MEDX
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

Trapeze

Trapeze equipment (E0910, E0940) is covered if the beneficiary needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

Heavy duty trapeze equipment (E0911, E0912) is covered if the beneficiary meets the criteria for regular trapeze equipment and the beneficiary's weight is more than 250 pounds.

A bed cradle (E0280) is covered when it is necessary to prevent contact with the bed coverings.

Side rails (E0305, E0310) or safety enclosures (E0316) are covered when they are required by the beneficiary's condition and they are an integral part of, or an accessory to, a covered hospital bed.

If a beneficiary's condition requires a replacement innerspring mattress (E0271) or foam rubber mattress (E0272) it will be covered for a beneficiary owned hospital bed.

GENERAL

A Detailed Written Order (DWO) (if applicable) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must also obtain a DWO before submitting a claim for any associated options, accessories, and/or supplies that are separately billed. In this scenario, if the supplier bills for associated options, accessories, and/or supplies without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

A WOPD (if applicable) must be received by the supplier before a DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a completed WOPD, the claim shall be statutorily denied. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

Summary of Evidence

N/A

malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements.

Hoyer Lift

The purpose of a Local Coverage Determination (LCD) is to provide information regarding "reasonable and necessary" criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the "reasonable and 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.

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 patient lift is covered if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the beneficiary would be bed confined.

A patient lift described by codes E0630, E0635, E0639, or E0640 is covered if the basic coverage criteria are met. If the coverage criteria are not met, the lift will be denied as not reasonable and necessary.

A multi-positional patient transfer system (E0636, E1035, E1036) is covered if both of the following criteria 1 and 2 are met:

1. The basic coverage criteria for a lift are met; and
2. The beneficiary requires supine positioning for transfers

If either criterion 1 or 2 is not met, codes E0636, E1035, and E1036 will be denied as not reasonable and necessary.

If coverage is provided for code E1035 or E1036, payment will be discontinued for any other mobility assistive equipment, including but not limited to: canes, crutches, walkers, rollabout chairs, transfer chairs, manual wheelchairs, power-operated vehicles, or power wheelchairs.

Code E0621 is covered as an accessory when ordered as a replacement for a covered patient lift.

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For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must also obtain a DWO before submitting a claim for any associated options, accessories, and/or supplies that are separately billed. In this scenario, if the supplier bills for associated options, accessories, and/or supplies without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

A WOPD (if applicable) must be received by the supplier before a DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a completed WOPD, the claim shall be statutorily denied. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not

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