



ND

# Medical Policies



Policy Number:	E-12		
Policy Name:	Beds- Accessories and Related Items		
Policy Type:	Medical	Policy Subtype:	Durable Medical Equipment (DME)
Effective Date:	09-15-2025	End Date:	11-02-2025

## Description

A hospital bed is a bed with head and leg elevation, and in some cases, height adjustment features that are used to assist individuals who require adjustment or repositioning.

## Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date; **and/or**

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

## Criteria

Coverage is subject to the specific terms of the member's benefit plan.

## Manual/Fixed Hospital Beds with/without variable height feature

### Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

A manual hospital bed without variable height feature (also known as a fixed height hospital bed) may be considered medically necessary when any **ONE** (1) of the following criteria is met:

- The individual's condition requires positioning of the body, e.g., to alleviate pain, promote good body alignment, prevent contractures **and/or** avoid respiratory infections, in ways not feasible in an ordinary bed; **or**
- The individual's condition requires special attachments that cannot be fixed and used on an ordinary bed; **or**
- The individual 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. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed.

A manual hospital bed with a variable height feature may be considered medically necessary when **BOTH** of the following conditions are met:

- The individual meets one of the criteria for a fixed height hospital bed; **and**
- BCBS may determine that a variable height feature of a hospital bed is medically necessary and, therefore, covered, for one of the following conditions:
  - Severe cardiac conditions. For those cardiac individuals who are able to leave bed, but who must avoid the strain of 'jumping' up or down; **or**
  - Severe arthritis and other injuries to lower extremities; e.g., fractured hip. The condition requires the variable height feature to assist the individual to ambulate by enabling the individual to place his or her feet on the floor while sitting on the edge of the bed; **or**
  - Spinal cord injuries, including quadriplegic and paraplegic individuals, multiple limb amputee and stroke individuals. For those individuals who are able to transfer from bed to a wheelchair, with or without help; **or**
  - Other severely debilitating diseases and conditions, if the variable height feature is required to assist the individual to ambulate.

A manual hospital bed not meeting the criteria as indicated in this policy is considered not medically necessary.

Procedure Codes

E0250	E0251	E0255	E0256	E0290	E0291	E0292
E0293						

Semi-Electric Hospital Beds

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date.

A semi-electric hospital bed may be considered medically necessary when **ALL** of the following criteria are met:

- The individual meets all requirements for a standard hospital bed; **and**
- The individual's condition requires frequent and/or immediate change in body position (i.e., no delay can be tolerated); **and**

- The individual can operate the controls himself, with the exception of spinal cord disease or injury, or brain damaged individuals.

Semi-electric beds not meeting the criteria as indicated in this policy are considered not medically necessary.

A semi-electric hospital bed is one with manual height adjustment and with electric head and leg elevation adjustments.

A semi-electric hospital bed which is provided **and/or** prescribed because of the absence or inability of a person caring for the individual, for aesthetic reasons, or for added convenience will be denied as non-covered. When a semi-electric hospital bed is provided but is not prescribed by the individual's physician, the claim should be processed for the type of bed that was prescribed.

A power chair conversion bed (e.g., The Total Care Bariatric Bed) is considered a convenience feature and therefore non-covered.

Procedure Codes

E0260	E0261	E0294	E0295
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Total Electric Beds

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date.

A total electric bed may be considered non-covered because the height and adjustment features are a convenience feature.

Procedure Codes

E0265	E0266	E0296	E0297
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Side Rails and Safety Enclosures

BCBS ND considers safety enclosures for beds medically necessary DME only when the member's condition places them at risk for falls or climbing out of bed is a concern and they are an integral part of, or an accessory to, a medically necessary hospital bed. A safety enclosure frame/canopy for use with a hospital bed is a safety enclosure used to prevent a member from leaving the bed.

BCBS ND considers bedside rails for beds medically necessary DME only when the member's condition requires them and they are an integral part of, or an accessory to, a medically necessary hospital bed. Examples of conditions where bedside rails may be considered medically necessary include members with seizures, vertigo, disorientation, and neurological disorders.

**Note:** Side rails and safety enclosures for beds are considered safety features; under most benefit plans, safety items are excluded from coverage. Under benefit plans with this exclusion, bedside rails and safety enclosures

are excluded from coverage unless they are an integral part of a medically necessary bed.

## Powered Air Flotation Beds (Low Air Loss Therapy)

### Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date.

Powered air flotation beds may be considered medically necessary for individuals in the third or fourth stages of decubitus ulceration and who meet all of the requirements for a manual hospital bed.

Institutional beds under the brand name of Flexicair will be denied as non-covered because they are inappropriate for home use. The appropriateness of all other brands of powered air flotation beds for use in the home must be established on an individual consideration basis.

Power Air Flotations Beds (Low Air Loss Therapy) not meeting the criteria as indicated in this policy are considered not medically necessary.

