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UTILIZATION MANAGEMENT GUIDELINE– 1.01.520

Hospital Beds and Accessories

Effective Date:	Apr. 1, 2025	RELATED MEDICAL POLICIES:	
Last Revised:	Mar. 10, 2025	1.01.530	Children's Therapeutic Positioning Equipment
Replaces:	1.01.01	10.01.517	Non-covered Services and Procedures

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Introduction

A hospital bed has specific features for people who need to be in certain positions because of their medical situation. A hospital bed can change the height of the whole bed, or just the head or feet, or both. When a hospital bed is used at home, it is usually for a person who spends a lot of time in bed or cannot get out of bed at all because of a medical condition. A hospital bed can be ordered (prescribed) by a doctor for many reasons. This includes changing positions in a way that cannot be done in a regular bed, laying or sleeping in certain positions to relieve pain, or raising the head of the bed higher than 30 degrees due to certain heart or lung problems. An adjustable home bed is not a hospital bed. A hospital bed is durable medical equipment, which is useful only to a person with a medical condition. This policy describes when a hospital bed may be covered for use at home.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

If coverage is available for Durable Medical Equipment (DME) then the following conditions apply.

Medically necessary hospital beds may be rented up to a period of 10 months up to the purchase price of an equivalent bed and in accordance with the member benefit as described in the member contract (see **Benefit Application** below)

Equipment	Medical Necessity
Hospital beds	**Hospital beds (which include fixed-height, variable-height, semi-electric and total electric) are considered medically necessary when any ONE of the following indications are met:** • The individual has a medical condition that requires positioning of the body in ways that are not feasible in an ordinary bed (elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed) **OR** • Requires frequent changes in body positioning **OR** • Requires the head of the bed to be elevated more than 30 degrees most of the time because of congestive heart failure, chronic pulmonary disease, or problems with aspiration. (pillows or wedges must first be considered and found impractical for reasons other than convenience) **OR** • Has a medical condition that makes it difficult to transfer from a standard bed to a chair, wheelchair, or to stand (e.g., severe arthritis, lower leg injury, fractured hip, a spinal cord injury, disability due to a stroke) **OR** • Requires traction equipment which can be attached only to a hospital bed **A heavy duty, extra wide/bariatric bed is considered medically necessary when criteria are met for a fixed-height bed and the individual's weight is more than 350 pounds but less than 600 pounds.**

Equipment	Medical Necessity
	An extra-heavy-duty bed is considered medically necessary when criteria are met for a fixed-height hospital bed and the individual's weight is 600 pounds or more. **An alternating pressure mattress is considered medically necessary when criteria are met for a hospital bed.**
Hospital beds, air-fluidized	**The air-fluidized bed is considered medically necessary in the treatment of extensive burns (no other criteria is required)** **OR** **The use of air-fluidized beds* is considered medically necessary when ALL of the following criteria are met:** • The individual is bed-ridden and unable to ambulate fully or partially **AND** • Has stage 3 (full thickness tissue loss) or stage 4 (deep tissue destruction) pressure sore **AND** • Has exhausted conservative treatment without improvement (such as frequent repositioning of the patient, optimization of nutritional status, debridement of wounds, wet to dry dressings) **AND** • Would require institutionalization in the absence of an air fluidized bed **AND** • Has 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** • Has a physician who directs the home treatment regimen and re-evaluates and recertifies the need for the air fluidized bed monthly

Equipment	Medical Necessity
	AND • Has used and failed to get wound healing from all other alternative equipment, including, but not limited to, gel flotation pads, egg crate mattresses, and pressure pads and pumps **Home use of the air-fluidized bed* is considered not medically necessary under any of the following circumstances:** • The individual requires treatment with wet soaks or has moist wound dressings that are not protected with impervious covering such as plastic wrap • The caregiver is unable to provide the type of care required by the patient on an air fluidized bed • Structural support is inadequate to support the weight of the air-fluidized bed system (it weighs 1600 pounds or more) • The home electrical system and home ventilation are insufficient for the anticipated increase in energy consumption and heat production of the air fluidized bed system **The following types of beds are considered not medically necessary as they are not appropriate for use in the home setting:** • Continuous lateral rotation beds • Institutional type beds • Kinetic therapy type beds • Oscillating beds • Stryker frame beds
Hospital beds, accessories	**The following bed accessories may be considered medically necessary when criteria are met for a hospital bed and there is documentation to support the medical necessity of the accessory:** • Trapeze equipment • Bed cradles (to prevent contact with the bed coverings) • Side rails and pads

