Hospital Beds, Pressure Reducing Support Surfaces, and Related Supplies

MEDICAL POLICY NUMBER: 403

Effective Date: 6/1/2024

Last Review Date: 2/2024

Next Annual Review: 2/2025

INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

Notice to Medicaid Policy Readers: For comprehensive rules and guidelines pertaining to this policy, readers are advised to consult the Oregon Health Authority. It is essential to ensure full understanding and compliance with the state's regulations and directives. Any conflict or variance between the OHA and Company Medical Policy will be resolved in favor of the OHA. Please refer to OHA's Oregon Administrative Rules (OARs) for the following coverage guidelines:

Hospital Beds: OAR 410-122-0380
Pressure Reducing Support Surfaces: OAR 410-122-0400
Hospital Bed Accessories: OAR 410-122-0420
Standing and Positioning Aids: OAR 410-122-0365

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

Fixed Height Hospital Beds (General Hospital Bed Coverage Criteria)

I. A fixed height hospital bed (E0250, E0251, E0290, E0291, and E0328) may be considered **medically necessary** when **one or more** of the following (A-D) are met:

   A. Member has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed; **or**
   B. The member requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain; **or**
   C. The member 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**
   D. The member requires traction equipment, which can only be attached to a hospital bed.

Variable Height Hospital Beds

II. A variable height hospital bed (E0255, E0256, E0292, and E0293) may be considered **medically necessary** for members who meet **both** of the following (A and B):

A. General hospital bed coverage criteria above are met; **and**
B. The member requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position. This includes, but may not be limited to, **one** of the following indications or situations:

1. The condition requires the variable height feature to assist the patient to ambulate by enabling the patient to place his or her feet on the floor while sitting on the edge of the bed (e.g., severe arthritis or other injury to lower extremities, such as a fractured hip); **or**
2. Severe cardiac conditions (cardiac patients who are able to leave bed, but who must avoid the strain of "jumping" up or down); **or**
3. Spinal cord injuries, including quadriplegic and paraplegic patients, multiple limb amputee and stroke patients. For those patients who are able to transfer from bed to a wheelchair, with or without help; **or**
4. Other severely debilitating diseases and conditions, if the variable height feature is required to assist the patient to ambulate (e.g., stroke).

Semi-Electric Hospital Beds

III. A semi-electric hospital bed (E0260, E0261, E0294, E0295, as well as **E0329** ***when specified as a semi-electric*** model) may be considered **medically necessary** for members who meet **all** of the following (A-C):

A. General hospital bed coverage criteria above are met; **and**
B. The member requires frequent changes in body position and/or has an immediate need for a change in body position ((i.e., no delay can be tolerated); **and**
C. The patient can operate the controls and cause the adjustments (exceptions to this can be made in cases of spinal cord injury and brain damaged patients).

Heavy Duty and Extra Heavy Duty Hospital Beds

IV. A heavy duty extra wide hospital bed (E0301, E0303) may be considered **medically necessary** for members who meet **both** of the following (A and B)

A. General hospital bed coverage criteria above are met; **and**
B. The member's weight is between 350-600 pounds (or 158.757 kg to 272.155 kg).

V. An extra heavy-duty hospital bed (E0302, E0304) may be considered **medically necessary** for members who meet **both** of the following (A and B):

A. General hospital bed coverage criteria above are met; **and**
B. The member's weight exceeds 600 pounds (>272.155 kg).

Non-Coverage of Hospital Beds

VI. Any type of the above hospital bed types (and any bed submitted with HCPCS code E1399) will be considered **not medically necessary** when the above criteria are not met, including but not limited to, the following situations:

A. Elevation of the head/upper body less than 30 degrees (this does not usually require the use of a hospital bed, but can be achieved by use of pillows, wedges, cushions, etc.).
B. The documentation does not justify the medical need for the type of bed requested or provided.

