Sentara Health Plans

Medicaid

Hospital Beds and Accessories, DME 03

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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

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.

Support Surfaces, fall into 3 Categories:

Group I are defined as follows:

- **Pressure pads for Mattresses:** Code E0185 and codes E0197, E0198 and E0199, termed pressure pad for mattresses, represent nonpowered pressure reducing mattress overlays. These devices are designed to be placed on top of a standard hospital or home mattress.

    - A gel/gel-like mattress overlay (E0185) is characterized by a gel or gel-like layer with a height of 2 inches or greater.
    - An air mattress overlay (E0197) is characterized by interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump.
    - A water mattress overlay (E0198) is characterized by a filled height of 3 inches or greater.
    - A foam mattress overlay (E0199) is characterized by all of the following:
    - Base thickness of 2" or greater and either of the following:
        - Peak height of 3" or greater if it is a convoluted overlay (e.g., eggcrate)
        - Overall height of at least 3 inches if it is a non-convoluted overlay,
        - Foam with a density and other qualities that provide adequate pressure reduction, and
        - Durable, waterproof cover
- **Nonpowered Pressure Reducing Mattresses**: An air, water or gel mattress (E0186, E0187, and E0196) has the following characteristics:
    - Height of five or more inches of air, water or gel layer.
    - Durable, waterproof cover.
    - Can be placed directly on a hospital frame.
    - A foam mattress (E0184) has the following characteristics:
        - Height of five or more inches.
        - Foam of such density and other qualities that it provides adequate pressure reduction.
        - Durable, waterproof cover.
        - Can be placed directly on a hospital bed frame
- **Powered Pressure Reducing Mattress Overlay Systems**: Codes E0181, E0182 and A4640 represent powered pressure reducing mattress overlay systems (alternating pressure or low air loss) that have the following characteristics:
    - An air pump or blower provides either, sequential inflation and deflation of air cells or low interface pressure throughout the overlay.
    - The inflated cell height of the air cells through which air circulates is 2.5 inches or more.
    - The height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate individual lift, reduce pressure and prevent bottoming out.

Group II are defined as follows:

- **Powered Pressure Reducing Mattress**: Code E0277 stands for a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) that has the following characteristics:
    - An air pump or blower provides either sequential inflation and deflation of the air cells or low interface pressure throughout the mattress.
    - The inflated cell height of the air cells through which air circulates is five inches or more.
    - The height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating mattresses), and air pressure provides adequate individual lift, reduce pressure and prevent bottoming out.
    - The surface is designed to reduce friction and shear.
    - The surface can be placed directly on a hospital bed frame.
- Code E0193 (RR) describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all of the characteristics defined above. **NOTE:** This code is available for use as a rental option only.
- Code E0371 describes an advanced nonpowered pressure-reducing mattress overlay which is characterized by all of the following:
    - The height and design of the individual cells provide significantly more pressure reduction than a Group I overlay and prevent bottoming out.
    - The total height is three inches or more.
    - The surface is designed to reduce friction and shear.
    - There is documented evidence to substantiate that the product is effective in treating conditions described by the coverage criteria for Group II support surfaces.
- **Powered Pressure Reducing Mattress Overlay:** Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) with the following characteristics:

    - An air pump or blower provides either sequential inflation or deflation of the air cells or low interface pressure throughout the overlay.
    - The inflated cell height of the air cells through which air circulates is 3.5 inches or more.
    - The height of the air chambers, proximity of air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate individual lift, reduce pressure and prevent bottoming out.
    - The surface is designed to reduce friction and shear.
- **Advanced Nonpowered Pressure Reducing Mattress:** Code E0373 describes an advanced, manually powered pressure reducing mattress with the following characteristics:
    - The height and design of the individual cells provide significantly more pressure reduction than those in a Group I mattress and prevent bottoming out.
    - The total height is five inches or more.
    - The surface is designed to reduce friction and shear.
    - There is documented evidence in treating conditions described by the coverage criteria for Group II support surfaces.
    - The mattress can be placed directly on a hospital bed frame.

Group III pressure reducing support surfaces (E0194 RR, rental only), and are defined by **All** of the following characteristics:

- The bed employs circulation of the filtered air through silicone-coated ceramic beads, creating the characteristics of fluid.
- The bed consists of a tank filled with silicone-coated microsphere beads that resemble grains of sand.
- The tank is covered with a loose fitting bed sheet that separates the individual from the micro beads.
- Room air is drawn into the base unit, then filtered, heated and pushed into the tank through a diffuser board.
- The bed sheet moves freely underneath the individual. Usually, the individual sinks only 4-6 inches into the beads, and the pressure put on the skin is well below capillary closing pressure.
- The sheet is permeable to the downward flow of body fluids (e.g., wound drainage, urine, and perspiration). As body fluids come in contact with beads, the beads clump and drop to the bottom of the tank, where the alkaline environment kills the bacteria. The clumps are removed during routine maintenance.
- Individual transfers in and out of the bed may be difficult and, in most models, the head cannot be elevated.
- When airflow is turned off, the beads settle into a mold around the body, creating a support surface that stabilizes the individual for nursing care, wound cleaning and other care needs.