Equipment	Medical Necessity
	• Innerspring/foam rubber mattresses as replacement mattresses for patient-owned hospital bed • Bed pans and urinals (for bed-confined patients)
Hospital beds, accessories (not covered)	**The following beds and accessories are not primarily intended for medical use and therefore, not covered as they are contractually excluded:** • Adjustable firmness/support mattresses (e.g., Select Comfort) • All nonhospital adjustable beds (e.g., Craftmatic Adjustable Bed, Simmons Beautyrest Adjustable Bed, Adjust-A-Sleep Adjustable Bed, Electropedic Adjustable Bed, Sleep Number or Tempur-Pedic with adjustable base, and others) • Bed boards/foot boards • Bed elevation blocks • Overbed tables/trays • Positioning pillow/cushion/wedge ○ Criteria for reflux wedge pillows used for infants with GERD is addressed in a **Related Policy** • Power/manual lounge beds • Restraints (e.g., body, chest, wrist, ankle, or any other type) • Safety, enclosure, or canopy type beds (e.g., SleepSafe Beds, Posey Enclosure Bed, Pedicraft canopy enclosed bed) • Safety accessories (e.g., belt, harness, or vest) • Vibrating beds • Viscoelastic or memory foam mattresses (e.g., Tempur-Pedic) • Water beds

Equipment	Descriptions and Additional Information
Hospital beds, types and categories	**A hospital bed is equipped to lower or raise the head and foot either manually or electrically. Hospital beds can be categorized as follows:** • Fixed-height beds – allow manual adjustments to head and leg elevation but not to height • Variable-height beds – allow manual adjustments to height, as well as to head and leg elevation

Equipment	Descriptions and Additional Information
	• Semi-electric beds – allow manual adjustments to height and electric adjustments to head and leg elevation • Total electric beds – allow electric adjustment to height, as well as to head and leg elevation ***An air-fluidized hospital bed uses warm air under pressure to set small ceramic beads in motion to simulate fluid movement. When an individual is placed in the bed, his/her body weight is evenly distributed over a large surface area, which creates a sensation of floating. It is used to treat or prevent bedsores or treat extensive burns.**

Documentation Requirements
An individual's medical records submitted for review should document that medical necessity criteria are met. The record needs to include clinical documentation of: • Diagnosis/condition • History and physical examination documenting the severity of the condition • Any medical equipment that will need to be attached to the bed • Weight if a heavy duty or extra heavy-duty bed is requested

Coding

Code	Description
HCPCS	
E0193	Powered air flotation bed (low air loss therapy)
E0194	Air fluidized bed
E0250	Hospital bed, fixed-height, with any type of side rails, with mattress
E0251	Hospital bed, fixed-height, with any type of side rails, without mattress
E0255	Hospital bed, variable height, hi-low, with any type side rails, with mattress
E0256	Hospital bed, variable height, hi-low, with any type side rails, without mattress

Code	Description
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
E0270	Hospital bed, institutional type includes oscillating, circulating, and Stryker frame, with mattress
E0277	Powered pressure-reducing air mattress
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 (safety item)
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

Code	Description
E0328	Hospital bed, pediatric, manual, 360-degree side enclosures, top of headboard, footboard, and side rails up to 24 in. above the spring, includes mattress
E0329	Hospital bed, pediatric, electric or semi-electric, 360-degree side enclosures, top of headboard, footboard, and side rails up to 24 in. above the spring, includes 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

Related Information

Benefit Application

Coverage for hospital beds and accessories depends on the member benefit as described in the member contract.

