ACCREDITED
Medical Equipment & Supply

MEDICARE ONLY
Durable Medical Equipment
Qualifications Guidelines

Reference Guide For:

- *Medicare Competitive Bid Options*
- *Medicare Non-Competitive Bid Options*
- *AMES Contracted Items*
- *AMES Non-Contracted Items*
- *Medicare Requirements on Face-to-Face Evaluations*

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Accredited Medical ***Contracted*** LOS ANGELES COUNTY ONLY

Accredited Medical *will contract out* LOS ANGELES COUNTY ONLY

††† Requires Face-to-Face evaluation within 6 months prior of dispensing item (Effective Date TBD in 2014)

Medicare Competitive Bid Items Only Apply to Los Angeles County for Accredited Medical Equipment

Standard & Semi-Electric HOSPITAL BEDS

Medicare Competitive Bid Item -- Accredited Medical Equipment Contracted
LOS ANGELES COUNTY ONLY

Qualification Guidelines:

SEMI-ELECTRIC HOSPITAL BED - manual height adjustment with electric head & leg elevation adjustments

Covered if one or more of the following items four are documented in patient's medical record,

1. Patient requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30° does not usually require the use of a hospital bed; **OR**
2. Patient requires positioning of the body not feasible with an ordinary bed to alleviate pain, prevent contractures or avoid respiratory infections; **OR**
3. Patient requires head of bed elevation more than 30° most of the time due to CHF, COPD, or problems with aspiration; **OR**
4. Patient requires traction equipment, which can only be attached to a hospital bed **AND**
    A. Patient requires frequent changes in body position and/or has an immediate need for change in body position

BED RAILS (Half or Full Length) - 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.

TOTAL ELECTRIC BED - not a Medicare covered item

HI-LOW FULL ELECTRIC BED - not a Medicare covered item

Sample Documentation (Must be in physician progress note format & signed by physician):

"Patient suffers from orthopnea, secondary to severe CHF. She needs the HOB elevated more than 30 degrees and has tried wedge pillows with poor results. She is at high risk of pressure ulcers and needs to frequently change body positions. Ordering a semi-electric hospital bed for home."

Dispensing Requirements:

1. **Face-to-Face encounter from prescribing practitioner (signed by physician)**
    - Encounter must have been within 6 months prior of dispensing the item (documenting above)
    - Effective Date TBD in 2014
2. Documentation of the specific criteria listed above including related diagnoses
3. **Detailed Written Order (DWO)**
    a. Beneficiary Name
    b. Item
    c. Prescribing Practitioner NPI
    d. Prescribing Practitioner's Signature
    e. Date of the Order

PATIENT LIFT

Medicare NON-Competitive Bid Item

Qualification Guidelines:

Does the patient's medical condition meet the following criteria?

1. The patient requires transfer between bed and a chair; **AND**
2. The patient would be bed confined without a lift;

OR

3. The patient requires transfer between bed and a wheelchair; **AND**
4. The patient would be bed confined without a lift

Sample Documentation (Must be in physician progress note format & signed by physician):

"Patient's caregiver is here expressing increased difficulty transferring him in and out of bed to wheelchair. Patient would be bed confined without use of a lift. Will request a hoyer lift to aid in transfer safety."

Dispensing Requirements:

1. Chart Notes
2. Supporting Documentation
3. **Detailed Written Order (DWO)**
   a. Beneficiary Name
   b. Item
   c. Prescribing Practitioner NPI
   d. Prescribing Practitioner's Signature
   e. Date of the Order

MANUAL WHEELCHAIRS

Medicare Competitive Bid Item -- Accredited Medical Equipment Contracted
LOS ANGELES COUNTY ONLY

Qualification Guidelines:

Does the patient's medical condition meet the following criteria?

1. Patient has mobility limitation in the home that significantly impairs their ability to perform at least one Mobility Related ADL including:
   · Toileting · Dressing · Feeding ·Grooming · Bathing
2. Patient's mobility limitation(s) cannot be resolved by the use of a cane or walker
3. The patient has sufficient upper extremity function and other physical and mental capabilities to safely self-propel OR has a caregiver able and willing to provide assistance.
4. The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair provided.
5. The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home.
6. The patient will use the wheelchair regularly in the home.

Does the patient require a lightweight wheelchair?

- The patient is not able to self-propel a standard wheelchair (43 lbs), but is able to self-propel in a lightweight wheelchair (34 lbs).
- The patient spends at least 2 hours a day in the wheelchair.