VII. The following types of beds are considered **not medically necessary** for all indications:

A. A total electric hospital bed (E0265, E0266, E0296, E0297, as well as **E0329 *when specified as a total electric*** model) (the height adjustment feature is considered a convenience feature).
B. Non-hospital beds (aka, ordinary beds; see Policy Guidelines for the definition of an "ordinary bed") (these do not meet the Medicare definition of DME).
C. Institutional-type beds (e.g., oscillating beds, springbase beds, circulating beds, and stryker frame beds) (these are not considered to be appropriate for home use).
D. Lounge beds (powered or manual) (these are not considered to be hospital beds, but are considered to be comfort or convenience item; also not primarily medical in nature).
E. Safety bed systems (manual or electric; e.g., SleepSafe, Posey Bed Enclosure Safety System, Vail Enclosure beds; this exclusion does not apply to rails or enclosures used in conjunction with medically necessary hospital-grade beds).

Group 1 Support Surfaces

VIII. A **Group 1** mattress overlay or mattress (E0181, E0182, E0184, E0185, E0186, E0187, E0188, E0189, E0196, E0197, E0198, E0199 and A4640) may be considered **medically necessary** for members who meet one of the following (A, B, or C):
A. Are *completely immobile* (i.e., cannot make changes in body position without assistance) when the support surface provided has been tested to ensure the member will not "bottom out" (see Policy Guidelines); **or**
B. Has either *limited mobility* (i.e., cannot independently make changes in body position significant enough to alleviate pressure) or *any stage pressure ulcer on the trunk or pelvis* when the support surface provided has been tested to ensure the member will not "bottom out" (see Policy Guidelines) **and** when the severity of the condition is sufficiently documented to demonstrate the medical necessity for a pressure reducing support surface by meeting **at least one** of the conditions (1-4) below:

1. Impaired nutritional status; **or**

2. Fecal or urinary incontinence; **or**
3. Altered sensory perception; **or**
4. Compromised circulatory status.

IX. A **Group 1** mattress overlay or mattress is considered **not medically necessary** in any of the following situations:

A. The above criteria are not met; **or**
B. A Group 1 support surface which does not meet the characteristics specified for Group 1 support surface items (See Group 1 Coding Guidelines below)**.**

Group 2 Support Surfaces

X. A **Group 2** support surface (HCPCS codes E0193, E0277, E0371, E0372, E0373) may be considered **medically necessary** when the member meets **all** of the following (A-C):

A. The support surface provided has been tested to ensure the member does not "bottom out" (see Policy Guidelines); **and**
B. There is a care plan established by the treating practitioner or home care nurse which includes the same elements as the comprehensive ulcer treatment program (see below for Comprehensive Ulcer Treatment Program requirements); **and**
C. The member has **one** of the following (1, 2 or 3):

1. *Multiple stage 2 pressure ulcers* located on the trunk or pelvis which have failed to improve over the prior month despite a comprehensive ulcer treatment program (see below for Comprehensive Ulcer Treatment Program requirements and Table 1 for Pressure Ulcer Staging); **or**
2. *Large or multiple stage 3 or 4 pressure ulcer(s)* on the trunk or pelvis (see Table 1 for Pressure Ulcer Staging); **or**
3. *Myocutaneous flap or skin graft for a pressure ulcer* on the trunk or pelvis within the past 60 days and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.

XI. Continued use of a Group 2 support surface for multiple stage 2 pressure ulcers or large/multiple stage 3 or 4 pressure ulcers (see Table 1 for Pressure Ulcer Staging) may be considered **medically necessary** when **one** of the following (A or B) are met:

A. Until the ulcer is healed; **or**
B. If healing does not continue, there is documentation in the medical record to show that **one** of the following are met (1 or 2):

1. Other aspects of the care plan are being modified to promote healing; **or**
2. The use of the Group 2 support surface is reasonable and necessary for wound management.

