Medical Documentation Requirements for DME

Walker

A standard walker (E0130, E0135, E0141, E0143) and related accessories are covered if all of the following criteria (1-3) are met:

1. The beneficiary 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. A mobility limitation is one that:
        i. Prevents the beneficiary from accomplishing the MRADL entirely, or
        ii. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, or
        iii. Prevents the beneficiary from completing the MRADL within a reasonable time frame; and
    b. The beneficiary is able to safely use the walker; and
    c. The functional mobility deficit can be sufficiently resolved with use of a walker.

If all of the criteria are not met, the walker will be denied as not reasonable and necessary.

A heavy duty walker (E0148, E0149) is covered for beneficiaries who meet coverage criteria for a standard walker and who weigh more than 300 pounds. If an E0148 or E0149 walker is provided and if the beneficiary weighs 300 pounds or less, it will be denied as not reasonable and necessary.

Leg extensions (E0158) are covered only for patients 6 feet tall or more.

Sample Documentation to be noted in chart:

Due to current medical condition of _____ the patient has a mobility limitation that prevents them from completing within a reasonable time frame (or at all) one of more MRADL in the home (MRADL includes toileting, feeding, dressing, grooming, and bathing). The patient is able to use the walker safely, and the functional mobility deficit can be sufficient resolved with the use of a walker.

Cane

Canes (E0100, E0105) and crutches (E0110, E0111, E0112, E0113, E0114, and E0116) are covered if all of the following criteria (1-3) are met:

1. The beneficiary 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.

The MRADLs to be considered in this and all other statements in this policy are toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home.

A mobility limitation is one that:

a. Prevents the beneficiary from accomplishing the MRADL entirely, or,

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

And,

2. The beneficiary is able to safely use the cane or crutch; and,
3. The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

If all of the criteria are not met, the cane or crutch will be denied as not reasonable and necessary.

Sample Documentation to be noted in chart:

Due to current medical condition of _____ the patient has a mobility limitation that prevents them from completing within a reasonable time frame (or at all) one or more MRDADL in the home (MRADL including toileting, feeding, dressing, grooming, and bathing). The patient is able to use the cane safely, and the functional mobility deficit can be sufficiently resolved with the use of a cane.

Wheelchair

A manual wheelchair for use inside the home (E1037, E1038, E1039, E1161, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0008, and K0009) is covered if:

- Criteria A, B, C, D, and E are met; and
- Criterion F or G is met.

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.

AND

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.

OR

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

If the manual wheelchair is only used outside the home, it will be denied as non-covered.

A transport chair (E1037, E1038 or E1039) is covered as an alternative to a standard manual wheelchair (K0001) and if basic coverage criteria A-E and G above are met.

A standard hemi-wheelchair (K0002) is covered when the beneficiary requires a lower seat height (17" to 18") because of short stature or to enable the beneficiary to place his/her feet on the ground for propulsion.

A lightweight wheelchair (K0003) is covered when a beneficiary meets both criteria (1) and (2):

1. Cannot self-propel in a standard wheelchair in the home; and
2. The beneficiary can and does self-propel in a lightweight wheelchair.

A high strength lightweight wheelchair (K0004) is covered when a beneficiary meets the criteria in (1) or (2):

1. The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.
2. The beneficiary requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

A high strength lightweight wheelchair is rarely reasonable and necessary if the expected duration of need is less than three months (e.g., post-operative recovery)

A heavy duty wheelchair (K0006) is covered if the beneficiary weighs more than 250 pounds or the beneficiary has severe spasticity.

An extra heavy duty wheelchair (K0007) is covered if the beneficiary weighs more than 300 pounds.

Sample Documentation to be notes in chart:

- *Standard Wheelchair (K0001)*
    - *Due to current medical condition of _____ the patient's mobility limitation prevents them from completing within a reasonable time frame (or at all) one or more MRADL in the home (MRADL includes toileting, feeding, dressing, grooming, and bathing). This mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted*

cane or walker. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary not expressed an unwillingness to use it and will use it on a regular basis in the home.
AND
The beneficiary has a sufficient upper extremity function and other physical and mental capabilities need to safely self-propel the manual wheelchair that is proved in the home during typical day
OR
The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

- *Light Weight Wheelchair (K0003)*
  - *(Same language as standard wheelchair, plus below)*
    Patient cannot self-propel in a standard wheelchair in the home; and the beneficiary can and does self-propel in a lightweight wheelchair.

- *High Strength Light Weight Wheelchair (K0004)*
  - *(Same language as standard wheelchair, plus below)*
    The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.

Beside Commode

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

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

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

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

A raised toilet seat is not covered by Medicare. If the commode chair is used as a raised toilet seat by positioning it over the existing commode it is also non-covered.

Sample documentation to be noted in chart:

- *Due to current medical condition of _____ the patient is incapable of utilizing regular toilet facilities because the patient is confined to a single room.*

Hospital Bed

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.

