Local Coverage Determination (LCD) for Hospital Beds And Accessories (L5049)

Contractor Information

Contractor Name	Contract Number	Contract Type
NHIC, Corp.	16003	DME MAC

LCD Information

Document Information

LCD Database ID Number
L5049

LCD Title
Hospital Beds And Accessories

AMA CPT / ADA CDT Copyright Statement

Jurisdiction
Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

DME Region LCD Covers
Jurisdiction A

Original Effective Date
For services performed on or after 10/01/1993

Revision Effective Date
For services performed on or after 08/01/2013

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
08/01/1993

Notice Period End Date
N/A

CMS National Coverage Policy

CMS Pub. 100-3 (Medicare National Coverage Determinations Manual) Chapter 1, Sections 280.1, 280.7

Coverage Guidance

Coverage Indications, Limitations and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this local coverage determination, the criteria for "reasonable and necessary", based on Social Security Act §1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

For an item to be covered by Medicare, a detailed written order (DWO) 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 the completed DWO, the item will be denied as not reasonable and necessary.

For some items in this policy to be covered by Medicare, a written order prior to delivery (WOPD) is required. Refer to the DOCUMENTATION REQUIREMENTS section of this LCD and to the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article for information about WOPD prescription requirements.

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.

A variable 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:

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.

Coding Information
Bill Type Codes:
Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

Revenue Codes:
Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

CPT/HCPCS Codes
Group 1 Paragraph: The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY - No physician or other licensed health care provider order for this item or service

GA – Waiver of liability statement issued as required by payer policy, individual case

GK - Reasonable and necessary item/service associated with a GA or GZ modifier

GL - Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN

GZ – Item or service expected to be denied as not reasonable and necessary

KX - Requirements specified in the medical policy have been met

HCPCS CODES:

FIXED HEIGHT BEDS:

Group 1 Codes:

E0250 HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITH MATTRESS

E0251 HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS

E0290 HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS

E0291 HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITHOUT MATTRESS

E0328 HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS

Group 2 Paragraph: VARIABLE HEIGHT BEDS

Group 2 Codes:

E0255 HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS

E0256 HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS

E0292 HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS

E0293 HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS

Group 3 Paragraph: SEMI-ELECTRIC BEDS

Group 3 Codes:

E0260 HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH MATTRESS

E0261 HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS

E0294 HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS

E0295 HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS

E0329 HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS

Group 4 Paragraph: TOTAL ELECTRIC BEDS

Group 4 Codes:

E0265 HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS

E0266 HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS

E0296 HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS). WITHOUT SIDE RAILS, WITH MATTRESS

E0297 HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS

Group 5 Paragraph: HEAVY DUTY BEDS

Group 5 Codes:

E0301 HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS

E0302 HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS

E0303 HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS

E0304 HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS

Group 6 Paragraph: ACCESSORIES

Group 6 Codes:

E0271 MATTRESS, INNERSPRING

E0272 MATTRESS, FOAM RUBBER

E0273 BED BOARD

E0274 OVER-BED TABLE

E0280 BED CRADLE, ANY TYPE

E0305 BED SIDE RAILS, HALF LENGTH

E0310 BED SIDE RAILS, FULL LENGTH

E0315 BED ACCESSORY: BOARD, TABLE, OR SUPPORT DEVICE, ANY TYPE

E0316 SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE

E0910 TRAPEZE BARS, A/K/A PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR

E0911 TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, ATTACHED TO BED, WITH GRAB BAR

E0912 TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, FREE STANDING, COMPLETE WITH GRAB BAR

E0940 TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR

Group 7 Paragraph: MISCELLANEOUS

Group 7 Codes:
E1399 DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

ICD-9 Codes that Support Medical Necessity
Group 1 Paragraph: Not specified.

Group 1 Codes:

Group 1 Asterisk: N/A

ICD-9 Codes that DO NOT Support Medical Necessity
Not specified.

General Information
Associated Information
DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

PRESCRIPTION (ORDER) REQUIREMENTS

GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

DISPENSING ORDERS (PIM 5.2.2)

Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary's name
- Prescribing Physician's name

- Date of the order and the start date, if the start date is different from the date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The dispensing order must be available upon request.

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.4)

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS codes specified in the table contained in the Policy Specific Documentation Requirements Section below. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. Refer the related Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about the statutory requirements associated with a WOPD.

DETAILED WRITTEN ORDERS (PIM 5.2.3)

A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

For items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only.

Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)

The detailed description in the written order may be either a narrative description or a brand name/model number.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.