XII. Coverage of a Group 2 support surface following a myocutaneous flap or skin graft may be considered **medically necessary** for up to 60-days.

XIII. A **Group 2** support surface is considered **not medically necessary** in any of the following situations:

A. The above criteria for Group 2 support surfaces are not met; **or**
B. A Group 2 support surface which does not meet the characteristics specified for Group 2 support surface items (See Group 2 Coding Guidelines below)**.**

Group 3 Support Surfaces (Air-Fluidized Beds)

XIV. A **Group 3** support surface (air-fluidized bed; E0194) may be considered **medically necessary** if **all** of the following criteria are met:

A. The member has a stage 3 (full thickness tissue loss) or stage 4 (deep tissue destruction) pressure ulcer (see Table 1 for Pressure Ulcer Staging); **and**
B. The member is bedridden or chair bound as a result of severely limited mobility; **and**
C. In the absence of an air-fluidized bed, the member would require institutionalization; **and**
D. The air-fluidized bed is ordered in writing by the treating practitioner, based on a comprehensive assessment and evaluation within one month prior to initiation of therapy with the air-fluidized bed after completion of a course of conservative treatment designed to optimize conditions that promote wound healing (see below for Comprehensive Treatment Requirements; **and**
E. The course of conservative treatment must have been at least one month in duration without progression toward wound healing (This prerequisite conservative treatment may include a period in an institution as long as there is documentation available to verify that the necessary conservative treatment was rendered); **and**
F. A trained adult caregiver is available to assist 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 (e.g., leakage); **and**
G. A treating practitioner directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis; **and**
H. All other alternative equipment has been considered and ruled out.

XV. An air-fluidized bed is considered **not medically necessary** for any of the following:

A. The above criteria for an air-fluidized bed are not met; **or**
B. The member has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions); **or**
C. The member 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; **or**
D. The caregiver is unwilling or unable to provide the type of care required by the member on an air-fluidized bed; **or**
E. Structural support is inadequate to support the weight of the air-fluidized bed system (these systems generally weigh 1600 pounds or more); **or**

F. Electrical system is insufficient for the anticipated increase in energy consumption; **or**
G. Other known contraindications exist.

Accessories, Supplies, Features, and Services

XVI. The following accessories, supplies and features may be considered **medically necessary** when the noted relevant criteria are met.

A. Trapeze equipment (E0910, E0940) for bed confined members who need the device to sit up due to a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.
B. Heavy duty trapeze equipment (E0911, E0912) if the member meets the criteria for regular trapeze equipment and the beneficiary's weight is more than 250 pounds.
C. A bed cradle (E0280) when needed to prevent contact with the bed coverings.
D. Bed pans (autoclavable hospital type) (E0275, E0276) or male/female urinals (autoclavable hospital type) (E0325, E0326) may be considered **medically necessary** for members who are bed confined.
E. Side rails (E0305, E0310) or safety enclosures (E0316) may be considered **medically necessary** when **both** of the following (1 and 2) are met:

1. Side rail or safety enclosure is required by the member's condition; and
2. The side rail or safety enclosure is an integral part of, or an accessory to, a *medically necessary* hospital bed.

XVII. The following accessories, supplies and services are considered **not medically necessary:**

A. Any accessory, supply, or feature listed above which does not meet the noted criteria.
B. A bed board (E0273, E0315) (not considered to be primarily medical in nature).
C. An over bed table (E0274, E0315) (not considered to be primarily medical in nature).
D. A bed lifter (or bed elevator) (not considered to be primarily medical in nature).
E. Trapeze bars attached to a bed (E0910, E0911) when used on an ordinary bed.
F. Safety equipment (e.g., belt, harness or vest) (E0700).
G. Restraints, any type (body, chest, wrist or ankle) (E0710).
H. Positioning devices (e.g., cushion, pillow, wedge, any shape or size) (E0190).
I. A foam overlay or mattress which does not have a waterproof cover (it does not meet Medicare's "durable" requirements to be considered durable medical equipment).
J. Caregiver fees.
K. Architectural adjustments to a home (e.g., electrical or structural improvements).
L. Mobility monitors (e.g., bed exit monitors, alarms, or fall detection systems) and bed wetting prevention devices (e.g., enuresis alarms, etc.).

