Hospital Beds And Accessories

Noridian Healthcare Solutions, LLC

Contractor Information
Contractor Name: Noridian Healthcare Solutions, LLC
Contract Type: DME MAC

LCD Information
LCD ID: L33820
Original ICD-9 LCD ID: L5049 - Hospital Beds And Accessories
LCD Title: Hospital Beds And Accessories

AMA CPT
ADA CDT
AHA NUBC
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CMS National Coverage Policy
CMS Pub. 100-3 (Medicare National Coverage Determinations Manual) Chapter 1, Sections 280.1, 280.7
Jurisdiction
Alaska
American Samoa
Arizona
California - Entire State
Guam
Hawaii
Idaho
Iowa
Kansas
Missouri - Entire State
Montana
Nebraska
Nevada
North Dakota
Northern Mariana Islands
Oregon
South Dakota
Utah
Washington
Wyoming

DME Region
LCD Covers
Jurisdiction D

Date Information
Original Effective Date  For services performed on or after 10/01/2015
Revision Effective Date  For services performed on or after 10/01/2015
Revision Ending Date
Retirement Date
Notice Period Start Date
Notice Period End Date

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.

Medicare does not automatically assume payment for a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) item that was covered prior to a beneficiary becoming eligible for the Medicare Fee For Service (FFS) program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary, may be required upon request of the DME MAC.
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
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**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0250</td>
<td>HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITH Mattress</td>
</tr>
<tr>
<td>E0251</td>
<td>HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITHOUT Mattress</td>
</tr>
<tr>
<td>E0290</td>
<td>HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH Mattress</td>
</tr>
<tr>
<td>E0291</td>
<td>HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITHOUT Mattress</td>
</tr>
<tr>
<td>E0328</td>
<td>HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS</td>
</tr>
</tbody>
</table>

**Group 2: Paragraph**

VARIABLE HEIGHT BEDS

**Group 2: Codes**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0255</td>
<td>HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH Mattress</td>
</tr>
<tr>
<td>E0256</td>
<td>HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT Mattress</td>
</tr>
<tr>
<td>E0292</td>
<td>HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH Mattress</td>
</tr>
<tr>
<td>E0293</td>
<td>HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT Mattress</td>
</tr>
</tbody>
</table>

**Group 3: Paragraph**

SEMI-ELECTRIC BEDS

**Group 3: Codes**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0260</td>
<td>HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH Mattress</td>
</tr>
<tr>
<td>E0261</td>
<td>HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT Mattress</td>
</tr>
<tr>
<td>E0294</td>
<td>HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH Mattress</td>
</tr>
<tr>
<td>E0295</td>
<td>HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT Mattress</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E0329</td>
<td>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</td>
</tr>
</tbody>
</table>

**Group 4: Paragraph**

**TOTAL ELECTRIC BEDS**

**Group 4: Codes**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0265</td>
<td>HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS</td>
</tr>
<tr>
<td>E0266</td>
<td>HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS</td>
</tr>
<tr>
<td>E0296</td>
<td>HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITH MATTRESS</td>
</tr>
<tr>
<td>E0297</td>
<td>HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS</td>
</tr>
</tbody>
</table>

**Group 5: Paragraph**

**HEAVY DUTY BEDS**

**Group 5: Codes**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0301</td>
<td>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</td>
</tr>
<tr>
<td>E0302</td>
<td>HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS</td>
</tr>
<tr>
<td>E0303</td>
<td>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</td>
</tr>
<tr>
<td>E0304</td>
<td>HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS</td>
</tr>
</tbody>
</table>