### Procedure Code

E0193

## Air-Fluidized Beds (Bead Bed)

### Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Use of air-fluidized beds, for treatment of pressure sores may be considered medically necessary following a medical review for **ALL** of the following conditions:

- The individual has a stage three (3) (full thickness tissue loss) or stage four (4) (deep tissue destruction) pressure sore; **and**
- The individual is bedridden, or chair bound as a result of severely limited mobility; **and**
- In the absence of an air-fluidized bed, the individual would require institutionalization; **and**
- The air-fluidized bed is ordered in writing by the individual's attending physician based upon a comprehensive assessment and evaluation of the individual after conservative treatment has been tried without success; **and**
- A trained adult caregiver is available to assist the individual 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 potential problems such as leakage; **and**
- A physician directs the home treatment regimen and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis; **and**
- All other alternative equipment has been considered and ruled out.

An Air-Fluidized Bed (Bead Bed) not meeting the criteria as indicated in this policy is considered not medically necessary.

Procedure Code

E0194
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Institutional Beds

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date.

The following institutional beds are considered not suitable for home use and will therefore non-covered:

- Oscillating Bed; or
- Stryker Frame; or
- Springbase Bed; or
- Circulating Bed; or
- Rotational Beds; or
- Cage Beds.

Procedure Code

E0270
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Fully Enclosed Pediatric Cribs or Pediatric Hospital Beds with 360° Side Enclosures

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date; **and/or**

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

A fully enclosed pediatric crib (manual or electric) or a pediatric hospital bed (manual or electric) with 360° side enclosures may be considered medically necessary when the child meets criteria for any of the afore-mentioned hospital beds.

A fully enclosed Pediatric Crib beds not meeting the criteria as indicated in this policy are considered not medically necessary.

Procedure Codes

E0300	E0328	E0329
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Safety Beds

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

A safety bed (manual or electric) is considered a convenience item and are non-covered:

- Included by not limited to: Safety bed systems (e.g., KayserBetten Secure Sleep Systems, SleepSafe Bed, Hannah Safety Bed, Dream Series, Safety Sleeper).

Procedure Code

E1399
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Heavy Duty Hospital Beds

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date.

A heavy duty extra wide hospital bed may be considered medically necessary following a medical review when **ALL** of the following criteria have been met:

- The individual has met one of the criteria for a fixed height hospital bed; **and**
- The individual's weight is more than 350 pounds but does not exceed 600 pounds.

An extra heavy-duty hospital bed may be considered medically necessary following a medical review when **ALL** of the following criteria have been met:

- The individual has met one of the criteria for a fixed height hospital bed; **and**
- The individual's weight exceeds 600 pounds.

Heavy duty hospital beds not meeting the criteria as indicated in this policy are considered not medically necessary.

Procedure Codes

E0301	E0302	E0303	E0304
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Mattress

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date; **and/or**

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

A mattress is considered medically necessary only when a hospital bed has been determined medically necessary. (Separate charge for replacement mattress should not be allowed when a hospital bed is rented.)

If an individual's condition requires a replacement innerspring mattress or foam rubber mattress, it may be considered medically necessary for an individual-owned hospital bed.

## Procedure Codes

E0184	E0185	E0186	E0187	E0196	E0197	E0198
E0199	E0271	E0272	E0277	E0371	E0372	E0373

## Bed Accessories

### Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date; **and/or**

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

The following hospital bed-accessories may be considered medically necessary when a hospital bed has been determined medically necessary:

- Bed cradles: as long as the cradles are not used as a personal comfort item
- Bed pans: if the individual is bed confined
- Bed rails: only when the rails are an integral part of a hospital bed
- Safety Enclosure Frame/Canopy for Use with Hospital Bed, following a medical review; any type:
  - Trapeze bars/bases: if the member is bed-confined and needs a trapeze bar to sit up because of respiratory conditions, to change body position for other medical reasons, or to get in and out of bed
  - Built-in Weight Scale\*.

\*A hospital bed with a built-in scale is considered medically necessary **ONLY** for non-ambulatory individuals who require periodic weight measurements.

Hospital bed accessories not meeting the criteria as indicated in this policy are considered not medically necessary.

## Procedure Codes

A4640	E0181	E0183	E0275	E0276	E0280	E0305
E0310	E0316	E0910	E0911	E0912	E0940	

Accessories and Related items

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date; **and/or**

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

The following accessories and related items as they are considered comfort or convenience items and therefore are considered non-covered:

- Bed baths; **or**
- Bed boards; **or**
- Bed lifter; **or**
- Bed lounge; **or**
- Over bed tables.

Procedure Codes

A9286	E0273	E0274	E0315
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Total payments for a rental item may not exceed its allowable purchase price, except for those items identified as life sustaining DME.