Replacement, Upgrade, and Repair Requests

XVIII. Replacement of a **non-functioning** hospital bed may be **medically necessary** when **all** of the following are met (A-D):

A. The use of a hospital bed continues to be medically necessary for the member; **and**

B. The hospital bed or non-functioning component of the hospital bed is **not** under manufacturer warranty; **and**
C. The cost to repair existing equipment exceeds the purchase price of a replacement; **and**
D. The hospital bed is non-functional due to **one** of the following situations (1 or 2):

1. The item is irreparable **damaged** (e.g., fire, flood, etc.); **or**
2. The item is irreparable worn **and** the reasonable useful lifetime (RUL) of the item has been reached (at least 5 years).

XIX. Replacement or upgrade of a **functioning** hospital bed may be **medically necessary** when required due to a significant change in the physical condition of the member and the records support the request because the current equipment is no longer sufficient for their medical needs.

XX. The replacement or upgrade of a hospital bed is considered **not medically necessary** for any of the following:

A. Replacement or upgrade criteria above are not met.
B. Replacement is needed due to irreparable wear and the RUL of at least 5 years for the item has **not** been reached.
C. Replacement is required due to member abuse, neglect or intentional damage.
D. The upgraded bed or accessory is determined to be a deluxe feature which exceeds the medical need for the individual patient.

XXI. A replacement innerspring mattress (E0271) or foam rubber mattress (E0272) may be considered **medically necessary** for a member-owned hospital bed when the member's condition requires one (e.g., worn or torn mattress, clinical change in member condition which causes the existing mattress is no longer sufficient for their medical needs, etc). (NOTE: Beds being rented are not considered "member-owned.")

XXII. Repairs (meaning to "fix or mend and to put the equipment back in good condition after damage or wear") for a member-owned hospital bed may be **medically necessary** when required to bring the equipment to a serviceable condition. (NOTE: Maintenance services, such as testing, cleaning, regulating, and checking, are not considered "repairs.")

Link to Evidence Summary

POLICY CROSS REFERENCES

- Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS), MP142

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

This policy may be primarily based on the following Center for Medicare and Medicaid Services (CMS) guidance resources:

- National Coverage Determination (NCD): Hospital Beds (280.7)
- NCD: Durable Medical Equipment Reference List (280.1)
- Local Coverage Determination (LCD): Hospital Beds And Accessories (L33820)
- Local Coverage Article (LCA): Hospital Beds And Accessories - Policy Article (A52508)
- Noridian Healthcare Solutions, Inc. webpage for Noncovered Items
- Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §110.2 - Repairs, Maintenance, Replacement, and Delivery, Subsections A and C

DOCUMENTATION REQUIREMENTS

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. Medical records to include documentation of all of the following:

- All medical records and chart notes pertinent to the request. This includes:
    - History
    - Physical examination
    - Treatment plan

DEFINITIONS

Air-fluidized beds use warm air under pressure to set small ceramic beads in motion which simulate the movement of fluid. When the patient is placed in the bed, body weight is evenly distributed over a large surface area, which creates a sensation of "floating." *(NCD 280.8)*

Bottoming out is the finding that an outstretched hand, placed palm up between the undersurface of the mattress overlay or mattress and the beneficiary's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the beneficiary in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side-lying position.

