

Hospital Beds (NCD 280.7)

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<p>Related Medicare Advantage Policy Guidelines</p> <ul style="list-style-type: none"> Air-Fluidized Bed (NCD 280.8) KX Modifier Pressure Reducing Support Surfaces
<p>Related Medicare Advantage Reimbursement Policy</p> <ul style="list-style-type: none"> Durable Medical Equipment Charges in a Skilled Nursing Facility Policy
<p>Related Medicare Advantage Coverage Summary</p> <ul style="list-style-type: none"> Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid

Policy Summary

[↪ See Purpose](#)

Overview

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; e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections, in ways not feasible in an ordinary bed; or
- The patient's condition requires special attachments that cannot be fixed and used on an ordinary bed.

Guidelines

For the items addressed in this policy, the criteria for "reasonable and necessary", based on Social Security Act §1862(a) (1) (A) provisions, are defined by the following indications and limitations of coverage and/or medical necessity.

For any item to be covered by Medicare, it must

- Be eligible for a defined Medicare benefit category,
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

A fixed height hospital bed is covered if one or more of the following criteria are met:

- 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
- The member requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, 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, or
- The member requires traction equipment, which can only be attached to a hospital bed.

Variable Height Feature

UnitedHealthcare 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 patients who are able to leave bed, but who must avoid the strain of "jumping" up or down;
- Severe arthritis and other injuries to lower extremities; e.g., fractured hip. The condition requires the variable height feature to assist the patient to ambulate by enabling the patient to place his or her feet on the floor while sitting on the edge of the bed;
- Spinal cord injuries, including quadriplegic and paraplegic patients, multiple limb amputee and stroke patients. For those patients 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 patient to ambulate.

Electric powered adjustments to lower and raise head and foot may be covered when the UnitedHealthcare medical staff determines that the patient's condition requires frequent change in body position and/or there may be an immediate need for a change in body position (i.e., no delay can be tolerated) and the patient can operate the controls and cause the adjustments. Exceptions may be made to this last requirement in cases of spinal cord injury and brain damaged patients.

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

An extra heavy-duty hospital bed is covered if the member meets one of the criteria for a hospital bed and the member's weight exceeds 600 pounds.

A total electric hospital bed is not covered; the height adjustment feature is a convenience feature. Total electric beds 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.

Accessories

- Trapeze equipment 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. Trapeze bars attached to a bed are noncovered when used on an ordinary bed.
- Heavy duty trapeze equipment 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 is covered when it is necessary to prevent contact with the bed coverings.
- Side rails or safety enclosures 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 or foam rubber mattress it will be covered for a member owned hospital bed.
- A bed board is non-covered since it is not primarily medical in nature.
- An over bed table is non-covered because it is not primarily medical in nature.

Documentation Requirements – General

There are numerous CMS manual requirements, reasonable and necessary requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justified. In the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying payment. Refer to the LCD, NCD, or other CMS Manuals for more information on what documents may be required.

Applicable Codes

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
E0193	Powered air flotation bed (low air loss therapy)
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
E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress
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, w/ mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, w/o mattress
E0329	Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress
Total Electric Beds	
E0265	Hospital bed, total electric (head, foot and height adjustments), w/any type side rails, with mattress (Not covered)
E0266	Hospital bed, total electric (head, foot and height adjustments), w/any type side rails, without mattress (Not covered)
E0296	Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress (Not covered)
E0297	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress (Not covered)
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

HCPCS Code	Description
Heavy Duty Beds	
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress
Accessories	
E0271	Mattress, innerspring
E0272	Mattress, foam rubber
E0273	Bed board (Not covered)
E0274	Over-bed table (Not covered)
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 (Not covered)
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

Modifier	Description
KX	Requirements specified in the medical policy have been met

Place of Service Code	Description
01	Pharmacy
04	Homeless shelter
09	Prison/Correctional Facility
12	Home
13	Assisted living facility
14	Group home
16	Temporary lodging
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
65	End Stage Renal Disease (ESRD) Treatment Facility

Diagnosis Code	Description
Diagnosis codes for HCPCS code E0193	
L89.100	Pressure ulcer of unspecified part of back, unstageable
L89.102	Pressure ulcer of unspecified part of back, stage 2

Diagnosis Code	Description
Diagnosis codes for HCPCS code E0193	
L89.103	Pressure ulcer of unspecified part of back, stage 3
L89.104	Pressure ulcer of unspecified part of back, stage 4
L89.110	Pressure ulcer of right upper back, unstageable
L89.112	Pressure ulcer of right upper back, stage 2
L89.113	Pressure ulcer of right upper back, stage 3
L89.114	Pressure ulcer of right upper back, stage 4
L89.120	Pressure ulcer of left upper back, unstageable
L89.122	Pressure ulcer of left upper back, stage 2
L89.123	Pressure ulcer of left upper back, stage 3
L89.124	Pressure ulcer of left upper back, stage 4
L89.130	Pressure ulcer of right lower back, unstageable
L89.132	Pressure ulcer of right lower back, stage 2
L89.133	Pressure ulcer of right lower back, stage 3
L89.134	Pressure ulcer of right lower back, stage 4
L89.140	Pressure ulcer of left lower back, unstageable
L89.142	Pressure ulcer of left lower back, stage 2
L89.143	Pressure ulcer of left lower back, stage 3
L89.144	Pressure ulcer of left lower back, stage 4
L89.150	Pressure ulcer of sacral region, unstageable
L89.152	Pressure ulcer of sacral region, stage 2
L89.153	Pressure ulcer of sacral region, stage 3
L89.154	Pressure ulcer of sacral region, stage 4
L89.200	Pressure ulcer of unspecified hip, unstageable
L89.202	Pressure ulcer of unspecified hip, stage 2
L89.203	Pressure ulcer of unspecified hip, stage 3
L89.204	Pressure ulcer of unspecified hip, stage 4
L89.210	Pressure ulcer of right hip, unstageable
L89.212	Pressure ulcer of right hip, stage 2
L89.213	Pressure ulcer of right hip, stage 3
L89.214	Pressure ulcer of right hip, stage 4
L89.220	Pressure ulcer of left hip, unstageable
L89.222	Pressure ulcer of left hip, stage 2
L89.223	Pressure ulcer of left hip, stage 3
L89.224	Pressure ulcer of left hip, stage 4
L89.300	Pressure ulcer of unspecified buttock, unstageable
L89.302	Pressure ulcer of unspecified buttock, stage 2
L89.303	Pressure ulcer of unspecified buttock, stage 3
L89.304	Pressure ulcer of unspecified buttock, stage 4
L89.310	Pressure ulcer of right buttock, unstageable
L89.312	Pressure ulcer of right buttock, stage 2

