DME Reference Guide

Medicare Eligibility Criteria

Hospital Beds
Support Surfaces
Wheelchairs
Cushions
Walkers
Patients Lifts
Lift Chairs
Home Oxygen
Commodes

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Medicare Criteria **Hospital Beds**

A **fixed height hospital bed** is covered if **<u>one or more</u>** of the following criteria are met:

1. The patient 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 patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, **or**

3. The patient 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. Pillows or wedges must have been considered and ruled out, **or**

4. The patient requires traction equipment, which can only be attached to a hospital bed.

A **semi-electric hospital bed** is covered if the patient 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** is covered if the patient meets **one of the criteria for a fixed height hospital bed and the patient's weight is more than 350 pounds, but does not exceed 600 pounds.**

Hospital Bed

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PATIENT: Name
Address
Phone
DOB
Initial Date
Revised Date
Recertification

PHYSICIAN: Name
Address
UPIN NPI
Phone Fax

Length of Need (in months)
Policy

DIAGNOSIS

ICD-9 Code Description

EQUIPMENT/SERVICES

Qty	Proc. Code	Item Name/Narrative
1	E0260	Bed Semi-Electric w/ rails and mattress

ADDITIONAL MEDICAL INFORMATION

Does the patient have a medical condition which requires positioning of the body in ways not feasible in an ordinary bed (elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed)? [yes] or [no]
Does the patient require body positioning in ways not feasible with an ordinary bed to alleviate pain? [yes] or [no]
Does the patient require the head of the bed to be elevated over 30 degrees most of the time due to CHF, Chronic Pulmonary Disease, or problems with aspiration that a pillow or wedge will not accommodate?[yes] or [no]
Does the patient require traction equipment which can only be attached to a hospital bed?[yes] or [no]
Does the patient require a variable height bed (E0255, E0256, E0292, E0293) to permit safe transfers to a chair, wheelchair or standing position?[yes] or [no]
Does the patient require a semi-electric bed (E0260, E0261, E0294, E0295) because patient requires frequent changes in body position and/or have an immediate need for change in body position?[yes] or [no]
Does the patient require a heavy duty extra wide bed (E0301, E0303) and weigh between 350 and 600 pounds?[yes] or [no]
Does the patient require an extra heavy-duty bed (E0302, E0304) weigh more than 600 pounds?[yes] or [no]
Does the patient require the use of a trapeze bar (E0910, E0940) to sit-up because of a respiratory condition or to change body positions or to get in and out of bed?].[yes] or [no]
Does the patient require side rails (E0305, E0310) or safety enclosures (E0316) because of patient's condition and they are an integral part of, or an accessory to the bed? [yes] or [no]

Physician Signature Date

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Medicare Criteria **Group I Support Surfaces**

A Group 1 mattress overlay or mattress is covered **if <u>one</u> of the following three criteria is met**:

1. The patient is completely immobile - i.e., patient cannot make changes in body position without assistance, **or**

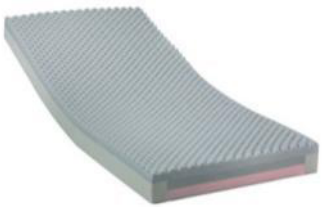
2. The patient has limited mobility - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure **<u>and</u> at least one of conditions A-D below**, **or**

3. The patient has any stage pressure ulcer on the trunk or pelvis **<u>and</u> at least one of conditions A-D below.**

Conditions for criteria 2 and 3 (in each case the medical record must document the severity of the condition sufficiently to demonstrate the medical necessity for a pressure reducing support surface):

A. Impaired nutritional status
B. Fecal or urinary incontinence
C. Altered sensory perception
D. Compromised circulatory status

Alternating Pressure Pad



Solace Mattress

Group 1 Support Surface

PROVIDER: Bellevue Healthcare
www.bellevuehealthcare.com

PHYSICIAN: Name
Address
UPIN NPI
Phone Fax

PATIENT: Name
Address
Phone
DOB
Initial Date
Revised Date
Recertification

Length of Need
(in months)
Policy

DIAGNOSIS

ICD-9 Code	Description

EQUIPMENT/SERVICES

Qty	Proc. Code	Item Name/Narrative	Charge	Allow
1	E0181-E0189,	Alternating Pressure Pad, Solace Mattress or Gel Overlay	NU: $200.00	