Coverage for bed rental will be covered for up to 10 months up to the purchase price of an equivalent bed and in accordance with the member benefit as described in the member contract.

When DME is purchased, the total benefits available cannot exceed the contracted fee schedule for the item.

When DME is rented, the benefits cannot exceed the total cost to purchase the DME or the contracted fee schedule for the item.

Evidence Review

In 2015, McInnes and colleagues updated a systematic review done by Callum and colleagues in 2004. The authors searched The Specialized Trials Register of the Cochrane Wounds Group in order to establish: 1) the extent to which pressure-relieving support surfaces reduce the incidence of pressure ulcers compared with standard support surfaces, and 2) their comparative effectiveness in ulcer prevention. Fifty-nine randomized clinical trials were included in the review. The authors concluded that in people at elevated risk of pressure ulcer development (like the elderly and the immobile) consideration should be given to the use of higher-specification foam mattresses rather than standard hospital foam mattresses. The relative merits of alternating and constant low-pressure devices, and of the different alternating pressure devices for pressure ulcer prevention were unclear. Medical grade sheepskins are associated with a decrease in pressure ulcer development. There was insufficient data to draw conclusions on the value of seat cushions, limb protectors and various constant low-pressure devices as pressure ulcer prevention strategies.

References

1. Centers for Medicare & Medicaid Services (CMS) National Coverage Determination (NCD) for Hospital Beds (280.7) Version 1, Effective 1/1/1966. **https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=227**. Accessed January 27, 2025.
2. Centers for Medicare & Medicaid Services (CMS) National Coverage Determination (NCD) for Air Fluidized Beds (280.8) Version 1. Effective 11/01/2020. **http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=228&ncdver=1&bc=AAAAgAAAAAAA&** Accessed January 27, 2025
3. Cullum N, McInnes E, Bell-Syer SEM, Legood R. Support surfaces for pressure ulcer prevention. Cochrane Database Syst Rev. 2004;(3):CD001735. PMID 15266452
4. Lyder CH. Pressure ulcer prevention and management. JAMA. 2003; 289(2):223-226. ISSN 00987484.
5. McInnes E1, Jammali-Blasi A, Bell-Syer SE, Dumville JC, Middleton V, Cullum N. Support surfaces for pressure ulcer prevention. Cochrane Database Syst Rev. 2015 Sep 3;(9):CD001735. PMID 26333288.
6. Centers for Medicare & Medicaid Services (CMS).. Local Coverage Determination (LCD) for Hospital Beds and Accessories (L33820). Effective 10/01/15. Revised 01/01/20. **https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33820**. Accessed January 27, 2025.
7. U.S. Food and Drug Administration (FDA), Center for Devices and Radiological Health (CDRH). Medical Devices. Hospital beds. 08/23/18. Available at: **http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/default.htm** Accessed January 27, 2025.
8. Sprigle S, Sonenblum S. Assessing evidence supporting redistribution of pressure for pressure ulcer prevention: A review. J Rehabil Res Dev. 2011;48(3):203-213. PMID 21480095.

9. Nixon J, Brown S, Smith I, et al. Comparing alternating pressure mattresses and high-specification foam mattresses to prevent pressure ulcers in high-risk patients: The PRESSURE 2 RCT. Health Technol Assess. 2019; 23 (52): 1-176. PMID: 31559948

