Hospital Beds
Corporate Medical Policy

File name: Hospital Beds
File code: UM.DME.08
Origination: 04/18/07
Last Review: 09/2015
Next Review: 09/2016
Effective Date: 04/01/2016

Description/Summary

Definitions:


Semi-electric hospital bed: Manual height adjustment and with electric head and leg elevation adjustments.

Total electric hospital bed: Electric height adjustment and with electric head and leg elevation adjustments.

Air Fluidized Bed: An air fluidized bed is a device employing the circulation of filtered air through ceramic spherules (small, round ceramic objects) that is marketed to treat or prevent bedsores or to treat extensive burns. An air fluidized bed uses warm air under pressure to set small ceramic beads in motion, which simulate a fluid movement. When the patient is placed in the bed, his/her body weight is evenly distributed over a large surface area, which creates a sensation of floating.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I- HCPCS Code Table & Instructions

The Plan provides benefits for the rental, rental to purchase or purchase of hospital beds when criteria outlined in this policy is met.

When a service may be considered medically necessary

A fixed-height hospital bed may be considered medically necessary when:
• The member’s condition requires positioning of the body; e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections, in ways not feasible in an ordinary bed; or
• 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. Pillows or wedges must have been considered; or
• The member’s condition requires special attachments (e.g. traction equipment) that cannot be fixed and used on an ordinary bed.

A variable-height bed may be medically necessary when criteria are met for a fixed-height bed and the individual requires a bed height other than that of a fixed-height hospital bed to permit transfers to a chair, wheelchair or standing position.

A semi-electric bed may be medically necessary when criteria are met for a fixed-height hospital bed and the individual requires frequent changes in body position, and/or has an immediate need for a change in body position, and is able to operate the controls for adjustment.

A total electric bed may be medically necessary when criteria are met for fixed hospital bed in individuals with a brain injury, spinal cord injuries, and/or with neurological damage that prevents them from getting in or out of bed.

A heavy-duty, extra-wide/bariatric bed may be indicated when criteria are met for a fixed-height bed and the individual’s weight is more than 350 pounds but less than 600 pounds.

An extra-heavy-duty bed may be indicated when criteria are met for a fixed-height hospital bed and the individual weighs 600 pounds or more.

The Plan covers a pediatric hospital bed/crib as medically necessary when the child meets criteria for any of the above hospital beds.

Use of the air fluidized bed is considered medically necessary when ALL of the following conditions are met in patients who:

• are bedridden and are unable to fully or partially ambulate; AND
• have a stage 3 (full-thickness tissue loss) or stage 4 (deep tissue destruction) pressure sore; AND
• have exhausted conservative treatment without improvement; AND
• in the absence of an air fluidized bed, the patient would require institutionalization; AND
• have a trained adult caregiver available to assist the patient 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; AND
• have a physician who directs the home treatment regimen, and reevaluates and recertifies the need for the air fluidized bed on a monthly basis; AND
• have utilized and ruled out all other alternative equipment. Such alternatives include, but are not limited to, gel flotation pads, egg crate mattresses, and pressure pads and pumps.

Repairs, maintenance, and replacement of eligible DME on an individual consideration basis when necessary to make the equipment usable. BCBSVT reserves the right to determine whether rental or rental to purchase or purchase of the equipment is more cost-effective and/or appropriate. The total rental benefits may not exceed our allowed price for the purchase of equipment.

**When a service is considered not medically necessary**

The Plan does not cover any of the following beds, as they are not considered to be appropriate for use in the home care setting and therefore **not medically necessary**:

- Institutional beds
- Kinetic therapy beds
- Stryker frame beds

Oscillating beds or other, similar beds in the home care setting are considered not medically necessary. For example, some institutional type and specialty beds deliver therapies that are known as kinetic therapy and continuous lateral rotational therapy. The CDC (Centers for Disease Control and Prevention) defines kinetic therapy as 40-degree rotation or greater to each side using a specialty bed, and continuous lateral rotational therapy as delivering less than 40-degree rotation to each side, also using a specialty bed. These types of beds are used to facilitate drainage of pulmonary secretions and to relieve pressure. They are often used for patients with spinal cord injuries or impaired respiratory function in an acute care hospital setting. Many clinical studies have been conducted to research the clinical benefits of various degrees of rotation, but all these studies have been conducted in acute care settings.