ADDITIONAL MEDICAL INFORMATION

Is the patient completely immobile? - i.e., Is the patient unable to make changes in body position without assistance? [yes] or [no]
Does the patient have limited mobility? - i.e., Is the patient able to make changes, independently, in body position significant enough to alleviate pressure? [yes] or [no]
Any stage pressure ulcer on the trunk or pelvis. (diagnosis must reflect)
Impaired nutritional status [yes] or [no]
Fecal or urinary incontinence? [yes] or [no]
Altered sensory perception? [yes] or [no]
Compromised Ciculatory status? [yes] or [no]

Physician Signature _____ Date _____

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Medicare Criteria **Group II Support Surfaces**

A group 2 support surface **is covered if the patient meets**:

a. Criterion 1 and 2 and 3, **or**
b. Criterion 4, **or**
c. Criterion 5 **and** 6.

1. The patient has multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02 -707.05), **and**

2. Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface, **and**

3. The ulcers have worsened or remained the same over the past month, **or**

4. The patient has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02 -707.05), **or**

5. The patient had a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) (ICD-9 707.02 - 707.05), **and**

6. The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

The comprehensive ulcer treatment described in #2 above should generally include:

- Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
- Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer).
- Appropriate turning and positioning.
- Appropriate wound care (for a stage II, III, or IV ulcer).
- Appropriate management of moisture/incontinence.
- Nutritional assessment and intervention consistent with the overall plan of care.

If the patient is on a group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements. The support surface provided for the patient should be one in which the patient does not "bottom out".

When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

Group 2 Support Surface

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PATIENT: Name
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Policy

DIAGNOSIS

ICD-9 Code	Description

EQUIPMENT/SERVICES

Qt	Proc. Code	Item Name/Narrative	Charge	Allow
1	E0277	POWERED PRESSURE-REDUCING AIR MATTRESS: Low Air Loss / Alternating Air Pressure	990.00	636.05

ADDITIONAL MEDICAL INFORMATION

Does the patient have multiple stage II pressure ulcers located on the trunk or pelvis (ICD.9 707.02-707.05)? [yes] or [no]
Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate Group 1 support surface? [yes] or [no] Who is the wound care nurse?_____ ph#_____
Have the patients ulcers worsened or remained the same in the last month? [Worsend] or [Same]
Does the patient have large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD.9 707.02-707.05)? [yes] or [no]
Within the past 60-days, has the patient had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis?[yes] or [no]
Within the past 30-days, was the patient on a Group 2 or 3 support surface prior to discharge from a hospital or nursing home?[yes] or [no]

Physician Signature _____ Date _____

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Medicare Criteria **Manual Wheelchairs**

A manual wheelchair is covered if:

a. **Criteria A, B, C, D, and E are met; AND**
b. **Criterion F or G is met.**

Additional coverage criteria for specific devices are listed below:

A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

   1. Prevents the beneficiary from accomplishing an MRADL entirely, **or**
   2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; **or**
   3. Prevents the beneficiary from completing an MRADL within a reasonable time frame.

B. The beneficiary's **mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.**

C. The beneficiary's **home provides adequate access between rooms, maneuvering space, and surfaces** for use of the manual wheelchair that is provided.

D. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate **in MRADLs** and the beneficiary will use it on a regular basis in the home.