Sample Documentation to be noted in chart:

- *Fixed Height Bed (E0250)*
  - *Due to current medical condition of _____ the patient requires positing of the body in way not feasible with an ordinary bed.*
- *Variable Height Bed (E0255)*
  - *Due to current medical condition of _____ the patient requires positioning of the body in ways not feasible with an ordinary bed. Patient requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.*

- *Semi-Electric Bed (E0260)*
    - *Due to current medical condition of _____ the patient requires positioning of the body in ways not feasible with an ordinary bed. Patient requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position. The patient also requires frequent changes in body position due to their condition.*

Trapeze

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.

Oxygen

Initial coverage of home oxygen therapy and oxygen equipment is reasonable and necessary for Groups I and II if all of the following conditions are met:

Group I:

1. The treating practitioner has ordered and evaluated (signed off on or documented in pt's signed medical record) the results of a qualifying blood gas study performed at the time of need*; and,
2. The beneficiary's blood gas study meets the criteria stated below (evidence of a study must be documented in the medical records; on prescription only is insufficient); and,
    A. Oxygen saturation at or below 88% (or PO^2 55mm Hg) taken at rest (awake) while breathing room air; or,
    B. Oxygen saturation at or below 88% (or PO^2 55mm Hg) taken during sleep for a beneficiary who demonstrates an oxygen saturation at or above 89 percent (or PO^2 56mm Hg) while awake; or,
    C. A decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent from baseline saturation, taken during sleep and associated with symptoms of hypoxemia such as impairment of cognitive processes and nocturnal restlessness or insomnia (not all inclusive)
    D. Oxygen saturation at or below 88% (or PO^2 55mm Hg) taken during exercise.
    This study MUST include all 3 parts and be documented in patient's chart:
        1. Test at rest without oxygen (89% or greater)
        2. Test during exercise without oxygen (at or below 88%)
        3. Test during exercise with oxygen applied (to demonstrate improvement of the hypoxemia).
3. The qualifying blood gas study was performed by a treating practitioner or by a qualified provider or supplier of laboratory services; and,
4. The provision of oxygen and oxygen equipment in the home setting will improve the beneficiary's condition.

*Time of need is defined as during the patient's illness when the presumption is that the provision of oxygen will improve the patient's condition in the home setting. For an inpatient hospital patient anticipated to require oxygen upon going home, the time of need would be within 2 days of discharge

Group II:

A. Oxygen saturation of 89 percent (or PO^2 56-59mm Hg); and,
B. Any of the following:
    1. Dependent edema suggesting congestive heart failure; or,
    2. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or,
    3. Erythrocythemia with a hematocrit greater than 56 percent.

Oxygen dispensing order must state:

- What is being dispensed – Oxygen
- The liter flow per minute – 2LPM (example)
- Method of delivery – Via nasal cannula (example)
- Usage – Continuous or Nocturnal (PRN is non-covered)

Example dispensing order: "O2 @ 2LPM via nasal cannula continuous"

To setup an O2 referral we need:

- Dispensing order (as outlined above)
- Oxygen saturation study (as outlined above) documented in the medical record; on prescription only is insufficient.
- Medical records/chart notes referencing need for oxygen

Negative Pressure Wound Therapy (NPWT)

A Negative Pressure Wound Therapy pump (E2402) and supplies (A6550, A7000) are covered when either criterion A or B is met:

A. Ulcers and Wounds in the Home Setting:
The beneficiary has a chronic Stage 3 or 4 pressure ulcer (see Appendices Section), neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology. A complete wound therapy program described by criterion 1 and criteria 2, 3, or 4, as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT.

1. For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT:
    a. Documentation in the beneficiary's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
    b. Application of dressings to maintain a moist wound environment, and
    c. Debridement of necrotic tissue if present, and
    d. Evaluation of and provision for adequate nutritional status

2. For Stage 3 or 4 pressure ulcers:
    a. The beneficiary has been appropriately turned and positioned, and
    b. The beneficiary has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see LCD on support surfaces), and
    c. The beneficiary's moisture and incontinence have been appropriately managed
3. For neuropathic (for example, diabetic) ulcers:
    a. The beneficiary has been on a comprehensive diabetic management program, and
    b. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities
4. For venous insufficiency ulcers:
    a. Compression bandages and/or garments have been consistently applied, and
    b. Leg elevation and ambulation have been encouraged

B. Ulcers and Wounds Encountered in an Inpatient Setting:
1. An ulcer or wound (described under A above) is encountered in the inpatient setting and, after wound treatments described under A-1 through A-4 have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating practitioner, the best available treatment option.
2. The beneficiary has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the beneficiary that will not allow for healing times achievable with other topical wound treatments).

OTHER EXCLUSIONS FROM COVERAGE:

A NPWT pump and supplies will be denied at any time as not reasonable and necessary if one or more of the following are present:

- The presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
- Osteomyelitis within the vicinity of the wound that is not concurrently being treated with intent to cure;
- Cancer present in the wound;
- The presence of an open fistula to an organ or body cavity within the vicinity of the wound.