Fixed height hospital beds are those with manual head and leg elevation adjustments but no height adjustment. *(LCA A52508)*

Variable height hospital beds are those with manual height adjustment and with manual head and leg elevation adjustments. *(LCA A52508)*

Semi-electric beds are those with manual height adjustment and with electric head and leg elevation adjustments. *(LCA A52508)*

Total electric beds are those with electric height adjustment and with electric head and leg elevation adjustments. *(LCA A52508)*

Ordinary beds, mattresses and/or supplies are considered to be those which are typically sold as furniture, usually by non-DME supplies. They may consist of a frame, box spring and mattress. They include either fixed height and those with head or leg elevation adjustment features. This includes all nonhospital adjustable beds (e.g., Craftmatic Adjustable Bed, Adjust-A-Sleep Adjustable Bed, Simmons Beauty Rest Adjustable Bed, etc.).

Bed confinement: According to the CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 10, Section 10.2.3, the following must be met for an individual to be considered bed-confined under Medicare:

- Unable to get up from bed without assistance; and
- Unable to ambulate; and
- Unable to sit up in a chair, wheelchair, geri chair, dialysis chair or ambulate in any way.

This reference adds clarification that the term "bed confined" is not synonymous with "bed rest" or "nonambulatory."

PRESSURE ULCER STAGING

The staging of pressure ulcers used in this policy is as follows (National Pressure Injury Advisory Panel, 2019 Revision):

Table 1: Pressure Ulcer Staging for Pressure-Reducing Support Surfaces (PRSS)

Pressure Ulcer Stage	Description
Stage 1 Pressure Injury: Non-blanchable erythema of intact skin	• Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis	• Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss	• Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Stage 4 Pressure Injury: Full-thickness skin and tissue loss	• Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss	• Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
Deep Tissue Pressure Injury	• Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Comprehensive Ulcer Treatment Program

Medicare requirements for a comprehensive ulcer treatment program includes **all** of the following (LCD L33642):

1. Use of an appropriate group 1 support surface, and
2. Regular assessment by a nurse, practitioner, or other licensed healthcare practitioner, and
3. Appropriate turning and positioning, and
4. Appropriate wound care, and
5. Appropriate management of moisture/incontinence, and
6. Nutritional assessment and intervention consistent with the overall plan of care

Conservative Treatment for Air-Fluidized Beds (Group 3 Pressure Support Surfaces)

Medicare requirements of a conservative treatment program prior to provision of a Group 3 support surface includes **all** of the following (LCD L33692):

1. Frequent repositioning of the member with particular attention to relief of pressure over bony prominences (usually every 2 hours); **and**
2. Use of a Group 2 support surface to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation; **and**
3. Necessary treatment to resolve any wound infection; **and**
4. Optimization of nutrition status to promote wound healing; **and**
5. Debridement by any means, including wet-to-dry gauze dressings, to remove devitalized tissue from the wound bed; **and**
6. When appropriate for the wound, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals (see below for Occlusive Barriers); **and**
7. Education of the member and caregiver on the prevention and management of pressure ulcers; **and**
8. Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly; **and**
9. Appropriate management of moisture/incontinence.

Occlusive Barriers

An occlusive barrier is required, when necessary, to maintain a moist wound-healing environment that may otherwise be compromised by the drying action of airflow generated by air-fluidized therapy. If moist dressings are NOT required because of the wound characteristics (e.g. heavily exudative wound, etc.), the occlusive barrier is not required as a condition for meeting medical necessity criteria.

Wet-to-dry dressings when used for debridement do not require an occlusive dressing. Use of wet-to-dry dressings for wound debridement, begun during the period of conservative treatment and which continue beyond 30 days will not preclude coverage of an air-fluidized bed. Should additional debridement again become necessary while a beneficiary is using an air-fluidized bed (after the first 30-day course of conservative treatment) that will not cause the air-fluidized bed to be denied.

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

BILLING GUIDELINES AND CODING

GENERAL

Suppliers should contact the PDAC contractor for guidance on the correct coding of these items.

Descriptions

Hospital Beds

The Noridian LCA A52508 describes the features of products and how they are intended to be code.