E. The beneficiary has **not** expressed **an unwillingness to use the manual wheelchair** that is provided in the home.

F. The beneficiary **has sufficient upper extremity function** and other **physical and mental capabilities needed to safely self-propel** the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

G. The beneficiary **has a caregiver** who is available, willing, and able to provide assistance with the wheelchair.

Standard Wheelchair

Lightweight Wheelchair

Wheelchair Manual

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Length of Need (in months)
Policy

DIAGNOSIS

ICD-9 Code	Description

EQUIPMENT/SERVICES

☑ Qty	Proc. Code	Item Name/Narrative	Charge	Allow
☐ 1	K0001	Wheelchair Manual (Specify Size)	57.21	57.21
☐ 1	E2611	Wheelchair Back Cushion	440.00	335.50
☐ 1	E2601	Wheelchair Seat Cushion	27.16	27.16

ADDITIONAL MEDICAL INFORMATION

Does the patient have a mobility limitation which impairs daily living activities? [yes] or [no]
Can the mobility deficit be resolved using a cane, crutches, or walker? [yes] or [no]
Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair [YES] or [NO]
Will the use of a manual wheelchair significantly improve the patients ability to participate in MRADL? Will the patient use the wheelchair regularly in the home? [yes] or [no]
Has the patient expressed an unwillingess to use the manual wheelchair that will be provided in the home? [yes] or [no]
The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. [YES] or [NO]
Does the patient have a caregiver who is available, willing and able to provide assistance with the wheelchair[YES]or[NO]
Can the patient safely self propel a standard weight wheelchair?[YES]or[NO] Can the patient safely self propel a Lightweight wheelchair? [YES] or [NO]
How many hours will the client spend in the wheelchair each day:_____

Physician Signature _____ Date _____

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Medicare Criteria **Basic Cushion**

A general use seat cushion (gel cushion, curve cushion) and a general use wheelchair back **cushion are covered for a patient who has a manual wheelchair or a power wheelchair with a sling/solid seat/back which meets Medicare coverage criteria**. If the patient does not have a covered wheelchair, then the cushion will be denied as not reasonable and necessary. If the patient has a POV or a power wheelchair with a captain's chair seat, it will be denied as not reasonable and necessary.

Foam Cushion

Gel Cushion

Rigid Back Cushion

Foldable Back Cushion

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Medicare Criteria **Combination Cushion**

A **skin protection seat cushion** is covered for a patient who meets **both** of the following criteria:

1. The patient has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the patient meets Medicare coverage criteria for it; **and**
2. The patient has either of the following:

   - Current pressure ulcer (ICD-9-CM codes 707.03, 707.04, 707.05) **or**
   - Past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface **or**
   - Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1)
   - Other spinal cord disease (336.0-336.3)
   - Multiple sclerosis (340)
   - Other demyelinating disease (341.0-341.9)
   - Cerebral palsy (343.0-343.9)
   - Anterior horn cell diseases including:
     - Amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9)
     - Post polio paralysis (138)
     - Traumatic brain injury resulting in quadriplegia (344.09
     - Spina bifida (741.00-741.93)
     - Childhood cerebral degeneration (330.0-330.9)
     - Alzheimer's disease (331.0)
     - Parkinson's disease (332.0)
     - Muscular dystrophy (359.0, 359.1)
     - Hemiplegia (342.00 – 342.92, 438.20-438.22)
     - Huntington's chorea (333.4)
     - Idiopathic torsion dystonia (333.6)
     - Athetoid cerebral palsy (333.71).

Skin Protection &
Skin Protection with
Positioning Cushions

A **positioning seat cushion** (E2605,E2606), positioning back cushion (E2613-E2616, E2620, E2621), and positioning accessory (E0955-E0957, E0960) is covered for a patient who meets both of the following criteria:

1. The patient has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the patient meets Medicare coverage criteria for it; and
2. The patient has any significant postural asymmetries that are due to one of the diagnoses listed in criterion 2b above or to one of the following diagnoses: monoplegia of the lower limb (344.30-344.32, 438.40-438.42) due to stroke, traumatic brain injury, or other etiology, spinocerebellar disease (334.0-334.9), above knee leg amputation (897.2-897.7), osteogenesis imperfecta (756.51), transverse myelitis (323.82).

A **combination skin protection and positioning seat cushion** (E2607, E2608, E2624, E2625) is covered for a patient who meets the criteria for both a skin protection seat cushion and a positioning seat cushion.