MEDICAL RECORD INFORMATION

GENERAL (PIM 5.7 - 5.9)

The **Coverage Indications, Limitations and/or Medical Necessity** section of this LCD contains numerous reasonable and necessary (R&N) requirements. The **Non-Medical Necessity Coverage and Payment Rules** section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

CONTINUED MEDICAL NEED

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the

beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or DIF with an appropriate length of need specified
- Timely documentation in the beneficiary's medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

CONTINUED USE

Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories and supplies
- Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements (This is deemed to be sufficient to document continued use for the base item, as well)
- Supplier records documenting beneficiary confirmation of continued use of a rental item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.

PROOF OF DELIVERY (PIM 4.26, 5.8)

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as any person who can sign and accept the delivery of DMEPOS on behalf of the beneficiary.

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. For items addressed in this policy, there are two methods of delivery:

1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service

Method 1—Direct Delivery to the Beneficiary by the Supplier

Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

- Beneficiary's name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the item is delivered directly by the supplier, the date the beneficiary received the DMEPOS item must be the date of service on the claim.

Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary

If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records.
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

KX, GA, AND GZ MODIFIERS:

Suppliers must add a KX modifier to a hospital bed code only if all of the criteria in the "Coverage Indications, Limitations and/or Medical Necessity" section of this policy have been met.

The KX modifier should also be added for an accessory when the applicable accessory criteria are met. If the requirements for the KX modifier are not met, the KX modifier must not be used.

If all of the coverage criteria have not been met, the GA or GZ modifier must be added to a claim line for a hospital bed and accessories. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claim lines billed without a KX, GA or GZ modifier will be rejected as missing information.

UPGRADE MODIFIERS:

When a hospital bed upgrade is provided, the GA, GK, GL and/or GZ modifiers must be used to indicate the upgrade. Fully electric hospital beds must always be billed with these modifiers.

Refer to the Supplier Manual for more information on documentation requirements.

AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS

ACA 6407 contains provisions that are applicable to certain specified items in this policy. In this policy the specified items are:

E0250	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE OF SIDE RAILS, WITH MATTRESS
E0251	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0255	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0256	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0260	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0261	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS

E0265	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0266	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0290	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS
E0291	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0292	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS
E0293	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0294	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS
E0295	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0296	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITH MATTRESS
E0297	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0301	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE OF SIDE RAILS, WITHOUT MATTRESS
E0302	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE OF SIDE RAILS, WITHOUT MATTRESS
E0303	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE OF SIDE RAILS, WITH MATTRESS
E0304	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE OF SIDE RAILS, WITH MATTRESS

These items require an in-person or face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing order is not sufficient to provide these items. A Written Order Prior to Delivery (WOPD) is required. Refer to the related Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about these statutory requirements.

The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

Suppliers are reminded that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

Appendices
PIM citations above denote references to CMS Program Integrity Manual, Internet Only Manual 100-8

Utilization Guidelines
Refer to Indications and Limitations of Coverage and/or Medical Necessity

Sources of Information and Basis for Decision

Revision History Information
Please note: The Revision History information included in this LCD prior to 1/24/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 1/24/2013 will display as a row in the Revision History section of the LCD and numbering will begin with "R2".

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
08/01/2013	R4	**Revision Effective Date: 08/01/2013 (March 2014 Publication)** COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013) POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: ACA 6407 information (requirements effective 07/01/2013)	Provider Education/Guidance
08/01/2013	R3	**Revision Effective Date: 08/01/2013** COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Removed: From criterion 3, the requirement of “Pillows or wedges must have been considered and ruled out”	Provider Education/Guidance
02/04/2011	R2	**Revision Effective Date: 02/04/2011 (March 2013 Publication)** COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirement language to specify a “detailed written order” Changed: Word “Patient” to “Beneficiary” DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the	Provider Education/Guidance

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		LCD for easy reference) Added: Standard Language	
02/04/2011	R1	**Revision Effective Date: 02/04/2011** INDICATIONS AND LIMITATIONS OF COVERAGE: DELETED: Least costly alternative language HCPCS CODES AND MODIFIERS: Revised: GA modifier **Revision Effective Date: 10/01/2009** HCPCS CODES AND MODIFIERS: Revised: KX modifier. DOCUMENTATION REQUIREMENTS: Added: Instructions for the use of GA and GZ modifiers. **03/01/2008** - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) LCD L5049 from DME PSC TriCenturion (77011) LCD L5049. **Revision Effective Date: 01/01/2008** INDICATIONS AND LIMITATIONS OF COVERAGE: Added: E0328 and E0329. HCPCS CODES AND MODIFIERS: Added: E0328 and E0329. **Revision Effective Date: 07/01/2007** HCPCS CODES AND MODIFIERS: Added: GA, GK, GL, and GZ modifiers. DOCUMENTATION REQUIREMENTS: Clarified: Instructions for KX modifiers. Added: Modifier requirements for upgrades. **06/01/2007** - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012). **Revision Effective Date: 01/01/2007** INDICATIONS AND LIMITATIONS OF COVERAGE: Clarified: Noncoverage of fully electric beds with LCA statement. HCPCS CODES AND MODIFIERS:	Maintenance (annual review with new changes, formatting, etc.)