Criteria:

Hospital beds, accessories and pressure-reducing overlays and beds are considered medically necessary for **1 or more** of the following:

- A **fixed hospital bed** *(E0250, E0251, E0290, E0291, and E0328)* is considered medically necessary for **1 or more** of the following**:**
    - Individual's medical condition requires positioning of body in ways not feasible with ordinary bed, **OR**
    - Individual requires positioning of body in ways not feasible with ordinary bed in order to alleviate pain**, OR**
    - Individual requires head of 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 other justified medical conditions**, OR**
    - Individual requires traction equipment, which can only be attached to a hospital bed.
- A **variable height hospital bed** *(E0255, E0256, E0292, and E0293)* may be covered if the individual meets **1 or more of the following** 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:
    - Individual's medical condition requires positioning of body in ways not feasible with ordinary bed**, OR**.
    - Individual requires positioning of body in ways not feasible with ordinary bed in order to alleviate pain.
    - Individual requires head of 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 tried and are not sufficient)
    - Individual requires traction equipment, which can only be attached to a hospital bed.

- A **semi-electric hospital bed** *(E0260, E0261, E0294, E0295, and E0329)* is covered if the individual meets **1 or more of the following** and requires frequent changes in body position and/or has an immediate need for a change in body position
    - Individual's medical condition requires positioning of body in ways not feasible with ordinary bed.
    - Individual requires positioning of body in ways not feasible with ordinary bed in order to alleviate pain.
    - Individual requires head of bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration and Pillows or wedges must have been tried and are not sufficient
    - Individual requires traction equipment, which can only be attached to a hospital bed.
- An **enclosed crib or enclosed bed** is considered medically necessary on a case by case basis.
- A **heavy–duty, hospital bed** *(E0301, E0303)* is covered if the individual meets **1 or more of the following** and the individual's weight is more than 350 pounds but does not exceed 600 pounds:
    - Individual has a medical condition that requires positioning of the body in ways not feasible with ordinary bed.
    - Individual requires positioning of body in ways not feasible with ordinary bed in order to alleviate pain
    - Individual requires head of 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 tried and are not sufficient)
    - Individual requires traction equipment, which can only be attached to a hospital bed.
- An **extra heavy-duty hospital bed** *(E0302, E0304)* is covered if the individual meets **1 or more** of the following and the individual's weight exceeds 600 pounds:
    - Individual has a medical condition that requires positioning of the body in ways not feasible with ordinary bed.
    - Individual requires positioning of body in ways not feasible with ordinary bed in order to alleviate pain
    - Individual requires head of 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 tried and are not sufficient)
    - Individual requires traction equipment, which can only be attached to a hospital bed.
- An **enclosed crib or enclosed bed** is considered medically necessary on a **case-by-case** basis with **ALL** of the following:
    - When a trial of enclosed bed is offered by the manufacturer, a 30-day trial of the enclosed bed is required prior to authorization.
- **Pressure Reducing Support Surfaces** for **1 or more** or more of the following:
    - **Group I** pressure reducing support surfaces *(E0181-E0187, E0197, E0198, E0199, and A4640)* are considered medically necessary for **initial authorization** when **1 or more** of the following criteria are met:
        - The individual has skin changes consistent with the development of a pressure ulcer **OR** The individual has decreased ability to make changes in body position **AND**:
        - Is at risk for developing a pressure ulcer due to **AND**
        - **On**e or more of the following criteria is met
            - Fecal or urinary incontinence; **OR**
            - Altered sensory perception; **OR**,
            - Compromised circulatory status
    - **Group II pressure reducing support surfaces** *(E0193, E0277, E0371, E0372 and E0373)* are considered medically necessary for **initial authorization** when **1 or more** of the following criteria are met:
        - The individual has large or multiple stage 3 or 4 pressure ulcer(s) on the trunk or pelvis, **OR**
        - The individual had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days and required a Group II or Group III pressure reducing support surface prior to discharge to home, (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), **OR**.

- The individual has multiple stage 2 pressure ulcers located on the trunk or pelvis which have failed to improve after a thirty-day trial of a comprehensive ulcer treatment program including **ALL** of the following:
    - Use of an appropriate group 1 support surface, **and**
    - Frequent repositioning (usually every 2 hours); **and**
    - Regular assessment by a nurse, practitioner or other licensed health care practitioner (usually at least twice weekly for individuals with a Stage III or IV) **AND**
    - Appropriate wound care for Stage II, III or IV ulcer **AND**
    - Appropriate management of moisture/incontinence, **AND**
    - Nutritional assessment and intervention consistent with the overall plan of care.
- Continued use of a group 2 support surface is considered to be medically necessary until the ulcer is healed, or if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface continues to be reasonable and necessary for wound management.