Sample Documentation (Must be in physician progress note format & signed by physician):

"Patient is having increased difficulty getting around the home for things such as caring for himself and getting to restroom. This has worsened since his heart failure hospitalization. The cane is no longer sufficient so he is using a wheeled walker but he is getting too fatigued to go beyond 10'. Patient would benefit from a wheelchair which he could propel around the house."

Dispensing Requirements:

1. **Face-to-Face encounter from prescribing practitioner (signed by physician)**
   - Encounter must have been within 6 months (documenting above)
   - Effective Date TBD in 2014
2. PT/OT Evaluation to support qualification (recommended)
3. Qualifying Diagnoses
4. **Detailed Written Order (DWO)**
   a. Beneficiary Name
   b. Item
   c. Prescribing Practitioner NPI
   d. Prescribing Practitioner's Signature
   e. Date of the Order

POWERED MOBILITY DEVICES

Medicare Competitive Bid Item -- Accredited Medical Equipment Contracted
LOS ANGELES COUNTY ONLY

Qualification Guidelines:

Does the patient's medical condition meet the following criteria?

1. Mobility limitations that impairs his/her ability to perform Mobility Related ADL's in the home
2. Mobility limitations cannot be resolved sufficiently by the use of a cane or walker
3. Patient does not have sufficient upper or lower extremity function to self-propel a manual wheelchair

Face-to-Face Evaluation Requirements:

- Reason for visit is for mobility evaluation
- Symptoms that limit ambulation
- Diagnoses that are responsible for the symptoms
- Progression of ambulation difficulty
- Inability to perform mobility related ADL's in the home
- Why a cane or walker is not sufficient
- Why patient cannot adequately self-propel

Face-to-Face Evaluation Requirements:

- History of falls, including frequency and circumstances leading to falls
- Physical examination performed*
  - Strength Assessment
  - Range of motion

* Or refer to PT/OT for mobility evaluation

Dispensing Requirements:

1. **Face-to-Face notes with documentation listed above**
2. PT/OT Evaluation (recommended but not required)
3. 7- element prescription
4. Home evaluation (done by supplier)
5. Detailed product description
6. Other supporting medical records

WALKERS

Medicare Competitive Bid Item -- Accredited Medical Equipment Contracted
LOS ANGELES COUNTY ONLY

Qualification Guidelines:

Does the patient's medical condition meet the following criteria?

1. Patient has mobility limitations that significantly impairs their ability to participate in one or more Mobility Related ADL's
2. A cane will not sufficiently resolve the mobility limitation
3. Able to safely use a walker
4. The functional mobility deficit can be sufficiently resolved with the use of a walker

Sample Documentation (Must be in physician progress note format & signed by physician):

"Patient fell earlier this week while going from the kitchen to the bathroom. He was using his cane but it isn't accommodating him due to his unsteady gait. Will order a wheeled walker for safety in and around the home."

Dispensing Requirements:

1. Chart Notes
2. Supporting Documentation
3. **Detailed Written Order (DWO)**
   a. Beneficiary Name
   b. Item
   c. Prescribing Practitioner NPI
   d. Prescribing Practitioner's Signature
   e. Date of the Order

NEBULIZERS

Medicare NON-Competitive Bid Item

Qualification Guidelines:

If you prescribed one or more of the following medications to your patient, please make sure your ICD-9 code is between 491.0-508.09 :

- Albuterol
- Arformoterol
- Budesonide
- Oromolyn
- Formoterol
- Ipratropium
- Dunoeb
- Perforomist
- Pulmicort
- Xopenex
- Metaproterenol
- Levalbuterol

If you prescribed one of more of the following medications to your patient, please make sure your ICD-9 code is 277.02:

- Dornase Alpha

If you prescribed one of more of the following medications to your patient, please make sure your ICD-9 code is one or more of the following 277.02, 494.0, 494.1, 748.61, 011.50-011.56 :

- Tobramycin

If you prescribed one of more of the following medications to your patient, please make sure your ICD-9 code is one or more of the following 042, 136.3 996.80-996.89:

- Pentamidine

If you prescribed one of more of the following medications to your patient, please make sure your ICD-9 code is one or more of the following 480.0-508.9, 786.4:

- Acetylcysteine

Sample Documentation (Must be in physician progress note format & signed by physician):

"Patient's COPD is worsening and experiencing an increase in SOB even with the inhalers. Gave treatment with nebulizer with Duoneb in office and she responded well. Will request a home nebulizer unit for Duoneb treatments, TID."

