

Local Coverage Determination (LCD): Hospital Beds And Accessories (L33820)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota Utah Washington Wyoming Northern Mariana Islands

LCD Information

Document Information

LCD ID

L33820

Original ICD-9 LCD ID

[L5049](#)

[L11557](#)

[L27216](#)

[L11572](#)

LCD Title

Hospital Beds And Accessories

Proposed LCD in Comment Period

N/A

Source Proposed LCD

N/A

Original Effective Date

For services performed on or after 10/01/2015

Revision Effective Date

For services performed on or after 01/01/2017

Revision Ending Date

N/A

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N/A

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N/A

Notice Period End Date

N/A

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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.

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

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

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

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

A 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.

GENERAL

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

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

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

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

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

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

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.

N/A

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.

N/A

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:

CODE	DESCRIPTION
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:

CODE	DESCRIPTION
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:

CODE	DESCRIPTION
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

CODE	DESCRIPTION
	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:

CODE	DESCRIPTION
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:

CODE	DESCRIPTION
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:

CODE	DESCRIPTION
E0271	MATTRESS, INNERSPRING
E0272	MATTRESS, FOAM RUBBER
E0273	BED BOARD

CODE	DESCRIPTION
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:

CODE	DESCRIPTION
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

ICD-10 Codes that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Additional ICD-10 Information

N/A

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.

GENERAL DOCUMENTATION REQUIREMENTS

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- Prescription (orders)
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

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

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

MISCELLANEOUS

APPENDICES

UTILIZATION GUIDELINES

Refer to Coverage Indications, Limitations and/or Medical Necessity

Sources of Information

N/A

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
01/01/2017	R4	<p>No changes have been made to this LCD</p> <p>04/05/2018: <i>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> • Other
01/01/2017	R3	<p>Revision Effective Date: 01/01/2017</p> <p>COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p> <p>Removed: Standard Documentation Language Added: New reference language and directions to Standard Documentation Requirements Added: General Requirements</p> <p>HCPCS CODES:</p> <p>Revised: HCPCS long descriptors for E0292, E0293, and E0296</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Removed: Standard Documentation Language Added: General Documentation Requirements Added: New reference language and directions to Standard Documentation Requirements</p> <p>POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:</p> <p>Removed: Standard Documentation Language Added: Direction to Standard Documentation Requirements</p> <p>Removed: Information under Miscellaneous and Appendices</p> <p>RELATED LOCAL COVERAGE DOCUMENTS:</p> <p>Added: LCD-related Standard Documentation Requirements article</p>	<ul style="list-style-type: none"> • Provider Education/Guidance • Revisions Due To CPT/HCPCS Code Changes
07/01/2016	R2	<p>Effective July 1, 2016 oversight for DME MAC LCDs is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the LCDs.</p>	<ul style="list-style-type: none"> • Change in Assigned States or Affiliated Contract Numbers
10/01/2015	R1	<p>Revision Effective Date: 10/01/2015</p> <p>COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p> <p>Revised: Standard Documentation Language to add</p>	<ul style="list-style-type: none"> • Provider Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		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	

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)

A52508 - Hospital Beds And Accessories - Policy Article

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

Related National Coverage Documents

N/A

Public Version(s)

Updated on 03/27/2018 with effective dates 01/01/2017 - N/A

Updated on 03/31/2017 with effective dates 01/01/2017 - N/A

Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

N/A

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.

Local Coverage Article: Hospital Beds And Accessories - Policy Article (A52508)

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Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota Utah Washington Wyoming Northern Mariana Islands

Article Information

General Information

Article ID

A52508

Original Article Effective Date

10/01/2015

Original ICD-9 Article ID

[A37213](#)

[A36959](#)

[A47240](#)

[A37079](#)

Revision Effective Date

01/01/2017

Revision Ending Date

N/A

Article Title

Hospital Beds And Accessories - Policy Article

Retirement Date

N/A

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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.

Requirements for specified DMEPOS items pursuant to 42 CFR 410.38(g)

42 CFR 410.38(g) requires a face-to-face evaluation and a specific written order prior to delivery for specified HCPCS codes. CMS provides a list of the specified codes, which is periodically updated, located [here](#).

Claims for the specified items subject to 42 CFR 410.38(g) that do not meet the requirements specified in the LCD-related Standard Documentation Requirements Article 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.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

MODIFIERS

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 the related LCD 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.

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.

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

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.

N/A

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.

N/A

CPT/HCPCS Codes

N/A

ICD-10 Codes that are Covered

N/A

ICD-10 Codes that are Not Covered

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/01/2017	R5	<i>01/31/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This is an article and not a local coverage determination.</i>
01/01/2017	R4	<p>Revision Effective Date: 01/01/2017 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES Added: 42 CFR 410.38(g) language, previously in Policy Specific Documentation Requirement section</p> <p><i>04/05/2018: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>
01/01/2017	R3	<p>Revision Effective Date: 01/01/2017 POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: 42 CFR 410.38(g) and Modifiers requirements RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article</p>
07/01/2016	R2	Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.
10/01/2015	R1	<p>Revision Effective Date: 10/01/2015 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Removed: "When required by state law" from ACA new prescription requirements</p> <p>Revised: Face-to-Face Requirements for treating practitioner</p>

Associated Documents

Related Local Coverage Document(s)

Article(s)

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

LCD(s)

L33820 - Hospital Beds And Accessories

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

Public Version(s)

Updated on 01/25/2019 with effective dates 01/01/2017 - N/A

Updated on 03/27/2018 with effective dates 01/01/2017 - N/A

Updated on 03/31/2017 with effective dates 01/01/2017 - N/A

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Keywords

N/A