- **Group III pressure reducing support surface** *(E0194 RR, rental only)* is considered medically necessary for **initial authorization** when **ALL** the following criteria are met:
    - The individual has a Stage III or Stage IV pressure ulcer, **AND**
    - The individual is bedridden or chair-bound as a result of severely limited mobility, **AND**
    - Without an air-fluidized bed, the individual would require institutionalization, **AND**
    - The member had at least a thirty-day trial of conservative treatment to promote wound healing without progression toward wound healing. Conservative treatment must include **ALL** of the following:
        - Use of a Group 2 support surface; and
        - Frequent repositioning (usually every 2 hours); and
        - Necessary treatment to resolve any wound infection; and
        - Optimization of nutrition status to promote wound healing; and
        - Debridement by any means, including wet-to-dry gauze dressings, to remove devitalized tissue from the wound bed; and
        - Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals, and
        - Education of the beneficiary and caregiver on the prevention and management of pressure ulcers; and
        - Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly, and
        - Appropriate management of moisture/incontinence.
    - A trained adult caregiver is available to assist the beneficiary with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage.
    - A treating practitioner directs the home treatment regimen and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis.
    - An air-fluidized bed will be denied as not reasonable and necessary under any of the following circumstances:
    - The beneficiary has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions);
    - The beneficiary requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material;
    - The caregiver is unwilling or unable to provide the type of care required by the beneficiary on an air-fluidized bed;
    - Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1600 pounds or more);

        - Electrical system is sufficient for the anticipated increase in energy consumption

NOTE: Continued use of an air fluidized bed is considered medically necessary until the ulcer is healed or, if healing does not continue, there is documentation to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the bed continues to be reasonable and necessary for wound management.

NOTE: Authorization of coverage for caregiver assistance or for environmental modifications such as electrical or structural improvement may be explored through waiver services programs if applicable)

- **Trapeze equipment** *(E0910, E0940)* is considered medically necessary with **1 or more** of the following:
    - Device necessary to sit up because of a respiratory condition **OR**
    - Device necessary to change body position for other medical reasons **OR**
    - Device necessary to get in or out of bed
- **Heavy duty trapeze equipment** *(E0911, E0912)* is considered medically necessary with **ALL** of the following:
    - Individual weighs more than 250 pounds
    - Individual needs device for **1 or more** of the following:
        - Device necessary to sit up because of a respiratory condition **OR**
        - Device necessary to change body position for other medical reasons **OR**
        - Device necessary to get in or out of bed
- **Bed cradle *(E0280)*** is considered medically necessary to prevent contact with the bed coverings
- **Side Rails *(E0305, E0310)*** are considered medically necessary with **ALL** of the following:
    - Required by the individual's medical condition
- **Replacement innerspring mattress or foam rubber mattress** is considered medically necessary with **ALL** of the following:
    - Required by the individual's medical condition
    - For an individual-owned hospital bed

The following hospital beds and accessories are either **not medically necessary**, **a convenience item** or **doesn't not meet the definition of medical necessary** for **ANY** of the following:

- All nonhospital adjustable beds (e.g., Craftmatic Adjustable Bed, Simmons Beautyrest Adjustable Bed, Adjust-A-Sleep Adjustable Bed.
- Bed baths, bed spectacles, bed trays/reading tables, call switches, foot boards, bed lapboards
- Bed boards
- Continuous lateral rotation beds
- Institutional type beds
- Kinetic therapy beds
- Oscillating beds
- Overbed table
- Power or manual lounge beds
- Side rails when requested with a non-hospital or ordinary bed
- Stryker frame beds
- Total electric hospital bed – reviewed on a case by case - See above
- Enclosed Bed System – reviewed on a case by case - See above

Document History:

Revised Dates:

- 2026: March – Implementation date of July 1, 2026. Annual review completed. Housekeeping and references updated.
- 2025: March – Implementation date of 6/1/2025. Annual completed, criteria added for total electric bed. Coding updated to align with criteria.
- 2025: January – Procedure codes updated to align with changes in service authorization status.
- 2024: August
- 2022: April

- 2021: April
- 2020: April
- 2019: September
- 2014: July
- 2013: July
- 2012: June

Reviewed Dates:

- 2023: April
- 2018: July
- 2017: November
- 2016: July
- 2015: July

Origination Date: July 2011

Coding:

Medically necessary with criteria:

