Medical Policy

Hospital Beds and Accessories

Policy Number: PG0245
Last Review: 05/01/2024

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

GUIDELINES:

- This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
- This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.
- Durable Medical Equipment (DME) frequency limitations are calculated based on The Center for Medicare and Medicaid Services (CMS) criteria and guidelines, National Coverage Determinations (NCD), and Local Coverage Determinations (LCD) rules and regulations.

SCOPE:

X Professional
X Facility

DESCRIPTION:

Hospital beds for patient home use come in a variety of designs, with a multitude of features and accessories to assist and protect the patient. A hospital bed is one that has manual head and leg elevation adjustment capabilities. Hospital beds can be categorized as follows:

- **Fixed-height** hospital beds allow manual adjustments to head and leg elevation but not to height.
- **Variable-height** hospital beds allow manual adjustments to height, as well as to head and leg elevation.
- **Semi-electric** beds allow manual adjustments to height and electric adjustments to head and leg elevation.
- **Totally electric** beds allow electric adjustment to height, as well as to head and leg elevation.

A physician's prescription and additional documentation including medical records and physicians' reports, must establish the medical necessity for a hospital bed due to one of the following reasons:

- The patient's condition requires positioning of the body or
- The patient's condition requires special attachments that cannot be fixed and used on an ordinary bed.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans
Effective 11/1/2020:

- **Prior Authorization required for:**
  - **Powered pressure-reducing air mattress (E0277)**
  - **Pediatric hospital bed or pediatric crib (E0300, E0328 and E0329)**
- **Codes E0265, E0266, E0270, E0273, E0274, E0296, E0297, and E0315 are non-covered.**

Some DME require prior authorization or may be non-covered. A provider must refer to the Paramount prior authorization list and specific medical policy in reference to specific DME for coverage determinations (this list may not be all-inclusive).

GENERAL DOCUMENTATION REQUIREMENTS

For an item to be covered, the supplier must receive a written, signed, and dated order before a claim is

submitted for reimbursement. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

In order to justify payment for DME items, suppliers must meet the following requirements:

- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Prescription (orders)
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

A fixed height hospital bed (E0250, E0251, E0290, and E0291) is covered if one or more of the following criteria (1-4) are met:

1. The member has a medical condition, which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or
2. The member requires positioning of the body in ways not feasible with an ordinary bed to alleviate pain, or
3. 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
4. The member requires traction equipment, which can only be attached to a hospital bed.

A variable height hospital bed (E0255, E0256, E0292, and E0293) is covered if

1. The member meets one of the criteria for a fixed height hospital bed and
2. The member requires a bed height different from a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

A semi-electric hospital bed (E0260, E0261, E0294, and E0295) is covered if

1. The member meets one of the criteria for a fixed height bed and
2. Requires frequent changes in body position and/or has an immediate need for a change in body position and
3. Member is able to operate the controls for adjustment

A heavy duty extra wide hospital bed (E0301, E0303) is covered if

1. The member meets one of the criteria for a fixed height hospital bed, and
2. The member's weight is more than 350 pounds but ~~does not exceed~~ less than 600 pounds.

An extra heavy-duty hospital bed (E0302, E0304) is covered if

1. The member meets one of the criteria for a hospital bed and
2. The member's weight exceeds 600 pounds.

A pediatric hospital crib/bed (E0300, E0328, E0329) is considered medically necessary when required by the member's condition and is an integral part of, or an accessory to, a medically necessary hospital bed.

A pediatric hospital bed or pediatric crib is defined as a fully enclosed bed with all of the following features:

1. A bed that allows adjustment of the head and foot of the bed.
2. A manual pediatric hospital bed (procedure code E0328) or pediatric crib (procedure code E0300) allows manual adjustment to the head and leg elevation.
3. A semi-electric or fully electric hospital bed (procedure code E0329) allows manual or electric adjustments to height and electric adjustments to head and leg elevation.
4. A headboard
5. A footboard