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		Added: KX modifier. DOCUMENTATION REQUIREMENTS: Removed: Requirement to submit a CMN. Added: KX modifier use. **03/01/2006** - In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011). **Revision Effective Date: 01/01/2006** INDICATIONS AND LIMITATIONS OF COVERAGE: Added: Criteria for E0911 and E0912. HCPCS CODES AND MODIFIERS: Added: E0911, E0912. **Revision Effective Date: 01/01/2006** LMRP converted to LCD and Policy Article. INDICATIONS AND LIMITATIONS OF COVERAGE: Added: E0316 to paragraph about side-rails. **Revision Effective Date: 04/01/2004** HCPCS CODES AND MODIFIERS: Added: E0301, E0302, E0303, E0304 Deleted: K0549, K0550. INDICATIONS AND LIMITATIONS OF COVERAGE: Added: References to new codes and removed deleted codes. CODING GUIDELINES: Added: References to new codes and removed deleted codes. Updated: Unbundling tables to include new codes. **Revision Effective Date: 04/01/2003** HCPCS CODES AND MODIFIERS: Added: EY modifier INDICATIONS AND LIMITATIONS OF COVERAGE: Added: Standard language concerning coverage of items without an order. DOCUMENTATION REQUIREMENTS: Added: Standard language concerning use of EY modifier for items without an order. **The revision dates listed below are the**	

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		dates the revisions were published and not necessarily the effective dates for the revisions. 04/01/2002 - HCPCS code E0316 added to policy. Deleted requirement to list ICD-9 diagnosis codes for bed cradles (E0280). 10/01/2001 - Consolidated DMERC policies for all types of hospital beds and their accessories. The revision involves coding guidelines and the newer codes for heavy duty and extra heavy duty beds. 06/01/1994 – Clerical correction. 12/01/1993 – Corrected HAO to HA0 in Documentation section.	

Associated Documents

Attachments

There are no attachments for this LCD

Related Local Coverage Documents

Article(s)

A37213 - Hospital Beds And Accessories - Policy Article - Effective July 2013

Related National Coverage Documents

All Versions

Updated on 02/28/2014 with effective dates 08/01/2013 - N/A
Updated on 06/28/2013 with effective dates 08/01/2013 - N/A
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Contractor Information

Contractor Information Table

Contractor Name	Contract Number	Contract Type
NHIC, Corp.	16003	DME MAC

Article Information

General Article Information Table

Article ID
A37213

Article Title
Hospital Beds And Accessories - Policy Article - Effective July 2013

AMA CPT / ADA CDT Copyright Statement

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Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
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Article Guidance

Article Text

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. “reasonable and necessary”).

Hospital Beds are covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary’s equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

A bed board (E0273, E0315) is noncovered since it is not primarily medical in nature.

An over bed table (E0274, E0315) is noncovered because it is not primarily medical in nature.

Trapeze bars attached to a bed (E0910, E0911) are noncovered when used on an ordinary bed.

AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS

ACA 6407 contains provisions that are applicable to specified items in this policy. In this policy the specified items are:

E0250	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE OF SIDE RAILS, WITH MATTRESS
E0251	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0255	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0256	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0260	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0261	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0265	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS
E0266	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
E0290	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS
E0291	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0292	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS
E0293	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0294	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS
E0295	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0296	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITH MATTRESS
E0297	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS
E0301	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE OF SIDE RAILS, WITHOUT MATTRESS

E0302	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE OF SIDE RAILS, WITHOUT MATTRESS
E0303	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE OF SIDE RAILS, WITH MATTRESS
E0304	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE OF SIDE RAILS, WITH MATTRESS

Face-to-Face Visit Requirements:

As a condition for payment, Section 6407 of the Affordable Care Act (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary that meets all of the following requirements:

- The treating physician must have an in-person examination with the beneficiary within the six (6) months prior to the date of the WOPD.
- This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

A new face-to-face examination is required each time a new prescription for one of the specified items is ordered. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals.
- When there is a change in the prescription for the accessory, supply, drug, etc.
- If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)
- When an item is replaced
- When there is a change in the supplier
- When required by state law

The first bullet, “For all claims for purchases or initial rentals”, includes all claims for payment of purchases and initial rentals for items not originally covered (reimbursed) by Medicare Part B. Claims for items obtained outside of Medicare Part B, e.g. from another payer prior to Medicare participation (including Medicare Advantage plans), are considered to be new initial claims for Medicare payment purposes.