History

Date	Comments
08/08/06	Add to Durable Medical Equipment Section - New Policy
03/13/07	Replace policy. Policy statement for total electronic beds clarified as a convenience item. No other changes.
11/13/07	Replace policy. Policy updated with literature search. Policy statement to include "A variable-height bed including a total electric bed is considered medically necessary when criteria are met for a fixed-height bed, and the patient requires a bed height other than that of a fixed-height hospital to permit transfers to a chair, wheelchair or standing position."
11/27/07	Codes Updated. HCPCS codes E0328 and E0329 added. No other changes.
11/11/08	Replace policy. Policy updated with literature search; no change to policy statement (formatting update only). Code E0194 (air fluidized bed) added. No other changes.
06/09/09	Replace policy. Policy statement revised. Statement referring to structural support is inadequate to support the weight of the air fluidized system deleted. Statement referring to the home electrical system is insufficient for the anticipated increase in energy consumption is also deleted. No other changes.
05/11/10	Replace policy. Policy statement re-worded. Intent of statements unchanged. No other changes.
07/12/11	Replace policy. Policy updated with literature search. Intent of policy statements unchanged. Additional HCPCS codes added.
02/14/12	Replace policy. No change to the policy statement. Code E0190 positioning pillow/cushion/wedge added with supporting statement of non-coverage within the Policy Guidelines section.
08/24/12	Update Coding Section – ICD-10 codes are now effective 10/01/2014.
02/13/13	Replace policy. Policy updated with literature review; no change to policy statements. HCPCS codes E0325 and E0326 removed; they do not relate to policy content.
02/24/14	Replace policy. No change to policy statements. HCPCS coding update: codes related to mattress pads and support removed: A4640, E0181 – E0182, E0185, E0188 – E0189, and E0197 – E0199.
02/25/15	Annual Review. No change to policy statements.
01/12/16	Annual Review. Policy reviewed; no changes in policy statements.

Date	Comments
01/10/17	Annual Review. Policy reviewed with literature search through November 2016; references added. Policy statements unchanged.
03/24/17	Policy moved into new format; no change to policy statements.
04/11/17	Coding update; removed HCPCS codes E0305 and E0310.
02/01/18	Annual Review, approved January 9, 2018. Policy edited for clarity. Policy statement on safety enclosure/canopies changed to not medically necessary.
02/01/19	Annual Review, approved January 22, 2019. Added list of beds that are not considered medically necessary as they are inappropriate for home use. Added statement to the non-covered section regarding pillows/wedges/cushions that criteria for reflux wedges used for infants with GERD is addressed in a Related Policy 1.01.530. Removed CPT codes E0184-E0191, E0196, E0271, E0272, E0275, E0276, E0280, E0370, E0910, E0911, E0940.
03/01/19	Minor update, Documentation Requirements section added.
03/08/19	Minor update, added 1.01.530 to the Related Medical Policies section.
03/01/20	Annual Review, approved February 4, 2020. Guideline reviewed. Added safety accessories (e.g., belt, harness, or vets) and restraints (e.g., body, chest, wrist, ankle or any type) to not covered list; otherwise guideline statements unchanged. Removed HCPCS code E0275. Also removed HCPCS codes E0190, E0273, E0274, E0315, E0700, E0710 as they are addressed in a separate policy.
04/01/20	Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020 and replaced with InterQual criteria for dates of service on or after July 2, 2020.
07/02/2020	Delete policy.
11/01/20	Policy reinstated effective February 5, 2021, approved October 13, 2020.
05/01/21	Interim Review, approved April 13, 2021. Safety enclosure/canopy beds changed from not medically necessary to non-covered as a contractual exclusion.
01/01/22	Annual Review, approved December 2, 2021. UM Guideline reviewed. Reference added. Guideline statements unchanged.
04/01/22	Annual Review, approved March 7, 2022. UM Guideline reviewed. Guideline statements unchanged. Removed HCPC code E0316.
02/01/23	Annual Review, approved January 23, 2023. UM Guideline reviewed. Added medically necessary indication for a hospital bed for an individual that has a medical condition that makes it difficult to transfer from a standard bed to a chair, wheelchair, or to stand. Changed the wording from "patient" to "individual" throughout the policy for standardization.
06/15/23	Update to Related Policies. 1.01.11 is replaced by 1.01.506 Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses.
04/01/24	Annual Review, approved March 25, 2024. UM guideline reviewed. Guideline statements unchanged. Deleted related policy 1.01.506 Adjustable Cranial Orthoses for Positional

Date	Comments
	Plagiocephaly and Craniosynostoses. Added related policy 1.01.530 Children's Therapeutic Positioning Equipment.
04/01/25	Annual Review, approved March 10, 2025. UM guideline reviewed. Guideline statements unchanged. Removed HCPCS code E0912.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.