Coding	Description
A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient
E0181	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy-duty
E0182	Pump for alternating pressure pad, for replacement only
E0183	Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty
E0184	Dry pressure mattress
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width
E0186	Air pressure mattress
E0187	Water pressure mattress
E0193	Powered air flotation bed (low air loss therapy)
E0194	Air fluidized bed
E0196	Gel pressure mattress
E0197	Air pressure pad for mattress, standard mattress length and width
E0198	Water pressure pad for mattress, standard mattress length and width
E0199	Dry pressure pad for mattress, standard mattress length and width
E0250	Hospital bed, fixed height, with any type side rails, with mattress
E0251	Hospital bed, fixed height, with any type side rails, without mattress
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
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
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
E0271	Mattress, innerspring
E0272	Mattress, foam rubber
E0277	Powered pressure-reducing air mattress
E0280	Bed cradle, any type
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height, without 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
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
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
E0300	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure
E0301	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350
E0302	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600
E0303	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350
E0304	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600
E0305	Bedside rails, half-length
E0310	Bedside 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
E0328	Hospital bed, pediatric, manual, 360
E0329	Hospital bed, pediatric, electric or semi-electric, 360
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width
E0372	Powered air overlay for mattress, standard mattress length and width
E0373	Nonpowered advanced pressure reducing mattress
E0840	Traction frame, attached to headboard, cervical traction
E0870	Traction frame, attached to footboard, extremity traction (e.g., Buck's)
E0890	Traction frame, attached to footboard, pelvic traction
E0910	Trapeze bars, a/k/a Individual helper, attached to bed, with grab bar
E0911	Trapeze bar, heavy duty, for Individual weight capacity greater than 250

E0912	Trapeze bar, heavy-duty, for Individual weight capacity greater than 250
E0920	Fracture frame, attached to bed, includes weights
E0940	Trapeze bar, freestanding, complete with grab bar complete with grab bar
E0946	Fracture, frame, dual with cross bars, attached to bed, (e.g., Balkan, four-poster)

Considered **Not Medically** Necessary:

Coding	Description
E0270	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress
E0273	Bed board
E0274	Over-bed table

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Individual specific benefits take precedence over medical policy.
- Application to Products: Policy is applicable to Sentara Health Plan Medicaid products
- Authorization Requirements: Pre-certification by the Plan is required.
    - After 2 months of rental Medical Director approval required for continued use for the following:
        - Advanced pressure-relieving support surface (Hospital bed with a fully integrated powered pressure reducing mattress)
        - Advanced pressure-relieving bed (Air-fluidized bed)
- Special Notes:
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
    - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

- **Documentation Requirements** Durable Medical Equipment appendix-b-21-excel-version-with-all-categories-of-appendix-b-july-2024-v2.xlsx
  - All durable medical equipment (DME) and supplies must be ordered by a practitioner on the form: CMN/DMAS-352 (revised 2017) and must be medically necessary to treat a health condition. The CMN/DMAS352 may be completed by the practitioner, DME provider, or other health care professionals, but the practitioner must sign and date the completed Certification of Medical Necessity (CMN).
  - The CMN and any supporting verifiable documentation must be completed (signed and dated by the practitioner) within 60 days.
  - The CMN shall be valid for a maximum period of six (6) months for Medicaid individuals under 21 years of age. The CMN shall be valid for a maximum period of twelve (12) months for Medicaid individuals 21 years and older.
- **Repair vs. Replacement Guidelines**
  - If individual owned equipment needs to be replaced prior to the service limit (Per Appendix B) expiring the provider will be required to justify and obtain service authorization.
  - Documentation for service authorization should include the required information as stated in this manual and the provider shall also include additional documentation as stated below:
    - What equipment the individual is currently using and why that equipment is no longer appropriate for the individual. This description shall include the reason why repairs could not be done or why the option to repair the equipment was not cost effective.
    - The provider shall include a breakdown of what items need to be repaired and include the cost to repair the items to justify why the purchase of new equipment would be more cost effective; and
    - If the item is no longer appropriate due to a change in medical condition, limitations and symptoms, or if the equipment was provided inappropriately, the provider shall give justification to describe the circumstances.
- **Rental vs. Purchase Guideline**
  - When determined to be cost effective by SHP, payment may be made for rental of the equipment in lieu of purchase. (12 VAC 30-50-165)
  - When usage is anticipated to be long-term, and the individual's need or condition is not expected to change, the items must be considered for purchase

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

Bed, Electric, Semi Electric, height, adjust, SHP Hospital Beds and Accessories, SHP Durable Medical Equipment 03, fixed height hospital bed, variable height hospital bed, semi-electric hospital bed, heavy-duty, extra-wide hospital bed, extra heavy-duty hospital bed, enclosed crib, enclosed bed, pediatric crib, Trapeze equipment, Heavy duty trapeze equipment, bed cradle, Side rails, replacement innerspring mattress, Dolphin Bed, fully integrated powered pressure reducing mattress, Advanced pressure-relieving support surface, Air-fluidized bed