Skin Protection Cushion V2

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PATIENT: Name
Address
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Revised Date
Recertification

PHYSICIAN: Name
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UPIN NPI
Phone Fax

Length of Need (in months)
Policy

DIAGNOSIS

ICD-9 Code	Description

EQUIPMENT/SERVICES

Qty	Proc. Code	Item Name/Narrative	Charge	Allow
1	E2622	Skin Protection Seat Cushion	356.03	356.03

ADDITIONAL MEDICAL INFORMATION

Does the patient have a Manual or Power wheelchair and Meet Medicare coverage criteria? [yes] or [no]
Does this patient have a current pressure ulcer (707.03, 707.04, 707.05) or past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface? [yes] or [no] OR
Does this patient have absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses:
post polio paralysis (138), childhood cerebral degeneration (330.0-330.9), Alzheimer's disease (331.0), Parkinson's disease (332.0), Huntington's chorea (333.4), idiopathic torsion dystonia (333.6), athetoid cerebral palsy (333.71), anterior horn cell diseases including amyotrophic lateral sclerosis (335.0 335.21, 335.23 335.9), other spinal cord disease (336.0 336.3), multiple sclerosis (340),
(diagnosis continued) other demyelinating disease (341.0-341.9), hemiplegia (342.00-342.92, 438.20-438.22), cerebral palsy (343.0-343.9), spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1), traumatic brain injury resulting in quadriplegia (344.09), muscular dystrophy (359.0, 359.1), spina bifida (741.00-741.93). [yes] or [no]

Physician Signature Date

Combination Cushion Skin Protection and Positioning

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PHYSICIAN: Name
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UPIN NPI
Phone Fax

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Initial Date
Revised Date
Recertification

Length of Need
(in months)
Policy

DIAGNOSIS

ICD-9 Code	Description

EQUIPMENT/SERVICES

Qty	Proc. Code	Item Name/Narrative	Charge	Allow
1	E2624	Combination Cushion: Skin Protection and Positioning	358.96	358.96

ADDITIONAL MEDICAL INFORMATION

Does the patient have a Manual or Power wheelchair and Meet Medicare coverage criteria? (must have chart notes in the file) [yes] or [no]
Does this patient have a current pressure ulcer (707.03, 707.04, 707.05) or past history of a pressure ulcer on the area of contact with the seating surface? [yes] or [no]
Does this patient have absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia. other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, Alzheimers, Parkinson's, or muscular dystrophy [yes] or [no]
Does the patient has any significant postural asymmetries that are due to one of the diagnoses listed in criterion above or to one of the following diagnoses: monoplegia of the lower limb (344.30-344.32, 438.40-438.42) or hemiplegia,due to stroke, traumatic brain injury, or other etiology, torsion dystonias,spinocerebellar disease (334.0-334.9)? [yes] or [no]

Physician Signature Date

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Medicare Criteria **Walker**

A **standard walker** and related accessories are covered if **all** of the following criteria (1-3) are met:

1. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home.

   A mobility limitation is one that:

   a. Prevents the patient from accomplishing the MRADL entirely, **or**
   b. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, **or**
   c. Prevents the patient from completing the MRADL within a reasonable time frame; **and**

2. The patient is able to safely use the walker; and
3. The functional mobility deficit can be sufficiently resolved with use of a walker.

This applies to both front and four wheel walkers.

Front Wheel Walker

Four Wheel Walker

Walker CMN

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PATIENT: Name
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(in months)
Policy

DIAGNOSIS

ICD-9 Code Description

EQUIPMENT/SERVICES

☑	Qty	Proc. Code	Item Name/Narrative
☐	1	E0143	Walker, Folding with wheels
☐	1	E0156	Walker Seat

ADDITIONAL MEDICAL INFORMATION

Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home? [Y] [N]
Is the patient able to safely use the walker? [Y] [N]
Does the patient require greater stability than can be provided with a cane or crutches? [Y] [N]
Can the functional mobility defiict be resolved with the use of a walker? [Y] [N]
Does the patient weight exceed 300 lbs? [Y] [N]
If yes above, what is the patient's weight? _____ lbs.
Does the patient have a severe neurologic disorder or other condition causing the restricted use of one hand? [Y] [N]

