



An Independent Licensee of the Blue Cross and Blue Shield Association.

## Hospital Beds Corporate Medical Policy

File Name: Hospital Beds  
File Code: 8.03.VT205  
Origination: 04/18/07  
Last Review: 08/2024  
Next Review: 08/2025  
Effective Date: 09/01/2025

### Description/Summary

#### Definitions:

**Durable Medical Equipment (DME):** Equipment that requires a prescription from your Provider:

- is primarily and customarily used for a medical purpose;
- is appropriate for use in the home;
- is designed for prolonged and repeated use; and
- is not generally useful to a person that is not ill or injured.

DME includes hospital-type beds as defined below:

**Fixed-height hospital bed:** Manual head and leg elevation adjustments but no height adjustments. **Variable height hospital bed:** Manual height adjustment and with manual head and leg elevation adjustments.

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

**Total electric hospital bed:** Electric height adjustment with electric head and leg elevation adjustments. Available in heavy-duty and extra heavy-duty, based on weight.

**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 Coding 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 on 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 member 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 member 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 a fixed-height hospital bed; **AND**

- the member requires frequent changes in body position and/or has an immediate need for a change in body position; **OR**
- the member has a condition that requires a variable height feature. Such conditions may include brain injury, spinal cord injury, severe arthritis or orthopedic conditions or severe cardiac conditions, among other severely debilitating diseases/conditions where the member requires a bed height other than a fixed-height hospital bed to permit transfers to a chair, wheelchair or standing position.

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

An **extra-heavy-duty bed** may be **medically necessary** when criteria are met for a fixed-height hospital bed and the member 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 or chair bound as a result of limited mobility; **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 Durable Medical Equipment (DME) are considered medically necessary when it is necessary to make the equipment usable. The Plan reserves the right to determine whether rental or purchase of the equipment is more cost-effective and/or appropriate. The total rental benefits may not exceed our allowed amount 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. 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.

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

- Personal service, comfort or convenience items. This includes items, additions or upgrades that are intended primarily for member/caregiver convenience.
- When a hospital bed does not provide a therapeutic benefit to a patient in need because of certain medical conditions or illnesses.

The Plan does not cover any of the following beds and accessories, as they are not primarily medical in nature and are therefore non-covered (benefit exclusion):

- 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); Synthetic or lambswool sheepskin pad, any

- size;
- Waterbeds

## 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. Policy archived 08/2018.
2. Centers for Medicare and Medicaid Services National Coverage Determination (NCD) for Air-Fluidized Bed (280.8). Reviewed 7/2022.
3. Blue Cross Blue Shield of Texas Medical Policy, Hospital Beds. 101.001 2/27/2004. [http://www.bcbstx.com/provider/pdf/medicalpolicies/dme/101\\_001.pdf](http://www.bcbstx.com/provider/pdf/medicalpolicies/dme/101_001.pdf)

### Related Policies

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

### 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.

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. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

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 an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

## Policy Implementation/Update information

07/2007	Reviewed by CAC
03/2008	Annual review. Naturopathic Physician added as eligible provider. Reviewed by CAC 05/2008.
10/2011	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.
10/2011	Medical/Clinical Coder reviewed and approved. SAF
09/2015	Criteria for total electric beds added. Sections headers added, updated and/or clarified. Code table updated.
05/2017	Changed medical policy language for bed and accessories from not being medically necessary to non-covered benefit exclusion to align with benefit configuration. Updated related policies.
02/2019	Updated references no changes in policy statements.

03/2020	Annual review. Minor language change to Air Fluidized Bed criteria. Updated references.
09/2021	Policy reviewed. Update to total electric bed criteria.
08/2022	No change to policy statement. References updated.
08/2023	Policy reviewed no changes to policy statements. Updated related policy section.
08/2024	Policy reviewed. Minor formatting changes. No change to policy statement.

### Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

### Approved by BCBSVT Medical Directors

Tom Weigel, MD, MBA  
Vice President and Chief Medical Officer

Tammaji P. Kulkarni, MD  
Senior Medical Director

### Attachment I HCPCS Code Table & Instructions

Code Type	Number	Description
<b>Services are considered medically necessary when applicable criteria outlined in the policy are met.</b>		
<b>Hospital beds require prior approval regardless of Purchase price. Hospital bed accessories require prior approval if purchase price is over the benefit dollar threshold.</b>		
<b>The following services are denied as benefit exclusions and therefore non-covered</b>		
HCPCS	E0187	Water pressure mattress
HCPCS	E0188	Synthetic sheepskin pad
HCPCS	E0189	Lambswool sheepskin pad, any size
HCPCS	E0190	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories

HCPCS	E0198	Water pressure pad for mattress, standard mattress length and width
HCPCS	E0199	Dry pressure pad for mattress, standard mattress length and width
HCPCS	E0270	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress
HCPCS	E0271	Mattress, innerspring
HCPCS	E0272	Mattress, foam rubber
HCPCS	E0273	Bed board
HCPCS	E0274	Over-bed table
HCPCS	E0315	Bed accessory: board, table, or support device, any type
HCPCS	E0316	Safety enclosure frame/canopy for use with hospital bed, any type