Prescription Requirements:

A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician’s signature and signature date, and must be in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier’s possession BEFORE the item is delivered. The WOPD must include all of the items below:

- Beneficiary's name,
- Physician’s Name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s)
- The prescribing practitioner's National Provider Identifier (NPI),
- The signature of the ordering practitioner
- Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include, in addition to the above:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills, if applicable

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DMEPOS items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, to assure that these ACA order requirements are met.

Date and Timing Requirements

There are specific date and timing requirements:

- The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than 6 months prior to the prescription date.
- The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.
- The date of the written order must be on or before the date of delivery.
- The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician's signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

Claim Denial

Claims for the specified items subject to ACA 6407 that do not meet the requirements specified above will be denied as statutorily noncovered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

CODING GUIDELINES

A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment.

A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments.

A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments.

A total electric bed is one with electric height adjustment and with electric head and leg elevation adjustments.

An ordinary bed is one which is typically sold as furniture. It may consist of a frame, box spring and mattress. It is a fixed height and may or may not have head or leg elevation adjustments.

E0301 and E0303 are hospital beds that are capable of supporting a beneficiary who weighs more than 350 pounds, but no more than 600 pounds.

E0302 and E0304 are hospital beds that are capable of supporting a beneficiary who weighs more than 600 pounds.

E0316 is a safety enclosure used to prevent a beneficiary from leaving the bed.

E1399 should be used for products not described by the specific HCPCS codes above.

A 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.

Column I	Column II
E0250	E0271, E0272, E0305, E0310
E0251	E0305, E0310
E0255	E0271, E0272, E0305, E0310
E0256	E0305, E0310
E0260	E0271, E0272, E0305, E0310
E0261	E0305, E0310
E0265	E0271, E0272, E0305, E0310
E0266	E0305, E0310
E0290	E0271, E0272
E0292	E0271, E0272
E0294	E0271, E0272
E0296	E0271, E0272
E0301	E0305, E0310
E0302	E0305, E0310
E0303	E0271, E0272, E0305, E0310
E0304	E0271, E0272, E0305, E0310
E0328	E0271, E0272, E0305, E0310
E0329	E0271, E0272, E0305, E0310

When mattress or bedside rails are provided at the same time as a hospital bed, use the single code that combines these items.

E0271, E0272: Mattress, innerspring/foam rubber

- When combined with E0251, bill as E0250
- When combined with E0291, bill as E0290
- When combined with E0293, bill as E0292
- When combined with E0295, bill as E0294
- When combined with E0266, bill as E0265
- When combined with E0297, bill as E0296
- When combined with E0301, bill as E0303
- When combined with E0302, bill as E0304

E0305, E0310: Bedside rails, half-length/full-length

- When combined with E0290, bill as E0250
- When combined with E0291, bill as E0251
- When combined with E0292, bill as E0255
- When combined with E0293, bill as E0256
- When combined with E0294, bill as E0260
- When combined with E0295, bill as E0261
- When combined with E0296, bill as E0265
- When combined with E0297, bill as E0266

E0271, E0272: Mattress, innerspring/foam rubber plus
E0305, E0310: Bedside rails, half-length/full-length

- When combined with E0291, bill as E0250
- When combined with E0293, bill as E0255
- When combined with E0295, bill as E0260
- When combined with E0297, bill as E0265

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

Coding Information

Revision History Information

Please note: The Revision History information included in this Article prior to 6/20/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 6/20/2013 will display as a row in the Revision History section of the Article and numbering will begin with "R2".

Revision History Date	Revision History Number	Revision History Explanation
07/01/2013	R2	**Revision Effective Date: 07/01/2013** NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: ACA 6407 requirements
04/01/2013	R1	**Revision Effective Date: 04/01/2013** NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble and benefit category statement CODING GUIDELINES: Changed: Word “Patient” to “Beneficiary” **Revision Effective Date: 10/01/2009** CODING GUIDELINES: Changed: SADMERC to PDAC.

Revision History Date	Revision History Number	Revision History Explanation
		03/01/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A37213 from DME PSC TriCenturion (77011) Article A37213. **Revision Effective Date: 01/01/2008** CODING GUIDELINES: Added E0328 and E0329. **06/01/2007** - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012). **Revision Effective Date: 01/01/2007** CODING GUIDELINES: Removed: Examples from E1399 guidelines. **03/01/2006** - In accordance with Section 911 of the Medicare Modernization Act of 2003, this article was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011). **Revision Effective Date: 01/01/2006** NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Clarified: Trapeze bars Added: Code E0911. **Revision Effective Date: 01/01/2006** LMRP converted to LCD and Policy Article.

Associated Documents
Related Local Coverage Document(s)
LCD(s)
L5049 - Hospital Beds And Accessories

Related National Coverage Documents

Statutory Requirements URL(s)

Rules and Regulations URL(s)

CMS Manual Explanations URL(s)

Other URL(s)

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Updated on 02/28/2014 with effective dates 07/01/2013 - N/A
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