The Plan does not cover any of the following beds and accessories, as they are not primarily medical in nature and therefore **not medically necessary**:

- All nonhospital adjustable beds (e.g., Craftmatic Adjustable Bed, Simmons Beautyrest Adjustable Bed, Adjust-A-Sleep Adjustable Bed);
- Bed boards;
- Bed elevators (e.g., blocks, lifters);
- Bed wedges/pillows;
- Bedrail pads;
- Custom bedroom equipment;
- Mattresses (e.g., inner spring, foam rubber, viscoelastic or memory foam mattresses [e.g., Tempur-Pedic], adjustable firmness/support mattresses [e.g., Select Comfort]);
- Over bed tables, trays, lap boards;
- Power/manual lounge beds;
- Safety accessories, such as enclosures/canopies (e.g., Vail Enclosed Bed Systems, Posey Bed Canopy beds);
- Waterbeds
Home use of the air fluidized bed is **not medically necessary** under any of the following circumstances:

- the patient requires treatment with wet soaks or has moist wound dressings that are not protected with an impervious covering such as plastic wrap; OR
- the caregiver is unable to provide the type of care required by the patient on an air fluidized bed; OR
- structural support is inadequate to support the weight of the air fluidized system (it weighs 1600 pounds or more); OR
- the home electrical system is insufficient for the anticipated increase in energy consumption.

**When a service is considered non-covered (benefit exclusion)**

- Durable Medical Equipment, supplies or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience.
- New technology introducing improved features for existing medical equipment. Benefits are considered not medically necessary for “deluxe” features to make the equipment more versatile or easier for the member to use if the standard/conventional equipment meets the member’s functional needs.
- When a hospital bed does not provide a therapeutic benefit to a patient in need because of certain medical conditions or illnesses.
- Items, add-ons, or upgrades that are intended primarily for member/caregiver convenience, or that do not significantly enhance DME functionality.

**Policy Guidelines**

The following information is required when requesting prior approval for a hospital bed:

- A detailed clinical summary from a physician including, but not limited to, the member’s diagnosis, summary of hospital stay if applicable, prognosis, and description of disabilities requiring the functions of a hospital bed.
- Anticipated length of time bed will be needed.
- HCPCS code, and monthly rental and purchase price.

For air fluidized beds, clinical information must be submitted **monthly** to determine medical necessity for ongoing use.

**Reference Resources**

1. Blue Cross and Blue Shield Association Medical Policy, Air Fluidized Beds 1.01.01. A search of literature was completed through the MEDLINE database for the period of January 1992 through April 1995 following Medical Subject Headings: Decubitus; Prevention and Control. Research was limited to English-language journals on humans.
2. See also: Medicare Guidelines for Air Fluidized Bed
Related Policies

Durable Medical Equipment (DME)

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract language, the member’s contract language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered complete, see policy guidelines above.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member’s health plan.

Federal Employee Program (FEP) members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure.

Coverage varies according to the member’s group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through a self-funded (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member’s plan documents or contact the customer service department.
Policy Implementation/Update information

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
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<tbody>
<tr>
<td>07/2007</td>
<td>Reviewed by CAC</td>
</tr>
<tr>
<td>10/2011</td>
<td>Updated and transferred to new policy format. Policy language added concerning special bed types. Definitions of standard hospital bed types added. Exclusions for accessories added. Coding updated to reflect additions to policy.</td>
</tr>
<tr>
<td>10/2011</td>
<td>Medical/Clinical Coder reviewed and approved. SAF</td>
</tr>
<tr>
<td>09/2015</td>
<td>Criteria for total electric beds added. Sections headers added, updated and/or clarified. Code table updated.</td>
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</tbody>
</table>

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s), to include:

Durable Medical Equipment (DME) providers

Approved by BCBSVT Medical Directors

<table>
<thead>
<tr>
<th>Date</th>
<th>Code Type</th>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/2011</td>
<td>HCPCS</td>
<td>E0187</td>
<td>Water pressure mattress</td>
</tr>
<tr>
<td>10/2011</td>
<td>HCPCS</td>
<td>E0188</td>
<td>Synthetic sheepskin pad</td>
</tr>
<tr>
<td>10/2011</td>
<td>HCPCS</td>
<td>E0189</td>
<td>Lambswool sheepskin pad, any size</td>
</tr>
</tbody>
</table>

Services are considered medically necessary when applicable criteria outlined in the policy are met.

Other hospital beds and accessories not listed below require prior approval if the purchase price is over $500.00

The following services are denied as benefit exclusions

<table>
<thead>
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<tr>
<td>HCPCS</td>
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</tr>
<tr>
<td>HCPCS</td>
<td>E0189</td>
<td>Lambswool sheepskin pad, any size</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0190</td>
<td>Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories</td>
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<td>--------</td>
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<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0198</td>
<td>Water pressure pad for mattress, standard mattress length and width</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0199</td>
<td>Dry pressure pad for mattress, standard mattress length and width</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0270</td>
<td>Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0271</td>
<td>Mattress, innerspring</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0272</td>
<td>Mattress, foam rubber</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0273</td>
<td>Bed board</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0274</td>
<td>Over-bed table</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0315</td>
<td>Bed accessory: board, table, or support device, any type</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0316</td>
<td>Safety enclosure frame/canopy for use with hospital bed, any type</td>
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</tbody>
</table>

**Type of Service**  
Durable medical equipment

**Place of Service**  
Home

102815RLG