Diagnosis Code	Description
Diagnosis codes for HCPCS code E0193	
L89.313	Pressure ulcer of right buttock, stage 3
L89.314	Pressure ulcer of right buttock, stage 4
L89.320	Pressure ulcer of left buttock, unstageable
L89.322	Pressure ulcer of left buttock, stage 2
L89.323	Pressure ulcer of left buttock, stage 3
L89.324	Pressure ulcer of left buttock, stage 4
L89.42	Pressure ulcer of contiguous site of back, buttock and hip, stage 2
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.45	Pressure ulcer of contiguous site of back, buttock and hip, unstageable

Definitions

Bottoming out: An outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. This bottoming out criterion should be tested with the member in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side lying position.

Fixed Height Hospital Bed: A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment.

Ordinary Bed: An ordinary bed is one which is typically sold as furniture. It may consist of a frame, box spring and mattress. It is a fixed height and may or may not have head or leg elevation adjustments.

Semi-Electric Hospital Bed: A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments.

Stage I Pressure Injury: Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage II Pressure Injury: Partial thickness loss of skin with exposed dermis is a Stage II Pressure Injury. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARS), or traumatic wounds (skin tears, burns, abrasions).

Stage III Pressure Injury: Full thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss, then this is an Unstageable Pressure Injury.

Stage IV Pressure Injury: Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer is a Stage IV Pressure Injury. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss, then this is an Unstageable Pressure Injury.

Total Electric Hospital Bed: A total electric bed is one with electric height adjustment and with electric head and leg elevation adjustments.

Unstageable Pressure Injury: Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Variable Height Hospital Bed: A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments.

References

CMS National Coverage Determinations (NCDs)

[NCD 280.7 Hospital Beds](#)

Reference NCDs: [NCD 280.1 Durable Medical Equipment Reference List](#)

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	DME MAC
L33820 (Hospital Beds And Accessories)	A52508 Hospital Beds And Accessories – Policy Article	CGS	AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX VA, VI, WV, IL, IN, KY, MI, MN, OH, WI
	A55426 (Standard Documentation Requirements for All Claims Submitted to DME MACs)	Noridian	AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, MP, CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
L33642 (Pressure Reducing Support Surfaces – Group 2)	A52490 (Pressure Reducing Support Surfaces – Group 2 – Policy Article)	CGS	AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX VA, VI, WV, IL, IN, KY, MI, MN, OH, WI
	A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs	Noridian	AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, MP, CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT

CMS Benefit Policy Manual

[Chapter 1: § 10 Covered Inpatient Hospital Services Covered Under Part A, § 130.4.1 Coverage and Payment of Durable Medical Equipment Under the RNHCI Home Benefit](#)

MLN Matters

[Article MM8304, Detailed Written Orders and Face-to-Face Encounters](#)

[Article MM9018, 2015 Durable Medical Equipment Prosthetics, Orthotics, and Supplies \(DMEPOS\) Healthcare Common Procedure Coding System \(HCPCS\) Code Jurisdiction List](#)

UnitedHealthcare Commercial Policy

[Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies, and Repairs/Replacements](#)

Other

[Place of Service – CGS](#)

[Place of Service – Noridian](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update <ul style="list-style-type: none">Reformatted policy; transferred content to new template
06/10/2020	Policy Summary <p><i>Overview</i></p> <ul style="list-style-type: none">Modified list of conditions needed to establish medical necessity for home use of a hospital bed; replaced “the patient's condition requires positioning of the body” with “the patient's condition requires positioning of the body; e.g., <i>to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections, in ways not feasible in an ordinary bed</i>” <p><i>Guidelines</i></p> <ul style="list-style-type: none">Removed detailed documentation requirementsAdded language to indicate:<ul style="list-style-type: none">There are numerous CMS manual requirements, reasonable and necessary requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justifiedIn the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying paymentRefer to the Local Coverage Determination (LCD), National Coverage Determination (NCD) or other Centers for Medicare & Medicare Services (CMS) manuals for more information on what documents may be requiredSee the Local Coverage Article (LCA) titled <i>Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)</i> <p><i>Applicable Codes</i></p> <ul style="list-style-type: none">Removed HCPCS code E1399 Removed modifiers EY, GZ, and RRAdded place of service codes 31, 32, and 33 <p><i>Supporting Information</i></p> <ul style="list-style-type: none">Updated <i>References</i> section to reflect the most current informationArchived previous policy version MPG144.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).