Professional Statements and Societal Positions Guidelines

Not Applicable

Diagnosis Codes

Not Applicable

CURRENT CODING

HCPCS:

A4640	Alternating pressure pad	Medicaid Expansion
A9286	Any hygienic item, device	Medicaid Expansion
E0181	Press pad alternating w/ pum	Medicaid Expansion
E0183	Press underlay alter w/pump	Medicaid Expansion

E0184	Dry pressure mattress	Medicaid Expansion
E0185	Gel pressure mattress pad	Medicaid Expansion
E0186	Air pressure mattress	Medicaid Expansion
E0187	Water pressure mattress	Medicaid Expansion
E0193	Powered air flotation bed	Medicaid Expansion
E0194	Air fluidized bed	Medicaid Expansion
E0196	Gel pressure mattress	Medicaid Expansion
E0197	Air pressure pad for mattres	Medicaid Expansion
E0198	Water pressure pad for matttr	Medicaid Expansion
E0199	Dry pressure pad for mattres	Medicaid Expansion
E0250	Hosp bed fixed ht w/ mattres	Medicaid Expansion
E0251	Hosp bed fixd ht w/o mattres	Medicaid Expansion
E0255	Hospital bed var ht w/ matttr	Medicaid Expansion
E0256	Hospital bed var ht w/o matt	Medicaid Expansion
E0260	Hosp bed semi-electr w/ matt	Medicaid Expansion
E0261	Hosp bed semi-electr w/o mat	Medicaid Expansion
E0265	Hosp bed total electr w/ mat	Medicaid Expansion
E0266	Hosp bed total elec w/o matt	Medicaid Expansion
E0270	Hospital bed institutional t	Medicaid Expansion
E0271	Mattress innerspring	Medicaid Expansion
E0272	Mattress foam rubber	Medicaid Expansion
E0273	Bed board	Medicaid Expansion
E0274	Over-bed table	Medicaid Expansion
E0275	Bed pan standard	Medicaid Expansion
E0276	Bed pan fracture	Medicaid Expansion
E0277	Powered pres-redu air mattres	Medicaid Expansion
E0280	Bed cradle	Medicaid Expansion
E0290	Hosp bed fx ht w/o rails w/m	Medicaid Expansion
E0291	Hosp bed fx ht w/o rail w/o	Medicaid Expansion
E0292	Hosp bed var ht no sr w/matt	Medicaid Expansion

E0293	Hosp bed var ht no sr no mat	Medicaid Expansion
E0294	Hosp bed semi-elect w/ mattr	Medicaid Expansion
E0295	Hosp bed semi-elect w/o matt	Medicaid Expansion
E0296	Hosp bed total elect w/ matt	Medicaid Expansion
E0297	Hosp bed total elect w/o mat	Medicaid Expansion
E0300	Enclosed ped crib hosp grade	Medicaid Expansion
E0301	Hd hosp bed, 350-600 lbs	Medicaid Expansion
E0302	Ex hd hosp bed > 600 lbs	Medicaid Expansion
E0303	Hosp bed hvy dty xtra wide	Medicaid Expansion
E0304	Hosp bed xtra hvy dty x wide	Medicaid Expansion
E0305	Rails bed side half length	Medicaid Expansion
E0310	Rails bed side full length	Medicaid Expansion
E0315	Bed accessory brd/tbl/supprt	Medicaid Expansion
E0316	Bed safety enclosure	Medicaid Expansion
E0328	Ped hospital bed, manual	Medicaid Expansion
E0329	Ped hospital bed semi/elect	Medicaid Expansion
E0371	Nonpower mattress overlay	Medicaid Expansion
E0372	Powered air mattress overlay	Medicaid Expansion
E0373	Nonpowered pressure mattress	Medicaid Expansion
E0910	Trapeze bar attached to bed	Medicaid Expansion
E0911	Hd trapeze bar attach to bed	Medicaid Expansion
E0912	Hd trapeze bar free standing	Medicaid Expansion
E0940	Trapeze bar free standing	Medicaid Expansion
E1399	Durable medical equipment mi	Medicaid Expansion
A4640	Alternating pressure pad	Commercial
A9286	Any hygienic item, device	Commercial
E0181	Press pad alternating w/ pum	Commercial
E0183	Press underlay alter w/pump	Commercial
E0184	Dry pressure mattress	Commercial
E0185	Gel pressure mattress pad	Commercial

