Original no stamps please)

Date: _____

NPI: _____

Showroom location for new patients and walk-ins:
1005 N Kingshighway Ste 12 Cape Girardeau ph. 573-803-2390 fax. 573-803-1247