GUIDELINES
This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

SCOPE
X Professional
_ 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. 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

HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan, Advantage
Effective 10/1/2020 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.

HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan
Codes E0265, E0266, E0270, E0273, E0274, E0296, E0297, and E0315 are non-covered.

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

HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan, Advantage
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):
PG0352 Air Fluidized Bed (E0194)
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
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 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
2. The beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
3. 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
4. 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:
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 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
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 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.

**HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan**

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

**Advantage**

Codes E0250, E0251, E0265, E0266, E0270, E0273, E0274, E0280, E0290, E0291, E0296, E0297, E0300, E0315, E0316, and E0911 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**

<table>
<thead>
<tr>
<th>Fixed Height Beds</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E0250 Hospital bed, fixed height, with any type side rails, with mattress</td>
<td></td>
</tr>
<tr>
<td>E0251 Hospital bed, fixed height, with any type side rails, without mattress</td>
<td></td>
</tr>
<tr>
<td>E0290 Hospital bed, fixed height, without side rails, with mattress</td>
<td></td>
</tr>
<tr>
<td>E0291 Hospital bed, fixed height, without side rails, without mattress</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable Height Beds</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E0255 Hospital bed, variable height, hi-lo, with any type side rails, with mattress</td>
<td></td>
</tr>
<tr>
<td>E0256 Hospital bed, variable height, hi-lo, with any type side rails, without mattress</td>
<td></td>
</tr>
<tr>
<td>E0292 Hospital bed, variable height, hi-lo, without side rails, with mattress</td>
<td></td>
</tr>
<tr>
<td>E0293 Hospital bed, variable height, hi-lo, without side rails, without mattress</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Semi Electric Beds</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E0260 Hospital bed, semi-electric (head and foot adjustment), w/any type side rails, w/mattress</td>
<td></td>
</tr>
<tr>
<td>E0261 Hospital bed, semi-electric (head and foot adjustment), w/any type side rails, w/o mattress</td>
<td></td>
</tr>
<tr>
<td>E0294 Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress</td>
<td></td>
</tr>
<tr>
<td>E0295 Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Electric Beds</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E0265 Hospital bed, total electric (head, foot and height adjustments), w/any type side rails, with mattress</td>
<td></td>
</tr>
<tr>
<td>E0266 Hospital bed, total electric (head, foot and height adjustments), w/any type side rails, without mattress</td>
<td></td>
</tr>
<tr>
<td>E0296 Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress</td>
<td></td>
</tr>
<tr>
<td>E0297 Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress</td>
<td></td>
</tr>
<tr>
<td>Heavy Duty Beds</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
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</tr>
<tr>
<td>E0301</td>
<td>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</td>
</tr>
<tr>
<td>E0302</td>
<td>Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress</td>
</tr>
<tr>
<td>E0303</td>
<td>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</td>
</tr>
<tr>
<td>E0304</td>
<td>Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress</td>
</tr>
<tr>
<td>Pediatric Crib/Beds</td>
<td></td>
</tr>
<tr>
<td>E0300</td>
<td>Pediatric crib, hospital grade, fully enclosed, with or without top enclosure</td>
</tr>
<tr>
<td>E0328</td>
<td>Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard, and side rails up to 24 inches above the spring, includes mattress</td>
</tr>
<tr>
<td>E0329</td>
<td>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</td>
</tr>
<tr>
<td>Institutional Beds</td>
<td></td>
</tr>
<tr>
<td>E0270</td>
<td>Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress</td>
</tr>
<tr>
<td>Accessories</td>
<td></td>
</tr>
<tr>
<td>E0271</td>
<td>Mattress, innerspring</td>
</tr>
<tr>
<td>E0272</td>
<td>Mattress, foam rubber</td>
</tr>
<tr>
<td>E0273</td>
<td>Bed board</td>
</tr>
<tr>
<td>E0274</td>
<td>Over-bed table</td>
</tr>
<tr>
<td>E0277</td>
<td>Powered pressure-reducing air mattress</td>
</tr>
<tr>
<td>E0280</td>
<td>Bed cradle, any type</td>
</tr>
<tr>
<td>E0305</td>
<td>Bed side rails, half length</td>
</tr>
<tr>
<td>E0310</td>
<td>Bed side rails, full length</td>
</tr>
<tr>
<td>E0315</td>
<td>Bed accessory: board, table or support device, any type</td>
</tr>
<tr>
<td>E0316</td>
<td>Safety enclosure frame/canopy for use with hospital bed, any type</td>
</tr>
<tr>
<td>E0910</td>
<td>Trapeze bars, a/k/a patient helper, attached to bed, with grab bar</td>
</tr>
<tr>
<td>E0911</td>
<td>Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar</td>
</tr>
<tr>
<td>E0912</td>
<td>Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar</td>
</tr>
<tr>
<td>E0940</td>
<td>Trapeze bar, free standing, complete with grab bar</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
</tr>
<tr>
<td>E1399</td>
<td>Durable medical equipment, miscellaneous</td>
</tr>
</tbody>
</table>

**REVISION HISTORY EXPLANATION**

**ORIGINAL EFFECTIVE DATE: 07/15/2009**


**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.
REFERENCES/RESOURCES
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review
Hayes, Inc.