Valley Mission Homecare Pharmacy
12509 E Mission, Ste 103
Spokane Valley, WA 99216
valleymissionrx.com
Phone (509) 928-6400 **Fax (509) 928-6441**

HOSPITAL BED (SEMI-ELECTRIC) +/- ATTACHED TRAPEZE ASSEMBLY

Eligibility Assessment & Order Guidance Tool

- **This guidance is based on requirements for traditional Medicare Beneficiaries. Although other insurers may have less or more stringent requirements - including potential need for prior authorization - CMS policies serve as the reference standard. For questions, please call Valley Mission Homecare Pharmacy[†] at (509) 928-6400.**

STEP 1: Verify the patient's medical condition meets Medicare coverage criteria. All below are REQUIRED and must be explicitly referenced in the client's chart record:

- **Patient has a medical condition that requires positioning of the body in ways not feasible with an ordinary bed. This medical condition must result in one or more of the following requirements:**
  - **Patient requires the head of the bed to be elevated above 30 degrees due to congestive heart failure, chronic pulmonary disease, or problems with aspiration AND such elevation cannot be accomplished by the use of traditional pillows and/or wedges, OR**
  - **Patient requires alleviation of pain via the use of body positioning in a manner that is not feasible with an ordinary bed, OR**
  - **The patient requires traction equipment, which can only be attached to a hospital bed.**
- **Patient has been evaluated face-to-face for the above medical condition and need for a Hospital Bed within the past 6 months and has a care plan for ongoing evaluation at least every 6 months.**
- **A semi-electric[‡] hospital bed (in contrast to a "manually-adjustable" hospital bed) is required because, in addition to one or more of the above criteria, patient requires frequent changes in body position and/or has immediate need for changes in body position.**
- ***Typical equipment variations***
  - **SIDE RAILS: In addition to the above requirements, the patient situation indicates the need for integrated safety rails with the bed assembly for safety.**
  - **TRAPEZE ASSEMBLY: In addition to the above criteria, patient has a medical condition requiring integrated trapeze equipment on the Hospital Bed to change body position or to get out of bed.**

STEP 2: Complete all sections of the Hospital Bed (Semi-electric) & Trapeze Assembly Detailed Written Order (see page 2)

STEP 3: In addition to the Detailed Written Order, fax the following documents to (509) 928-6441:

1. **The most recent face-to-face visit summary pertaining to medical need for a Hospital bed. This must include documentation of required qualifications outlined in STEP 1 above.**
2. **Demographic face-sheet for the patient.**

[†] ***Valley Mission Homecare Pharmacy specializes in the provision of Durable Medical Equipment (DME) and Supplies to Medicare beneficiaries. Information provided here is intended solely to facilitate communication between the Ordering Provider and the DME Supplier to help ensure medical criteria are sufficient for presumptive coverage. This does NOT in any manner replace formal guidance located in the relevant Local Coverage Determination (LCD) specified by the Medicare Administrative Contractor.***

[‡] ***A "semi-electric" bed has powered elevation for head and foot segments. This is in contrast to a "full electric" which, in addition to the head and foot segments, the entire bed height can be power-adjusted. Note that the overall bed height for a "semi-electric" can still be manually adjusted with a hand crank and therefore a "full electric" hospital bed is rarely medically justifiable and never covered by Medicare. All hospital beds from Valley Mission Homecare Pharmacy are provided with a foam group-I pressure-reducing mattress. Any other mattress type requires additional medical certification. "Half-length" side rails are also standard. If needed the bed frame can be fitted with an attached trapeze assembly with grab handle. Please identity this need on the Detailed Written Order.***

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Detailed Written Order

Patient Information

Last Name	First Name	Middle Name	Date of Birth

Physical Address	City	State	Zip Code
Billing Address (if different)	**City**	**State**	**Zip Code**

Phone	Alternate Phone

Prescriber Information

Last Name	First Name	Credential Type	NPI

Practice Location Address	City	State	Zip Code	Tax ID

Practice Location Phone	Practice Location Fax	Supervising Provider Name and NPI if applicable

Order Detail

Rx (i.e., Semi-Electric Hospital bed with accessory specifications, i.e., Side-rails and/or Trapeze)
Length of Need
Diagnosis (ICD-10) – list all codes pertinent to Hospital Bed requirement

Patient Height	Patient Weight

Additional information/instruction

I certify that I am the ordering prescriber specified above and hereby attest that information on this page is true, accurate and complete to the best of my knowledge and that the patient has suitable medical criteria documented in his/her patient record indicating medical necessity for the items listed above. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil or criminal liability. The patient (and his/her caregivers, when applicable) is capable of using this equipment and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Prescriber Signature	Date