Physician Signature Date

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Medicare Criteria **Patient Lifts**

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

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

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

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

Patient Lift

Sit to Stand Lift

Electric Patient Lift

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DIAGNOSIS

ICD-9 Code	Description

EQUIPMENT/SERVICES

☑	Qty	Proc. Code	Item Name/Narrative	Charge	Allow
☐	1	E0630	Patient Lift, Hydraulic	109.43	109.43
☐	1	E0630	Patient Lift, Sit-to-Stand Hydraulic	150.00	109.43

ADDITIONAL MEDICAL INFORMATION

Does the patient require transfer between bed and chair, wheelchair or commode? [yes] or [no]
Will the patient be bed confined without the use of a lift? [yes] or [no]
HT_____ WT_____

Physician Signature _____ Date _____

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Medicare Criteria **Lift Chairs**

A **seat lift mechanism** is covered if **all of the following criteria are met**:

1. The patient must have **severe arthritis of the hip or knee** or **have a severe neuromuscular disease**.

2. The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the patient's condition.

3. The **patient must be completely incapable of standing up from a regular armchair or any chair in their home. (The fact that a patient has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism**. Almost all patients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.)

4. **Once standing**, the patient must have the **ability to ambulate**.

Coverage of seat lift mechanisms is limited to those types which operate smoothly, can be controlled by the patient, and effectively assist a patient in standing up and sitting down without other assistance. Excluded from coverage is the type of lift which operates by spring release mechanism with a sudden, catapult-like motion and jolts the patient from a seated to a standing position.

The physician ordering the seat lift mechanism must be the treating physician or a consulting physician for the disease or condition resulting in the need for a seat lift. The physician's record must document that all appropriate therapeutic modalities (e.g., medication, physical therapy) have been tried and failed to enable the patient to transfer from a chair to a standing position.

Form Approved
OMB No. 0938-0679

DME 07.03A

CERTIFICATE OF MEDICAL NECESSITY
CMS-849 — SEAT LIFT MECHANISMS

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER
_____ _____ _____ (__ __ __) __ __ __ - __ __ __ __ HICN _____	Bellevue Healthcare _____ _____ (__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____

PLACE OF SERVICE_____	HCPCS CODE	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____(lbs.)
NAME and ADDRESS of FACILITY if applicable (see reverse)	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN _____ _____ _____ (__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #_____

SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (Circle Y for Yes, N for No, or D for Does Not Apply)
Y N D	1. Does the patient have severe arthritis of the hip or knee?
Y N D	2. Does the patient have a severe neuromuscular disease?
Y N D	3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?
Y N D	4. Once standing, does the patient have the ability to ambulate?
Y N D	5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed? If YES, this is documented in the patient's medical records.

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER:_____

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory , and option. (see instructions on back)

SECTION D PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____ DATE _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

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Medicare Criteria **Home Oxygen**

Home oxygen therapy is reasonable and necessary **only if all of the following conditions are met**:

1. The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The beneficiary's blood gas study meets the criteria stated below, **and**
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, **and**
4. The qualifying blood gas study was obtained under the following conditions:
    - If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, **or**
    - If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the beneficiary is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, **and**
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

In this policy, the term blood gas study refers to either an oximetry test or an arterial blood gas test.

Group I criteria include any of the following:

1. An arterial PO_2 at or below 55 mmHg or an arterial oxygen saturation at or below 88 percent taken at rest (awake), **or**
2. An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a beneficiary who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake, **or**
3. A decrease in arterial PO_2more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent from baseline saturation, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia, **or**
4. An arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a beneficiary who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the beneficiary was breathing room air.

Initial coverage for beneficiaries meeting Group I criteria is limited to 12 months or the physician-specified length of need, whichever is shorter. (Refer to the Certification section for information on recertification).