6. A mattress
7. Side rails of any type (A side rail is defined as a hinged or removable rail, board, or panel.)
8. A bed that has side rails that extend 24 inches or less above the mattress is considered a pediatric hospital bed (procedure code E0328 or E0329).
9. A pediatric hospital bed may be fixed or variable height. Variable height beds may be adjusted manually or electrically as required for the client's medical condition.
10. A bed that has side rails that extend more than 24 inches above the mattress is considered a pediatric crib (procedure code E0300)

A semi-electric hospital pediatric bed (E0329) is covered if the following criteria is met:

1. There is a medical condition, which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30° does not usually require the use of a hospital bed, Or
2. There is a medical condition that requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, Or
3. A medical condition requires the head of the bed to be elevated more than 30° most of the time due to CHF, COPD, or problems with aspiration. Pillows or wedges must have been considered and ruled out, Or
4. Traction equipment that can only be attached to a hospital bed is required. And
5. There is a requirement for frequent changes in body position and/or there is an immediate need for a change in body position.

For any of the above hospital beds, if documentation does not justify the medical need of the type of bed billed, payment will be denied as not reasonable and necessary.

If the member does not meet any of the coverage criteria for any type of hospital bed, it will be denied as not reasonable and necessary.

NON-MEDICAL NECESSITY COVERAGE

A total electric hospital bed (E0265, E0266, E0296, and E0297) is non-covered; the height adjustment feature is a convenience feature. Total electric beds will be denied as not reasonable and necessary.

Trapeze bars attached to a bed (E0910, E0911) are non-covered when used on an ordinary bed.

The following types of beds are considered not medically necessary and inappropriate for use in the home setting:

- Institutional type beds (e.g., E0270)
- Kinetic therapy beds
- Oscillating beds
- Stryker frame beds
- Continuous lateral rotation beds

The following beds and accessories are not primarily medical in nature and/or are specifically excluded under many benefit plans:

- all nonhospital adjustable beds (e.g., Craftmatic® Adjustable Bed, Simmons® Beautyrest® Adjustable Bed, Adjust-A-Sleep Adjustable Bed)
- bed boards (E0273, E0315)
- bed elevators (e.g., blocks, lifters)
- bed wedges/pillows
- bed rail pads
- bed spectacles
- call switches
- custom bedroom equipment

- mattresses (e.g., innerspring, foam rubber [E0271, E0272], viscoelastic or memory foam mattresses [e.g., Tempur-Pedic®], adjustable firmness/support mattresses [e.g., Select Comfort]))
- overbed tables (E0274), trays, lap boards
- power/manual lounge beds, including electric chair positioning features
- waterbeds

Bed wedges are not primarily medical in nature and/or are specifically excluded under many benefit plans. An exception may be made for infants with gastroesophageal reflux disease (GERD).

ACCESSORIES

Powered pressure reducing mattress, alternating pressure, low air loss, or powered flotation without low air loss, (E0277) is characterized by All of the following:

1. 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
2. Inflated cell height of the air cells through which air is being circulated is 5 in. or greater; and
3. Air cell height, inter-cell proximity, frequency of air cell inflating/deflation (for alternating pressure mattresses) and air pressure level provide adequate patient lift, reduce pressure, and prevent bottoming out; and
4. A surface designed to reduce friction and shear; and
5. Can be placed directly on a hospital bed frame.

Coverage is met when documentation justifies the medical necessity as indicated below, All of the following:

1. Multiple Stage II pressure ulcers located on the trunk or pelvis; and
2. Member has been on a comprehensive ulcer treatment program for at least the preceding 30 days, which has included the use of nonpowered pressure reducing mattress overlay support surface; and
3. The ulcers have worsened or remained unchanged over the past month.

OR

4. Large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis; or

OR

5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days)

The comprehensive ulcer treatment described in # 2 above should generally include:

i. Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
ii. Regular assessment by a nurse, physician, or other licensed health care practitioner (usually at least weekly for a patient with a Stage III or IV ulcer).
iii. Appropriate turning and positioning.
iv. Appropriate wound care (for a Stage II, III, or IV ulcer).
v. Appropriate management of moisture/incontinence.
vi. Nutritional assessment and intervention consistent with the overall plan of care.

