Gammie HomeCare

Compassionate. Knowledgeable. Solutions.

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Hospital Bed
Insurance Coverage Criteria

1 Prescription of Ordered Item – electric hospital bed

2 Hospital Bed Questionnaire (form provided by Gammie HomeCare)

3 Medical Records Documenting:

1. Patient has medical condition that requires positioning that an ordinary bed can't accommodate. Elevation of the head of the bed less than 30 degrees usually does not require the need for hospital bed. **OR**
2. Patient requires body positioning in ways an ordinary bed can't accommodate to alleviate pain. **OR**
3. Patient requires head of the bed to be elevated greater than 30 degrees most of the time due to CHF, COPD, or problems with aspiration. Pillows and wedges must have been tried and ruled out. **OR**
4. Patient requires traction equipment which can only be attached to a hospital bed **AND**
5. Patient needs a bed height different than the ordinary bed to permit transfers to chair, wheelchair, or standing position. **AND**
6. For an electric bed – documentation shows a <u>frequent need</u> to change body position or an <u>immediate need</u> to change body position.

4 Letter of Medical Necessity
(Form supplied by Gammie HomeCare if documentation qualifies for coverage)

Coverage criteria is taken from the CMS Medicare Local Coverage Determination policies. These guidelines are subject to change without notice. Last Updated 8.16.19.

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Hospital Bed Questionnaire

Please answer the following questions and provide supporting documentation from the patient's medical record. The questionnaire does not replace the requirement for documentation in the medical record.

Patient Name: ______________________________ Date of Birth: ____________________

ICD10: ____________ , ____________, ____________, ____________

1. Does the patient have an acute or chronic condition? ____________________
2. What is the duration of need for a hospital bed? ____________________
3. Does the patient have a medical condition which requires positioning of the body in ways not feasible with an ordinary bed (Note: elevation of the head / upper body less than 30 degrees does not usually require the use of a hospital bed)?
   ☐ Yes ☐ No
   If yes, specify:
   a. Medical Condition: ____________________
   b. Position Required: ____________________
4. Does the patient have a medical condition which requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain? ☐ Yes ☐ No
   If yes, specify:
   a. Medical Condition: ____________________
   b. Position Required: ____________________
5. Does the patient require 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? ☐ Yes ☐ No
   If yes, specify:
   a. Medical Condition: ____________________
   b. Position Required: ____________________
6. Does the patient have a medical condition which requires traction equipment that can only be attached to hospital bed?
   ☐ Yes ☐ No
   If yes, specify:
   a. Medical Condition: ____________________
7. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position? ☐ Yes ☐ No
8. Does the patient have a medical condition which requires frequent changes in body position? ☐ Yes ☐ No
   If yes, specify:
   a. Medical Condition: ____________________
   b. Position Required: ____________________
9. Does the patient have a medical condition which requires immediate need for a change in body position? ☐ Yes ☐ No
   If yes, specify:
   a. Medical Condition: ____________________
   b. Position Required: ____________________

____________________	____________________	__________
Printed Name of Evaluator	Signature of Evaluator	Date
____________________	____________________	__________
Printed Name of Physician	Signature of Physician	Date