E0186	Air pressure mattress	Commercial
E0187	Water pressure mattress	Commercial
E0193	Powered air flotation bed	Commercial
E0194	Air fluidized bed	Commercial
E0196	Gel pressure mattress	Commercial
E0197	Air pressure pad for mattres	Commercial
E0198	Water pressure pad for mattr	Commercial
E0199	Dry pressure pad for mattres	Commercial
E0250	Hosp bed fixed ht w/ mattres	Commercial
E0251	Hosp bed fixd ht w/o mattres	Commercial
E0255	Hospital bed var ht w/ mattr	Commercial
E0256	Hospital bed var ht w/o matt	Commercial
E0260	Hosp bed semi-electr w/ matt	Commercial
E0261	Hosp bed semi-electr w/o mat	Commercial
E0265	Hosp bed total electr w/ mat	Commercial
E0266	Hosp bed total elec w/o matt	Commercial
E0270	Hospital bed institutional t	Commercial
E0271	Mattress innerspring	Commercial
E0272	Mattress foam rubber	Commercial
E0273	Bed board	Commercial
E0274	Over-bed table	Commercial
E0275	Bed pan standard	Commercial
E0276	Bed pan fracture	Commercial
E0277	Powered pres-redu air mattrs	Commercial
E0280	Bed cradle	Commercial
E0290	Hosp bed fx ht w/o rails w/m	Commercial
E0291	Hosp bed fx ht w/o rail w/o	Commercial
E0292	Hosp bed var ht no sr w/matt	Commercial
E0293	Hosp bed var ht no sr no mat	Commercial
E0294	Hosp bed semi-elect w/ mattr	Commercial

E0295	Hosp bed semi-elect w/o matt	Commercial
E0296	Hosp bed total elect w/ matt	Commercial
E0297	Hosp bed total elect w/o mat	Commercial
E0300	Enclosed ped crib hosp grade	Commercial
E0301	Hd hosp bed, 350-600 lbs	Commercial
E0302	Ex hd hosp bed > 600 lbs	Commercial
E0303	Hosp bed hvy dty xtra wide	Commercial
E0304	Hosp bed xtra hvy dty x wide	Commercial
E0305	Rails bed side half length	Commercial
E0310	Rails bed side full length	Commercial
E0315	Bed accessory brd/tbl/supprt	Commercial
E0316	Bed safety enclosure	Commercial
E0328	Ped hospital bed, manual	Commercial
E0329	Ped hospital bed semi/elect	Commercial
E0371	Nonpower mattress overlay	Commercial
E0372	Powered air mattress overlay	Commercial
E0373	Nonpowered pressure mattress	Commercial
E0910	Trapeze bar attached to bed	Commercial
E0911	Hd trapeze bar attach to bed	Commercial
E0912	Hd trapeze bar free standing	Commercial
E0940	Trapeze bar free standing	Commercial
E1399	Durable medical equipment mi	Commercial

## References

1. CMS Manual System. Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Sections 280.1, 280.7, 280.8.
2. Noridian Healthcare Solutions, LLC. DME MAC L33820; Revised 01/01/2017.
3. Xia Weidong, Mao Cong, Lou Xu, Xu Jianjun, Chen Xiaofeng, Lin Cai. A 13 year retrospective study evaluating the efficacy of using air-fluidised beds for toxic epidermal necrolysis patients. *Aust J of Derm.* 2016;57,205-209.
4. S. Government Accountability Office. Medicare Fee of Service: Information on the first year of nationwide reduced payment rates for durable medical equipment. GAO-18-534. Published July 2018. Accessed Jan 22, 2021.

## ND Committee Review

Internal Medical Policy Committee 5-15-2019 New policy - *Effective July 01, 2019*

- **Removed** statement regarding Franklin Beds

Internal Medical Policy Committee 5-19-2020 Annual Review - *Effective July 06, 2020*

Internal Medical Policy Committee 9-21-2020 - *Effective November 02, 2020*

- **Added** additional criteria specific for Blue Cross Blue Shield of North Dakota

Internal Medical Policy Committee 3-17-2021 Revision - *Effective May 03, 2021*

- **Updated** the way non-covered or not medically necessary is stated.

Internal Medical Policy Committee 11-23-2021 - *Effective January 03, 2022*

- **Updated** clarifying language for Safety beds

Internal Medical Policy Committee 3-23-2022 - *Effective May 02, 2022*

- **Updated** with clarifying language throughout policy.

Internal Medical Policy Committee 9-28-2022 Coding update - *Effective October 01, 2022*

- **Added** Procedure Code E0183

Internal Medical Policy Committee 9-12-2023-Annual Review-no changes in criteria - *Effective November 06, 2023*

Internal Medical Policy Committee 5-14-2024 Revision- *Effective July 01, 2024*

- **Updated** statement regarding safety beds; and
- **Added** Policy Application

Internal Medical Policy Committee 9-17-2024 Annual Review - *Effective November 04, 2024*

## Disclaimer

*Current medical policy is to be used in determining a Member's contract benefits on the date that services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, must be considered in determining eligibility for coverage. Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information. Likewise, medical policy, which addresses the issue(s) in any specific case, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and the Company reserves the right to review and update medical policy periodically.*