Continued use of a support surface may be considered medically necessary until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that:

i. Other aspects of the care plan are being modified to promote healing; or
ii. The continued use is medically necessary for wound management.

The staging of pressure ulcers used in this policy is as follows:

- Stage I: Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.
- Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

- Stage III: Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
- Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

Trapeze equipment (E0910, E0940) is covered if the member needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

Heavy-duty trapeze equipment (E0911, E0912) is covered if the member meets the criteria for regular trapeze equipment and the member's weight is more than 250 pounds.

A bed cradle (E0280) is covered when it is necessary to prevent contact with the bed coverings. Examples of medical conditions that may require decreased contact with bed coverings are: acute gouty arthritis, diabetic foot ulcers, pressure injuries, and burns.

Side rails (E0305, E0310) or safety enclosures (E0316) are covered when they are required by the member's condition and they are an integral part of, or an accessory to, a covered hospital bed.

If a member's condition requires a replacement, innerspring mattress (E0271) or foam rubber mattress (E0272) it will be covered for a member owned hospital bed.

Codes E0265, E0266, E0270, E0273, E0274, E0296, E0297, and E0315 are non-covered.

CODING/BILLING INFORMATION:
The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

HCPCS CODES	
Fixed Height Beds	
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
Variable Height Beds	
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
Semi Electric Beds	
E0260	Hospital bed, semi-electric (head and foot adjustment), w/any type side rails, w/mattress
E0261	Hospital bed, semi-electric (head and foot adjustment), w/any type side rails, w/o 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
Total Electric Beds	
E0265	Hospital bed, total electric (head, foot and height adjustments), w/any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot and height adjustments), w/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
Heavy Duty Beds	
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
Pediatric Crib/Beds	
E0300	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure
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
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
Institutional Beds	
E0270	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress
Accessories	
E0271	Mattress, innerspring
E0272	Mattress, foam rubber
E0273	Bed board
E0274	Over-bed table
E0277	Powered pressure-reducing air mattress
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
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
Miscellaneous	
E1399	Durable medical equipment, miscellaneous

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 07/15/2009

Date	Explanation & Changes
09/11/2018	• Codes E0275, E0276, E0325, E0326, E0350, E0352, E0370 removed from policy per CMS guidelines • Codes E0910, E0911, E0912, E0940, E1399 added to policy per CMS guidelines • Codes E0265, E0266, E0270, E0273, E0274, E0296, E0297, E0315 are non-covered for HMO, PPO, Individual Marketplace, Elite per CMS guidelines • Codes E0250, E0251, E0265, E0266, E0270, E0273, E0274, E0280, E0290, E0291, E0296, E0297, E0300, E0315, E0316, E0911 are non-covered for Advantage per ODM guidelines • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee

09/01/2020	• Medical Policy updated • Procedure E0277 added to the medical policy. • Prior Authorization determination made for procedure codes E0300, E0328, E0329 and E0277 • Coverage criteria indicated/documented
09/04/2020	• Corrected the documentation error related to HCPCS E0300 • In error, the policy indicated that HCPCS E0300 was both covered and noncovered for the Advantage Product line • The documentation was corrected to indicate that HCPCS E0300 is noncovered for the Advantage Product line, per ODM
09/25/2020	• Effective Prior Authorization requirement date moved/extended to be in effect 11/1/2020
12/17/2020	• Medical policy placed on the new Paramount Medical Policy Format
02/16/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
03/29/2023	• Medical Policy updated to reflect DME limits calculated by CMS criteria/guidelines.
03/04/2024	• Medical policy placed on the new Paramount Medical Policy format
05/01/2024	• Medical Policy reviewed and updated to reflect the most current clinical evidence

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/
Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review

Medical Policy Prior to 05/01/2024:

DESCRIPTION:

Hospital beds for patient home use come in a variety of designs, with a multitude of features and accessories to assist and protect the patient. Hospital beds provide features such as head and leg elevation and height adjustment.