**Group 6: Paragraph**

**ACCESSORIES**

**Group 6: Codes**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0271</td>
<td>MATTRESS, INNERSPRING</td>
</tr>
<tr>
<td>E0272</td>
<td>MATTRESS, FOAM RUBBER</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E0273</td>
<td>BED BOARD</td>
</tr>
<tr>
<td>E0274</td>
<td>OVER-BED TABLE</td>
</tr>
<tr>
<td>E0280</td>
<td>BED CRADLE, ANY TYPE</td>
</tr>
<tr>
<td>E0305</td>
<td>BED SIDE RAILS, HALF LENGTH</td>
</tr>
<tr>
<td>E0310</td>
<td>BED SIDE RAILS, FULL LENGTH</td>
</tr>
<tr>
<td>E0315</td>
<td>BED ACCESSORY: BOARD, TABLE, OR SUPPORT DEVICE, ANY TYPE</td>
</tr>
<tr>
<td>E0316</td>
<td>SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE</td>
</tr>
<tr>
<td>E0910</td>
<td>TRAPEZE BARS, A/K/A PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR</td>
</tr>
<tr>
<td>E0911</td>
<td>TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, ATTACHED TO BED, WITH GRAB BAR</td>
</tr>
<tr>
<td>E0912</td>
<td>TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, FREE STANDING, COMPLETE WITH GRAB BAR</td>
</tr>
<tr>
<td>E0940</td>
<td>TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR</td>
</tr>
</tbody>
</table>

**Group 7: Paragraph**

**MISCELLANEOUS**

**Group 7: Codes**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1399</td>
<td>DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS</td>
</tr>
</tbody>
</table>

**Does the CPT 30% Coding Rule Apply? No**

**ICD-10 Codes that Support Medical Necessity**

Note: Performance is optimized by using code ranges.

**Group 1: Paragraph**

**Group 1: Codes**

**ICD-10 Codes that DO NOT Support Medical Necessity**

Note: Performance is optimized by using code ranges.

**Group 1: Paragraph**

**Group 1: Codes**

**Additional ICD-10 Information**
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 5.2.3.1)

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. (PIM 5.2.3)

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 date of service (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 document. The POD document 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

The date delivered on the POD must be the date that the DMEPOS item was received by the beneficiary or designee. The date of delivery may be entered by the beneficiary, designee or the supplier. When the supplier’s delivery documents have both a supplier-entered date and a beneficiary or beneficiary’s designee signature date on the POD document, the beneficiary or beneficiary’s designee-entered date is the date of service.

In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply 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.
EQUIPMENT RETAINED FROM A PRIOR PAYER

When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage plan) becomes eligible for the Medicare FFS program, the first Medicare claim for that item or service is considered a new initial Medicare claim for the item. Even if there is no change in the beneficiary’s medical condition, the beneficiary must meet all coverage, coding and documentation requirements for the DMEPOS item in effect on the date of service of the initial Medicare claim.

A POD is required for all items, even those in the beneficiary’s possession provided by another insurer prior to Medicare eligibility. To meet the POD requirements for a beneficiary transitioning to Medicare, the supplier:

1. Must obtain a new POD as described above under “Methods of Delivery” (whichever method is applicable); or,
2. Must obtain a statement, signed and dated by the beneficiary (or beneficiary's designee), attesting that the supplier has examined the DMEPOS item, it is in good working order and that it meets Medicare requirements.

For the purposes of reasonable useful lifetime and calculation of continuous use, the first day of the first rental month in which Medicare payments are made for the item (i.e., date of service) serves as the start date of the reasonable useful lifetime and period of continuous use. In these cases, the proof of delivery documentation serves as evidence that the beneficiary is already in possession of the item.

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.

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:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0250</td>
<td>HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE OF SIDE RAILS, WITH MATTRESS</td>
</tr>
<tr>
<td>E0251</td>
<td>HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS</td>
</tr>
<tr>
<td>E0255</td>
<td>HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS</td>
</tr>
<tr>
<td>E0256</td>
<td>HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS</td>
</tr>
<tr>
<td>E0260</td>
<td>HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH MATTRESS</td>
</tr>
<tr>
<td>E0261</td>
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<tr>
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<td>HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS</td>
</tr>
<tr>
<td>E0266</td>
<td>HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS</td>
</tr>
<tr>
<td>E0290</td>
<td>HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS</td>
</tr>
<tr>
<td>E0291</td>
<td>HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITHOUT MATTRESS</td>
</tr>
<tr>
<td>E0292</td>
<td>HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS</td>
</tr>
<tr>
<td>E0293</td>
<td>HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS</td>
</tr>
<tr>
<td>E0294</td>
<td>HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS</td>
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</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E0297</td>
<td>HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS</td>
</tr>
<tr>
<td>E0301</td>
<td>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</td>
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<tr>
<td>E0302</td>
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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.