Table 2: Hospital Beds and Features (LCA A52508)

Bed Type	Code(s)	Head Elevation	Leg Elevation	Height Adjustment
Fixed height	E0250, E0251, E0290, E0291, and E0328	Manual	Manual	N/A
Variable height	E0255, E0256, E0292, and E0293	Manual	Manual	Manual
Semi-electric	E0260, E0261, E0294, E0295, and E0329	Electric	Electric	Manual
Total electric	E0265, E0266, E0296, and E0297	Electric	Electric	Electric
Heavy duty	E0301, E0303	Hospital bed capable of supporting patient weights of greater than 350 lbs, and less or equal to 600 lbs.		
Extra heavy-duty	E0302, E0304	Hospital bed capable of supporting patient weights greater than 600 lbs.		

Accessories and Supplies

Various accessories and supplies may be used with hospital beds. Table 3 provides a brief description of such items, but is not an all-inclusive list.

Table 3: Miscellaneous Accessories and Supplies

Bed Type	Code(s)	Description
Bed cradle	E0280	A frame installed at the foot of a bed, designed to keep sheets and blankets off the individual's legs and/or feet.

		It can assist with air circulation, sensitive skin and keeping skin dry.
Safety enclosure	E0316	Used to prevent an individual from leaving the bed.
Trapeze equipment	E0910, E0911, E0912, E0940	Used to help patients who are unable to move on their own get in and out of bed. They consist of a bar that can be lowered or raised as needed. The patient grabs onto the bar and uses it to pull themselves up into a sitting position or to swing their legs over the side of the bed. Some types are attached to the bed (E0910, E0911), while others are free-standing (E0912, E0940).
Bed (Side) rails	E0305, E0310	Used to prevent rolling out of bed, reduce the risk of falling, and provide support while adjusting position. Some types run the full length of the bed (E0305), while others only run part (or half) the bed length (E0310).
Bed board	E0273, E0315	A large, flat board placed under a mattress to make the mattress firmer and prevent the mattress from sagging.
Over-bed table	E0274, E0315	A table designed to fit over a bed. Generally on wheels to make it moveable. Intended for hospital patients, individuals with limited mobility or those confined to their beds.
Air pressure elevator for heel	E0370	Inflatable device used to keep the individual's heel off of the bed surface.

Concurrently Billing for a Hospital Bed and a Mattress-Type Pressure Reducing Support Surface (PRSS)

Billing a hospital bed with mattress in conjunction with a mattress-type support surface (i.e., not a support surface mattress overlay) is considered to be duplicate items (same/similar). Suppliers must **not** bill HCPCS codes for two types of mattresses concurrently. Possible billing scenarios include:

Table 4: Billing Hospital Beds and PRSS Together

Billing Scenario	Billing Instruction
Member-owned hospital bed with mattress	• Providing a mattress-type PRSS to replace an existing mattress is allowed if there is a change in the member's medical condition that justifies coverage of the PRSS. • Since the member owns the regular mattress, it is their decision regarding the disposition of the regular mattress. • The supplier is allowed to report the appropriate HCPCS code for the PRSS provided for reimbursement.
Hospital bed with mattress currently in a capped rental	• Providing a mattress-type PRSS to replace an existing mattress is allowed if there is a change in the

	beneficiary's medical condition that justifies coverage of the PRSS. • The regular mattress must be returned to the supplier and the supplier must stop billing the HCPCS code for the combination bed with mattress. Only then may the supplier change the HCPCS code being billed to the corresponding HCPCS code for the hospital bed frame without a mattress. • The hospital bed frame **without** mattress rental payments will resume in the capped rental cycle in the month following discontinuation of the hospital bed with mattress. A new capped rental does **not** begin with the change in hospital bed HCPCS code. • The supplier may bill for the appropriate HCPCS code for the PRSS provided.
New, initial rental of both a hospital bed and PRSS	• Combination hospital bed and mattress codes and a PRSS must not be billed at initial issue. • Suppliers must bill the appropriate HCPCS code for the hospital bed frame **without** mattress plus the HCPCS code for the mattress-type PRSS.