Dispensing Requirements:

1. **Face-to-Face encounter from prescribing practitioner (signed by physician)**
   - Encounter must have occurred within 6 months prior of dispensing the item
   - Effective Date TBD in 2014
2. Medication List (including 1 or more of the medications listed above)
3. Qualifying Diagnoses
   ICD-9 between 491.0 - 508.9
4. **Detailed Written Order (DWO)**
   a. Beneficiary Name
   b. Item
   c. Prescribing Practitioner NPI
   d. Prescribing Practitioner's Signature
   e. Date of the Order

3-in-1 COMMODE

Medicare NON-Competitive Bid Item

Qualification Guidelines:

Does the patient's medical condition meet the following criteria?

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 is no toilet facilities in the home

* Contradictory ambulatory status, such as being able to ambulate with a walker or wheelchair, would disqualify for insurance reimbursement of a commode. If a change in ambulatory condition has occurred, this must be clearly documented to justify the need for coverage of a commode.

Sample Documentation (Must be in physician progress note format & signed by physician):

"Patient is non-ambulatory since her debilitating hospitalization and is confined to her bedroom, therefore she needs a bedside commode."

Dispensing Requirements:

1. Chart Notes
2. Supporting Documentation
3. **Detailed Written Order (DWO)**
   a. Beneficiary Name
   b. Item
   c. Prescribing Practitioner NPI
   d. Prescribing Practitioner's Signature
   e. Date of the Order

Medicare NON-Competitive Bid Item

Qualification Guidelines:

Does the patient's medical condition meet the following criteria?

1. Patient is completely immobile

OR

2. Limited mobility, OR any stage pressure ulcer on the trunk or pelvis, and has at least one:
   - Impaired nutritional status: (e.g. Severe Anemia, Insidious Weight Loss, Anorexia)
   - Fecal or urinary incontinence: (Documented in medical records)
   - Altered sensory perception: (e.g. Neurological Disorders)
   - Compromised circulatory status: (e.g. Cardiovascular Disorders, Respiratory Disorders)

Sample Documentation (Must be in physician progress note format & signed by physician):

"Patient being seen by nurse at home. Concerns of skin breakdown due to incontinence and her limited mobility require her to spend most of the time in bed. Will order pressure relieving mattress to prevent decub."

Dispensing Requirements:

1. **Face-to-Face encounter from prescribing practitioner (signed by physician)*****
   - Encounter must have been within 6 months prior of dispensing the item (documenting above)
   - Effective Date TBD in 2014

   ***GEL OVERLAY ONLY**

2. Qualifying Diagnoses
3. Statement of Ordering Physician (SOP) Required
   - Refer to page 9 for example

→

Once Accredited Medical Equipment receives your order for a support surface,
we will pre-fill this form with patient and physician information.

STATEMENT OF ORDERING PHYSCIAN
GROUP I SUPPORT SURFACE

Patient Name: Sample Patient

Address: _____

HIC# _____

Initial Date: _____

Diagnosis (ICD-9): _____

Group I Support Surface
Cost Information:

Medicare Allowable: $346.31

The Information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

Indicate which of the following conditions describe the patient (see below for qualifications). Circle all that apply. Criterion A, B, or C.

A) Criterion 1
OR
B) Criterion 2, and at least one of 4 through 7.
OR
C) Criterion 3, and at least one of 4 through 7.

#1,2 or 3 needs circling

1. Completely immobile - i.e., patient cannot independently make changes in body position without assistance.
2. Limited Mobility - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure.
   OR
3. Any pressure ulcer on the trunk or pelvis.

If 2 or 3 is circled, then one of 4-7 must be circled

And, one of the following:
4. Impaired nutritional status.
5. Fecal or urinary incontinence.
6. Altered sensory perception.
7. Compromised circulatory status.

*** The conditions circled on this form must be supported with accompanying medical records.

Estimated Length of Need: 99 99 = Lifetime

Physician Information

Name _____
Address _____
NPI # _____

Physician Signature: _____ Date: _____

** This completed and signed Statement of Ordering Physician must be received prior to dispensing the Group I Support Surface.

GROUP II SUPPORT SURFACES

Low Air Loss
High-End APP

Medicare Competitive Bid Item -- Accredited Medical Equipment NOT Contracted
AMES will facilitate ALL orders with contracted companies
LOS ANGELES COUNTY ONLY

Qualification Guidelines:

Does the patient's medical condition meet any of the following scenarios?