A physician's prescription and additional documentation including medical records and physicians' reports, must

establish the medical necessity for a hospital bed due to one of the following reasons:

- The patient's condition requires positioning of the body or
- The patient's condition requires special attachments that cannot be fixed and used on an ordinary bed.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans
Effective 11/1/2020:
Prior Authorization required for:

- **Procedure E0277- Powered pressure-reducing air mattress**
- **Pediatric hospital bed or pediatric crib; procedures E0300, E0328 and E0329.**
- **Exception: procedure E0300 is not covered for the Advantage Product line.**

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans
Codes E0265, E0266, E0270, E0273, E0274, E0296, E0297, and E0315 are non-covered.

Paramount Advantage Medicaid
Codes E0250, E0251, E0265, E0266, E0270, E0273, E0274, E0280, E0290, E0291, E0296, E0297, E0300, E0315, E0316, and E0911 are non-covered.

Paramount Commercial Insurance Plans, Elite (Medicare Advantage) Plans, and Paramount Advantage Medicaid

Some DME require prior authorization or may be non-covered. A provider must refer to the Paramount prior authorization list and specific medical policy in reference to specific DME for coverage determinations (this list may not be all

GENERAL DOCUMENTATION REQUIREMENTS
For an item to be covered, the supplier must receive a written, signed, and dated order before a claim is submitted for reimbursement. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

In order to justify payment for DME items, suppliers must meet the following requirements:

- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Prescription (orders)
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

COVERAGE CRITERIA:
Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

A fixed height hospital bed (E0250, E0251, E0290, and E0291) is covered if one or more of the following criteria (1-4) are met:

5. The beneficiary has a medical condition, which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or
6. The beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
7. The beneficiary 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
8. The beneficiary requires traction equipment, which can only be attached to a hospital bed.

A variable height hospital bed (E0255, E0256, E0292, and E0293) is covered if the beneficiary meets one of the criteria for a fixed height hospital bed and requires a bed height different from a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

A semi-electric hospital bed (E0260, E0261, E0294, and E0295) is covered if the beneficiary meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

A heavy duty extra wide hospital bed (E0301, E0303) is covered if the beneficiary meets one of the criteria for a fixed height hospital bed and the beneficiary's weight is more than 350 pounds, but does not exceed 600 pounds.

An extra heavy-duty hospital bed (E0302, E0304) is covered if the beneficiary meets one of the criteria for a hospital bed and the beneficiary's weight exceeds 600 pounds.

A pediatric hospital crib/bed (E0300, E0328, E0329) is considered medically necessary when required by the individual’s condition and is an integral part of, or an accessory to, a medically necessary hospital bed.

A pediatric hospital bed or pediatric crib is defined as a fully enclosed bed with all of the following features:

11. A bed that allows adjustment of the head and foot of the bed.
12. A manual pediatric hospital bed (procedure code E0328) or pediatric crib (procedure code E0300) allows manual adjustment to the head and leg elevation.
13. A semi-electric or fully electric hospital bed (procedure code E0329) allows manual or electric adjustments to height and electric adjustments to head and leg elevation.
14. A headboard
15. A footboard
16. A mattress
17. Side rails of any type (A side rail is defined as a hinged or removable rail, board, or panel.)
18. A bed that has side rails that extend 24 inches or less above the mattress is considered a pediatric hospital bed (procedure code E0328 or E0329).
19. A pediatric hospital bed may be fixed or variable height. Variable height beds may be adjusted manually or electrically as required for the client’s medical condition.
20. A bed that has side rails that extend more than 24 inches above the mattress is considered a pediatric crib (procedure code E0300)

A semi-electric hospital pediatric bed (E0329) is covered if the following criteria is met:

6. There is a medical condition, which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30° does not usually require the use of a hospital bed,

Or

7. There is a medical condition that requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain,

Or

8. A medical condition requires the head of the bed to be elevated more than 30° most of the time due to CHF, COPD, or problems with aspiration. Pillows or wedges must have been considered and ruled out,

Or

9. Traction equipment that can only be attached to a hospital bed is required.

And

10. There is a requirement for frequent changes in body position and/or there is an immediate need for a change in body position.

For any of the above hospital beds, if documentation does not justify the medical need of the type of bed billed, payment will be denied as not reasonable and necessary.