Oxygen Concentrator

Oxygen Tank & Regulator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY
CMS-484 — OXYGEN

DME 484.03

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and INSURANCE NUMBER
NAME: _____
ADDRESS: _____
_____
(__ __ __) __ __ __ - __ __ __ __ INS. ID #: _____

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER
BT-CMN200
Bellevue Healthcare
_____
_____
(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____

PLACE OF SERVICE 12

HCPCS CODE
E1390

PT DOB ____/____/____ Sex ____ (M/F)

NAME and ADDRESS of FACILITY if applicable (see reverse)

PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI #
NAME: _____
ADDRESS: _____
_____
(__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #_____

SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1–99 (99=LIFETIME)

DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1–9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
a)_____mm Hg b)_____% c)____/____/____	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test; (c) date of test.
1 2 3	2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
Y N D	4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.
_____LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X".
a)_____mm Hg b)_____% c)____/____/____	6. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
	ANSWER QUESTIONS 7-9 ONLY IF PO2 = 56–59 OR OXYGEN SATURATION = 89 IN QUESTION 1
Y N	7. Does the patient have dependent edema due to congestive heart failure?
Y N	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N	9. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions on back.)

E1390	Concentrator 5 Liter	176.06	176.06

SECTION D Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

BellevueHealthcare

Medicare Criteria **Commodes**

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

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

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

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

Commode chair with seat lift mechanism is covered if the patient has medical necessity for a commode and meets the coverage criteria for a seat lift. However, a commode with seat lift mechanism is intended to allow the patient to walk after standing. If the patient can ambulate, he/she would rarely meet the coverage criterion for a commode.

3-in 1 Commode

Bariatric Commode

Bedside Commode

PROVIDER: Bellevue Healthcare
www.bellevuehealthcare.com

PHYSICIAN: Name
Address
UPIN NPI
Phone Fax

PATIENT: Name
Address
Phone
DOB
Initial Date
Revised Date
Recertification

Length of Need
(in months)
Policy

DIAGNOSIS

ICD-9 Code	Description

EQUIPMENT/SERVICES

Qty	Proc. Code	Item Name/Narrative	Charge	Allow
1	E0163	Commode Bedside 3 in 1	120.00	118.46

ADDITIONAL MEDICAL INFORMATION

Is the Patient confined to a room without toileting facilities? [yes] or [no]
Is the Patient confined to a single floor without bathroom facilities? [yes] or [no]
Is the patient confined to a home in which there are no toilet facilities? [yes] or [no]
Does the patient require an extra wide/heavy duty commode chair (E0168) because the patient weighs 300lbs or more? [yes] or [no] Patient weight? _____
Does the patient require a bedside commode with detachable arms (E0165) to facilitate transferring of the patient or does the patient's body configuration require extra width? [yes] or [no]

Physician Signature Date

BellevueHealthcare

At Bellevue Healthcare,

it is our mission to enhance the quality of life for people who need medical equipment by providing excellent products and unmatched service. We serve with honesty, integrity and reliability. Through each interaction with Bellevue Healthcare, our clients know we care.

Locations

Bellevue
P: 425-451-2842
F: 425-467-6661

Bellingham
P: 360-527-0475
F: 360-527-0477

Bremerton
P: 360-373-3600
F: 360-373-3660

Coeur d'Alene, ID
P: 208-676-1768
F: 208-665-9630

Everett
P: 425-258-6700
F: 425-258-6710

Kennewick
P: 509-586-2778
F: 509-585-2777

Lacey
P: 360-438-2955
F: 360-438-2112

Portland, OR
P: 503-659-1270
F: 503-659-1520

Pullman
P: 509-339-4754
F: 509-436-1582

Redmond
P: 425-451-2842
F: 425-467-6661

Seattle
P: 206-724-0033
F: 206-388-0033

Sequim
P: 360-681-0111
F: 360-681-2444

Spokane
P: 509-532-7779
F: 509-532-1088

Tacoma
P: 253-274-8500
F: 253-274-8501

Wenatchee
P: 509-662-8700
F: 509-662-8715

Yakima
P: 509-452-3700
F: 509-452-3701