Scenario 1:

1. Multiple (2 or more) stage II pressure ulcers on the trunk or pelvis; AND
2. 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 (such as a Gel Overlay, Alternating Pressure Pad or Egg Crate)

Comprehensive Ulcer Treatment Program

A. Use of appropriate group 1 support surface documented and,
B. Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and
C. Appropriate turning and positioning, and
D. Appropriate wound care, and
E. Appropriate management of moisture/incontinence, and
F. Nutritional assessment and intervention consistent with overall plan of care

OR

Scenario 2:

1. Large or multiple stage III or IV pressure ulcers on the trunk of pelvis (Large = 8 sq. centimeters)

OR

Scenario 3:

1. Has had a recent myocutaneous flap or skin graft on the trunk or pelvis; **AND**
2. Recently been on a group 2 or 3 support surface immediately prior to a recent discharge from a

Sample Documentation (Must be in physician progress note format & signed by physician):

"Patient receiving wound care at home from chronic decub on sacral area and right gluteal fold. Both areas are struggling to heal and appear unchanged from last month - both decubs are stage II. I do not think the overlay is enough, even with frequent changes in position - will obtain an alternating air mattress to help this heal."

Dispensing Requirements:

1. Chart Notes
2. Wound Notes (within 30 days)*
   *Comprehensive Ulcer Treatment Program Included
3. Qualifying Diagnoses
   - → 707.02 - Pressure Ulcer, Upper Back
   - → 707.03 - Pressure Ulcer, Lower Back
   - → 707.04 - Pressure Ulcer, Hip
   - → 707.05 - Pressure Ulcer, Buttock
4. Statement of Ordering Physician (SOP) required
   - Refer to page 11 for example

→

Once Accredited Medical Equipment receives your order for a support surface, we will pre-fill this form with patient and physician information.

STATEMENT OF ORDERING PHYSCIAN
GROUP II SUPPORT SURFACE

Patient Name: Sample Patient

Address: _____

HIC# _____

Initial Date: _____

Diagnosis (ICD-9): _____

Power Pressure Reducing Mattress E0277
Cost Information:

Medicare Allowable: $656.51

The Information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

Indicate which of the following conditions describe the patient.
Circle Y for Yes, N for No, D for does not apply, unless otherwise noted.

If # 1 is YES, #2 must be YES

(Y) N D 1) Does the patient have multiple stage II pressure ulcers on the trunk or pelvis.

(Y) N D 2) Has the patient been on a comprehensive ulcer treatment program for the past month which has included the use of an alternating pressure or low air loss overlay which is less than 3.5 inches or a non-powered pressure reducing overlay or mattress?

#3 must have 2 or 3 circled

1 (2) 3 3) Over the past month, the patient's ulcer(s) has/have: 1) improved 2) remained the same 3) worsened

If # 1 & #2 are circled N or D, #4 must be YES

Y N D 4) Does the patient have a large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis.

Y N D 5) Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? If yes give date _____.

Y N D 6) Was the patient on an alternating pressure or low air loss mattress or bed or on a fluidized bed immediately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility?

Estimated Length of Need: (99) 99 = Lifetime

*** The conditions circled on this form must be supported with accompanying medical records.

Physician Information

Name _____
Address _____
NPI # _____

Physician Signature: _____ Date: _____

** This completed and signed Statement of Ordering Physician must be received prior to dispensing the Air Mattress.

PRIVATE PAY DISCOUNT PRICE GUIDE

20% Discount for all Medicare Beneficiaries that DO NOT qualify for item(s).

Payment MUST be received upfront prior to delivery.

Recipients MUST provide copy of valid Medicare card.

{ALL Rentals MUST have credit card on file}

Item	Monthly Rental Cost	Monthly w/ Medicare Card	Purchase Price	Purchase w/ Medicare Card
Semi-Electric Bed (5310)	$175.00	$140.00	$1,200.00	$960.00
Full Electric Bed (5410)	$190.00	$152.00	$1,350.00	$1,080.00
Hi-Low Bed (5410 Low)	$200.00	$160.00	$1,500.00	$1,200.00
Solace Mattress Replacement	$40.00	$32.00	$300.00	$240.00
Gel Overlay	$40.00	$32.00	$300.00	$240.00
Transport WC w/ footrests	$55.00	$44.00	$190.00	$152.00
Standard WC w/ footrests (EX2)	$60.00	$48.00	$275.00	$220.00
Lightweight WC w/footrests (9SL)	$80.00	$64.00	$437.50	$350.00
Leg Rests	$20.00	$16.00	$100.00	$80.00
Power Scooter	$275.00	$220.00	$1,400.00	$1,120.00
Walk-In Items PURCHASE ONLY at our Woodland Hills Showroom with valid proof of Medicare Card				
3-in-1 Commode		(Invacare 9630)	$100.00	$80.00
Front Wheeled Walker		(Invacare 6240)	$100.00	$80.00
4-Wheeled Walker		(Invacare 65650)	$190.00	$150.00