



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

Bedside Commode

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 commode is covered when the beneficiary is physically incapable of utilizing regular toilet facilities. This would occur in the following situations:

1. The beneficiary is confined to a single room, or
2. The beneficiary is confined to one level of the home environment and there is no toilet on that level, or
3. The beneficiary is confined to the home and there are no toilet facilities in the home.

An extra wide/heavy duty commode chair (E0168) is covered for a beneficiary who weighs 300 pounds or more. If an E0168 commode is ordered and the beneficiary does not weigh more than 300 pounds, it will be denied as not reasonable and necessary.

A commode chair with detachable arms (E0165) is covered if the detachable arms feature is necessary to facilitate transferring the beneficiary or if the beneficiary has a body configuration that requires extra width. If coverage criteria are not met payment will be denied as not reasonable and necessary.

Commode chair with seat lift mechanism (E0170, E0171) is covered if the beneficiary has medical necessity for a commode and meets the coverage criteria for a seat lift mechanism (see Local Coverage Determination (LCD) and Policy Article on Seat Lift Mechanisms). However, a commode with seat lift mechanism is intended to allow the beneficiary to walk after standing. If the beneficiary can ambulate, he/she would rarely meet the coverage criterion for a commode. Therefore, if the beneficiary is capable of walking from the bed to the bathroom, a KX modifier must not be added to the code for the commode with seat lift mechanism.

Bidets and bidet toilet seats are non-covered (no benefit – see related Policy Article).

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.

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.



DETAILED PHYSICIANS ORDER
DURABLE MEDICAL EQUIPMENT

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

Address: _____ DOB: _____ Length of Need: 99

_____ Diagnosis Codes: _____

Equipment Needed:

- | | |
|--|--|
| <input type="checkbox"/> E1038 Transport chair (weight <= 300 lbs.) | <input type="checkbox"/> E0260 Semi-electric hospital bed w/ mattress |
| <input type="checkbox"/> K0001 Standard Manual Wheelchair | <input type="checkbox"/> E0261 Semi-electric hospital bed w/o mattress |
| <input type="checkbox"/> K0003 Lightweight Manual Wheelchair | <input type="checkbox"/> E0265 Full electric hospital bed (ABN required) |
| <input type="checkbox"/> K0004 High Strength Lightweight Manual Wheelchair | <input type="checkbox"/> E0303 HD hospital bed extra wide (350-600 lbs) |
| <input type="checkbox"/> K0006 HD Manual Wheelchair (weight > 250 lbs.) | <input type="checkbox"/> E0143 Standard Walker (No wheels) |
| <input type="checkbox"/> K0007 Extra HD Manual Wheelchair (weight > 300 lbs.) | <input type="checkbox"/> E0143 Wheeled walker |
| Additional Accessories for K0001 – K0007 wheelchairs | |
| Non Standard Seat Width | |
| <input type="checkbox"/> E2201 (>=20"-<24") <input type="checkbox"/> E2202 (24"-27") | <input type="checkbox"/> E0143 Wheeled walker with seat (Rollator) |
| <input type="checkbox"/> Seat Cushion – Please specify: | <input type="checkbox"/> E0156 Walker Seat for Rollator |
| E2601, E2602, E2603*, E2604*, E2622*, E2623* | <input type="checkbox"/> E0100 Cane-Standard Aluminum |
| <input type="checkbox"/> Back Cushion – Please specify: | <input type="checkbox"/> E0105 Quad Cane (sm or lg) |
| E2611, E2612 | <input type="checkbox"/> If other please specify: |
| <input type="checkbox"/> Heel Loops/ Standard leg rests (E0951) <input type="checkbox"/> Right <input type="checkbox"/> Left | _____ |
| <input type="checkbox"/> Elevating Leg rests (K0195) <input type="checkbox"/> Right <input type="checkbox"/> Left | _____ |
| <input type="checkbox"/> Articulating Leg rests (K0053) | _____ |
| <input type="checkbox"/> Anti-Tippers (E0971) <input type="checkbox"/> Right <input type="checkbox"/> Left | _____ |
| <input type="checkbox"/> Brake extensions (E0961) <input type="checkbox"/> Right <input type="checkbox"/> Left | _____ |
| <input type="checkbox"/> Height adjustable arms (E0973) <input type="checkbox"/> Right <input type="checkbox"/> Left | _____ |
| <input type="checkbox"/> Arm Trough (E2209)* <input type="checkbox"/> Right <input type="checkbox"/> Left | _____ |
| <input type="checkbox"/> Amputee support (E1020)* <input type="checkbox"/> Right <input type="checkbox"/> Left | _____ |
| <input type="checkbox"/> Swing away Hardware (E1028) <input type="checkbox"/> Right <input type="checkbox"/> Left | _____ |
| <input type="checkbox"/> 1 arm drive attachment (E0958) <input type="checkbox"/> Right <input type="checkbox"/> Left | _____ |
| <input type="checkbox"/> Lap tray (E0950) | _____ |
| <input type="checkbox"/> Oxygen tank holder (E2208) | _____ |

Verify covered diagnosis

Physicians
Name: _____

Physicians
Signature: _____
(Original no stamps please)

Address: _____

Date: _____

Phone: _____

Fax: _____

NPI: _____

Showroom location for new patients and walk-ins:

1005 N Kingshighway Ste 12 Cape Girardeau ph. 573-803-2390 fax. 573-803-1247