REPAIR/REPLACEMENT (100-02, Ch 15, §110.2)

A new Certificate of Medical Necessity (CMN) and/or physician’s order is not needed for repairs.

In the case of repairs to a beneficiary-owned DMEPOS item, if Medicare paid for the base equipment initially, medical necessity for the base equipment has been established. With respect to Medicare reimbursement for the repair, there are two documentation requirements:

1. The treating physician must document that that the DMEPOS item being repaired continues to be reasonable and necessary (see Continued Medical Need section above); and,
2. Either the treating physician or the supplier must document that the repair itself is reasonable and necessary.
The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time to restore the item to its functionality.

A physician’s order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

MISCELLANEOUS

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

Appendices
PIM citations above denote references to CMS Program Integrity Manual, Internet Only Manual 100-08

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

Sources of Information and Basis for Decision

Revision History Information
Revision History Table

<table>
<thead>
<tr>
<th>Revision History Number</th>
<th>Revision History Date</th>
<th>Revision History Explanation</th>
<th>Reason for Change</th>
</tr>
</thead>
</table>
| 1                       | 10/01/2015            | Revision Effective Date: 10/01/2015  
  COVERAGE INDICATIONS, LIMITATIONS AND/OR  
  MEDICAL NECESSITY:  
  Revised: Standard Documentation Language to add  
  covered prior to a beneficiary’s Medicare eligibility  
  DOCUMENTATION REQUIREMENTS:  
  Revised: Standard Documentation Language to add  
  who can enter date of delivery date on the POD  
  Added: Instructions for Equipment Retained from a  
  Prior Payer  
  Added: Repair/Replacement section | Provider  
  Education/Guidance |

Associated Documents
Attachments
There are no attachments for this LCD.

Article(s)
A52508 - Hospital Beds And Accessories - Policy Article -  
Effective October 2015
END OF LOCAL COVERAGE DETERMINATION

Per the Code of Federal Regulations, 42 C.F.R § 426. 325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.
Hospital Beds And Accessories - Policy Article - Effective October 2015

Noridian Healthcare Solutions, LLC

Contractor Information
Contractor Name Noridian Healthcare Solutions, LLC
Contract Type DME MAC

Article Information
Article ID A52508
Original ICD-9 Article ID A37213 - Hospital Beds And Accessories - Policy Article - Effective October 2014
Article Title Hospital Beds And Accessories - Policy Article - Effective October 2015
Article Type Article

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Jurisdiction
Alaska
American Samoa
Arizona
California - Entire State
Guam
Hawaii
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:

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

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.

The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However the prescriber must:
• Verify that the in-person visit occurred within the 6-months prior to the date of their prescription, and
• Have documentation of the face-to-face examination that was conducted, and
• Provide the DMEPOS supplier with copies of the in-person visit records

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 that 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.

<table>
<thead>
<tr>
<th>Column I</th>
<th>Column II</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0250</td>
<td>E0271, E0272, E0305, E0310</td>
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<tr>
<td>E0251</td>
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<tr>
<td>E0328</td>
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</tr>
</tbody>
</table>
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
- Bill Type Codes
- Revenue Codes

CPT/HCPCS Codes
Group 1: Paragraph

Group 1: Codes

Does the CPT 30% Coding Rule Apply? No

Covered ICD-10 Codes

Note: Performance is optimized by using code ranges.
Group 1: Paragraph

Group 1: Codes

Non-Covered ICD-10 Codes

Note: Performance is optimized by using code ranges.
Group 1: Paragraph

Group 1: Codes

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<td>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Removed: “When required by state law” from ACA new prescription</td>
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requirements
Revised: Face-to-Face Requirements for treating practitioner

Associated Documents

Related Local Coverage Documents

Related National Coverage Documents

Statutory Requirements URL(s)
Rules and Regulations URL(s)
CMS Manual Explanations URL(s)
Other URL(s)

LCD(s)

L33820 - Hospital Beds And Accessories

This Article version has no Related National Coverage Documents.

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Back to Top of Policy Article