Medical Documentation Requirements for DME

CONTINUED COVERAGE:

C. For wounds and ulcers described under A or B above, once placed on a NPWT pump and supplies, in order for coverage to continue, a licensed medical professional must do the following:
    1. On a regular basis,
        a. Directly assess the wound(s) being treated with the NPWT pump, and
        b. Supervise or directly perform the NPWT dressing changes, and
    2. On at least a monthly basis, document changes in the ulcer's dimensions and characteristics.

If criteria C-1 and C-2 are not fulfilled, continued coverage of the NPWT pump and supplies will be denied as not reasonable and necessary.

WHEN COVERAGE ENDS:

D. For wounds and ulcers described under A or B above, a NPWT pump and supplies will be denied as not reasonable and necessary with any of the following, whichever occurs earliest:
    1. Criteria C1-C2 cease to occur,
    2. In the judgment of the treating practitioner, adequate wound healing has occurred to the degree that NPWT may be discontinued,
    3. Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound
    4. **4 months** (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using a NPWT pump in the treatment of the most recent wound
    5. Once equipment or supplies are no longer being used for the beneficiary, whether or not by the treating practitioner's order

SUPPLIES:

Coverage is provided up to a maximum of **15 dressing kits** (A6550) per wound per month.

Coverage is provided up to a maximum of **10 canister sets** (A7000) per month unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day).

To setup a NPWT referral we need:

- Prescription with pressure setting
- Wound measurements
- Medical records justifying need for equipment (as outlined above; including previous treatments attempted)

ENTERAL NUTRITION

Enteral nutrition is covered for a beneficiary who requires feedings via an enteral access device to provide sufficient nutrients to maintain weight and strength commensurate with the beneficiary's overall health status and has a permanent:

A. full or partial non-function or disease of the structures that normally permit food to reach the small bowel; OR,
B. disease that impairs digestion and/or absorption of an oral diet, directly or indirectly, by the small bowel.

Coverage of enteral nutrition requires that a beneficiary must have a permanent impairment. However, this does not require a determination that there is no possibility that the beneficiary's condition may improve sometime in the future. If the medical record, including the judgment of the treating practitioner, indicates that the impairment will be of long and indefinite duration, the test of permanence is considered met.

Adequate nutrition must not be possible by dietary adjustment and/or oral supplements

Typical examples of conditions associated with non-function or disease of the structures that permit food from reaching the small bowel that qualify for coverage are head and neck cancer with reconstructive surgery and central nervous system disease leading to interference with the neuromuscular mechanisms of ingestion of such severity that the beneficiary cannot be maintained with oral feeding (not all inclusive).

Typical examples of conditions associated with impaired digestion and/or absorption of an oral diet by the small bowel that may qualify for coverage include inflammatory bowel disease, surgical resection of small bowel, cystic fibrosis, chronic pancreatitis, and advanced liver disease (not all inclusive).

NON-COVERED:

- Enteral nutrition for temporary impairments
- Enteral nutrition for beneficiaries with a functioning gastrointestinal tract whose need for enteral nutrition is not due to reasons related to the non-function or disease of the structures that normally permit food to reach the small bowel
- Orally administered enteral nutrition products, related supplies and equipment

NUTRIENTS:

Enteral formulas consisting of semi-synthetic intact protein/protein isolates (B4150 or B4152) are appropriate for the majority of beneficiaries requiring enteral nutrition.

The medical necessity for special enteral formulas (B4149, B4153, B4154, B4155, B4157, B4161, and B4162) must be justified in each beneficiary. If a special enteral nutrition formula is provided and if the medical record does not document why that item is medically necessary, it will be denied as not reasonable and necessary.

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EQUIPMENT AND SUPPLIES:

Enteral nutrition may be administered by syringe, gravity, or pump. Some enteral beneficiaries may experience complications associated with syringe or gravity method of administration.

If a pump (B9002) is ordered, there must be documentation in the beneficiary's medical record to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding). If the medical necessity of the pump is not documented, the pump will be denied as not reasonable and necessary.

Order must include:

- Beneficiary's name
- Description or name of nutrient to be administered
- Quantity to be dispensed (Should correspond with the total amount of each item to be provided per refill. This information may be expressed as can, bottles/bags, cases, or billing units (1 unit=100 calories)
- General description of the other item(s) (ex. bags, syringes, iv pole, pump, feeding tube)
- Treating Practitioner Name or NPI
- Treating Practitioner's signature
- Order date

To set up an enteral referral we need:

- Order (as outlined above)
- Medical records
    - Must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items order and for the frequency of use or replacement. Beneficiary must have a permanent impairment. The information should include the beneficiary's diagnosis and other pertinent information including, but not limited to, duration of the beneficiary's condition, clinical course (worsening or improvement, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.