If the beneficiary does not meet any of the coverage criteria for any type of hospital bed, it will be denied as not reasonable and necessary.

NON-MEDICAL NECESSITY COVERAGE
A total electric hospital bed (E0265, E0266, E0296, and E0297) is non-covered; the height adjustment feature is a convenience feature. Total electric beds will be denied as not reasonable and necessary.

Trapeze bars attached to a bed (E0910, E0911) are non-covered when used on an ordinary bed.

The following types of beds are considered not medically necessary and inappropriate for use in the home setting:

- institutional type beds (e.g., E0270)
- kinetic therapy beds
- oscillating beds
- Stryker frame beds
- continuous lateral rotation beds

The following beds and accessories are not primarily medical in nature and/or are specifically excluded under many benefit plans:

- all nonhospital adjustable beds (e.g., Craftmatic® Adjustable Bed, Simmons® Beautyrest® Adjustable Bed, Adjust-A-Sleep Adjustable Bed)
- bed boards (E0273, E0315)
- bed elevators (e.g., blocks, lifters)
- bed wedges/pillows
- bedrail pads
- bed spectacles
- call switches
- custom bedroom equipment
- overbed tables (E0274), trays, lap boards
- power/manual lounge beds, including electric chair positioning features
- waterbeds

Bed wedges are not primarily medical in nature and/or are specifically excluded under many benefit plans. An exception may be made for infants with gastroesophageal reflux disease (GERD).

ACCESSORIES
Powered pressure reducing mattress, alternating pressure, low air loss, or powered flotation without low air loss, (E0277) is characterized by All of the following:

1. 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
2. Inflated cell height of the air cells through which air is being circulated is 5 in. or greater; and
3. Air cell height, inter-cell proximity, frequency of air cell inflating/deflation (for alternating pressure mattresses) and air pressure level provide adequate patient lift, reduce pressure and prevent bottoming out; and
4. A surface designed to reduce friction and shear; and
5. Can be placed directly on a hospital bed frame.

Coverage is met when documentation justifies the medical necessity as indicated below, All of the following:

1. Multiple Stage II pressure ulcers located on the trunk or pelvis; and
2. Member has been on a comprehensive ulcer treatment program for at least the preceding 30 days, which has included the use of nonpowered pressure reducing mattress overlay support surface; and
3. The ulcers have worsened or remained unchanged over the past month.

OR

5. Large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis; or

OR
5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days)

The comprehensive ulcer treatment described in # 2 above should generally include:

i. Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
ii. Regular assessment by a nurse, physician, or other licensed health care practitioner (usually at least weekly for a patient with a Stage III or IV ulcer).
iii. Appropriate turning and positioning.
iv. Appropriate wound care (for a Stage II, III, or IV ulcer).
v. Appropriate management of moisture/incontinence.
vi. Nutritional assessment and intervention consistent with the overall plan of care.

Continued use of a support surface may be considered medically necessary until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that:

iii. Other aspects of the care plan are being modified to promote healing; or
iv. The continued use is medically necessary for wound management.

The staging of pressure ulcers used in this policy is as follows:

- Stage I: Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.
- Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
- Stage III: Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
- Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

Trapeze equipment (E0910, E0940) is covered if the beneficiary needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

Heavy-duty trapeze equipment (E0911, E0912) is covered if the beneficiary meets the criteria for regular trapeze equipment and the beneficiary's weight is more than 250 pounds.

A bed cradle (E0280) is covered when it is necessary to prevent contact with the bed coverings.

Side rails (E0305, E0310) or safety enclosures (E0316) are covered when they are required by the beneficiary's condition and they are an integral part of, or an accessory to, a covered hospital bed.

If a beneficiary's condition requires a replacement, innerspring mattress (E0271) or foam rubber mattress (E0272) it will be covered for a beneficiary owned hospital bed.

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Codes E0265, E0266, E0270, E0273, E0274, E0296, E0297, and E0315 are non-covered.

Paramount Advantage Medicaid

Codes E0250, E0251, E0265, E0266, E0270, E0273, E0274, E0280, E0290, E0291, E0296, E0297, E0300, E0315, E0316, and E0911 are non-covered.