CODING GUIDELINES

When HCPCS code E1399 is used, the manufacturer and the model name/number must be provided.

Hospital Beds and Accessories

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.

Pressure-Reducing Support Surfaces

<u>Group 1 PRSSs</u>

Codes E0185, E0197, E0198 and E0199 termed "pressure pad for mattress" describe 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 peak height of 3" or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least 3 inches if it is a non-convoluted overlay, and
- Foam with a density and other qualities that provide adequate pressure reduction, and
- Durable, waterproof cover

Codes E0184, E0186, E0187 and E0196 describe nonpowered pressure reducing mattresses.

A foam mattress (E0184) is characterized by all of the following:

- Foam height of 5 inches or greater, and
- Foam with a density and other qualities that provide adequate pressure reduction, and
- Durable, waterproof cover, and
- Can be placed directly on a hospital bed frame

An air, water or gel mattress (E0186, E0187, E0196) is characterized by all of the following:

- Height of 5 inches or greater of the air, water, or gel layer (respectively), and
- Durable, waterproof cover, and
- Can be placed directly on a hospital bed frame

Codes E0181, E0182, and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss). They are characterized by all of the following:

- An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and
- 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 patient lift, reduce pressure and prevent bottoming out

A foam overlay or mattress which does not have a waterproof cover should be coded using A9270. Other Group 1 support surfaces which do not meet the characteristics specified in this section should be billed using code E1399.

Alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0181, E0182, and A4640.

Codes A4640 or E0182 should only be used when they are provided as replacement components for a member-owned E0181 mattress overlay system.

Group 2 PRSSs

Heavy duty and bariatric devices are included in the codes for pressure reducing support surfaces: E0193, E0277, E0371, E0372 and E0373. Therefore, HCPCS code E1399 would **not** be used to account for a heavy duty/bariatric feature.

Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following:

- An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, and
- Inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate beneficiary lift, reduce pressure and prevent bottoming out, and
- A surface designed to reduce friction and shear, and
- Can be placed directly on a hospital bed frame.

Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above.

Code E0371 describes an advanced nonpowered pressure-reducing mattress overlay which is characterized by all of the following:

- Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out, and
- Total height of 3 inches or greater, and
- A surface designed to reduce friction and shear, and
- Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces.

Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by all of the following:

- An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and
- Inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate beneficiary lift, reduce pressure and prevent bottoming out, and
- A surface designed to reduce friction and shear.

Code E0373 describes an advanced nonpowered pressure reducing mattress which is characterized by all of the following:

- Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out, and
- Total height of 5 inches or greater, and
- A surface designed to reduce friction and shear, and
- Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces, and
- Can be placed directly on a hospital bed frame.

The only products that may be billed using codes E0371 or E0373 are those for which a written coding verification review (CVR) has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor and subsequently published on the Product Classification List (PCL). Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Request can be found on the PDAC web site or by contacting the PDAC. A PCL with products that have received a coding verification can be found on the PDAC web site. If a product is billed to Medicare using a HCPCS code that requires written CVR, but the product is not on the PCL for that particular HCPCS code, then the claim line will be denied as incorrect coding.

Group 2 support surfaces are coded based on the characteristics specified in the above definitions. Products which do not meet these definitional characteristics but meet the characteristics for another support surface grouping (i.e., Group 1 support surfaces) will be coded based on the characteristics specified in the Coding Guidelines section of the Group 1 Pressure Reducing Support Surfaces related Policy Article. Products which do not meet the characteristics specified in either the Group 1 or Group 2 Support Surfaces related Policy Article must be coded using code E1399.

Either alternating pressure mattresses or low air loss mattresses are coded using code E0277.

Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with 3" powered air cells on top of a 3" foam base would be coded as a powered overlay (code E0181) not as a powered mattress (E0277).

Suppliers should contact the PDAC contractor for guidance on the correct coding of these items.

<u>Group 3 PRSS</u>

An air-fluidized bed (E0194) is a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid.

Heavy duty and bariatric devices are included in the Group 3 pressure reducing support surfaces coded E0194. Therefore, HCPCS code E1399 would **not** be used to account for a heavy duty/bariatric feature.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

Bundling

Charges for codes found in Column II are included in the allowance for the corresponding Column I code when provided at the same time and must not be billed separately at the time of billing the Column I code.

Table 5: Items that must not be separately reported

Column I	Column II
E0250	E0271, E0272, E0305, E0310
E0251	E0305, E0310
E0255	E0271, E0272, E0305, E0310
E0256	E0305, E0310
E0260	E0271, E0272, E0305, E0310
E0261	E0305, E0310
E0265	E0271, E0272, E0305, E0310
E0266	E0305, E0310
E0290	E0271, E0272
E0292	E0271, E0272
E0294	E0271, E0272
E0296	E0271, E0272
E0301	E0305, E0310
E0302	E0305, E0310
E0303	E0271, E0272, E0305, E0310
E0304	E0271, E0272, E0305, E0310
E0328	E0271, E0272, E0305, E0310
E0329	E0271, E0272, E0305, E0310

When mattress or bedside rails are provided at the same time as a hospital bed, suppliers are to use the single HCPCS code which combines these items. Additional billing of hospital beds can be found in the Noridian LCA A52508.

CODES*		
CPT	None	
Hospital Beds – Fixed Height		
HCPCS	E0250	Hospital bed, fixed height, with any type side rails, with mattress
	E0251	Hospital bed, fixed height, with any type side rails, without mattress
	E0290	Hospital bed, fixed height, without side rails, with mattress
	E0291	Hospital bed, fixed height, without side rails, without mattress
	E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress

Hospital Beds – Variable Height		
	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
	E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
	E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress
Hospital Beds – Semi Electric		
	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
	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
	E0329	Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress
Hospital Beds – Total Electric		
	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
	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
Hospital Beds – Heavy Duty		
	E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
	E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
	E0303	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress
	E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress
Institutional Hospital Beds		
	E0270	Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress
Hospital Beds – Accessories		
	E0271	Mattress, innerspring
	E0272	Mattress, foam rubber
	E0273	Bed board
	E0274	Over-bed table
	E0275	Bed pan, standard, metal or plastic
	E0276	Bed pan, fracture, metal or plastic
	E0280	Bed cradle, any type

	E0305	Bed side rails, half length
	E0310	Bed side 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
	E0325	Urinal; male, jug-hyphentype, any material
	E0326	Urinal; female, jug-hyphentype, any material
	E0370	Air pressure elevator for heel
	E0910	Trapeze bars, a/k/a patient helper, attached to bed, with grab bar
	E0911	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar
	E0912	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar
	E0940	Trapeze bar, free standing, complete with grab bar
Pressure Reducing Support Surfaces – Group 1		
	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
	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
	E0188	Synthetic sheepskin pad
	E0189	Lambswool sheepskin pad, any size
	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
Pressure Reducing Support Surfaces – Group 2		
	E0193	Powered air flotation bed (low air loss therapy)
	E0277	Powered pressure-reducing air mattress
	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
Pressure Reducing Support Surfaces – Group 3		
	E0194	Air fluidized bed
Miscellaneous Codes		
	A9270	Non-covered item or service
	E0190	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories
	E0700	Safety equipment (e.g., belt, harness or vest)
	E0710	Restraints, any type (body, chest, wrist or ankle)
	E1399	Durable medical equipment, miscellaneous

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

References are completed through EndNote

For removing bullet points from EndNote references, see this link. If link has expired, google: "endnote word bullets" to find new link.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
6/2024	New Company medical policy based primarily on CMS guidance