Policy Number	DME101.001
Policy Effective Date	11/15/2024

Hospital Beds and Related Equipment

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Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

HOSPITAL BEDS:
A fixed height hospital bed (HCPCS codes E0250, E0251, E0290, or E0291) **may be considered medically necessary** if one or more of the following criteria are met:

1. The individual requires positioning of the body to alleviate pain, promote good body alignment, prevent contractures and/or avoid respiratory infection, in ways not feasible with an ordinary bed; or
2. 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. **NOTE 1:** Pillows or wedges should first have been considered and ruled out. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed; or
3. The individual requires special attachments (e.g., traction equipment) that cannot be attached to or used with an ordinary bed.

A variable height hospital bed (HCPCS codes E0255, E0256, E0292, or E0293) **may be considered medically necessary** if the individual meets one or more of the criteria for a fixed

height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position. This includes, but is not limited to:

- Severe arthritis;
- Fractured hips or other lower extremity injuries;
- Spinal cord injuries, including quadriplegia and paraplegia, multiple limb amputees;
- Severe cardiac conditions (those individuals who are able to leave the bed, but must avoid the strain of "jumping" up or down); or
- Stroke.

A semi-electric hospital bed (HCPCS codes E0260, E0261, E0294, or E0295) **may be considered medically necessary** if the individual meets one or more of the criteria for a fixed height hospital bed and requires frequent changes in body position or has an immediate need for a change in body position.

A heavy-duty, extra wide hospital bed (HCPCS codes E0301 or E0303) **may be considered medically necessary** if the individual meets one or more 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 (HCPCS codes E0302 or E0304 **may be considered medically necessary** if the individual meets one or more of the criteria for a fixed height hospital bed and the individual's weight exceeds 600 pounds.

A total electric hospital bed (HCPCS codes E0265, E0266, E0296, or E0297) is rarely indicated except in cases of spinal cord injuries, brain injuries, and individuals with neurological damage that prevents them from getting in or out of bed. These individuals also require assistance with the basic activities of daily living (i.e., bathing, use of toilet).

Air-fluidized Beds:

Coverage of an air-fluidized bed (HCPCS code E0194) **may be considered medically necessary** when all the following criteria are met:

- The individual has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure sore; AND
- The individual is bedridden, or chair bound as a result of limited mobility; AND
- In the absence of an air-fluidized bed, the individual would require institutionalization; AND
- The bed is ordered by the individual's attending physician based upon a comprehensive assessment and evaluation of the individual after a course of conservative treatment designed to optimize conditions that promote wound healing. The evaluation must be performed within one month prior to initiation of therapy with the air-fluidized bed; AND
- The course of conservative treatment must have been at least one month in duration without progression toward wound healing. This month of prerequisite conservative treatment may include some period in an institution as long as there is documentation to

verify that the necessary conservative treatment was rendered. Conservative treatment should include:

1. Frequent repositioning of the individual with particular attention to relief of pressure over bony prominences (usually every two hours); and
2. Use of a Group 2 support surface (see Pressure Reducing Support Surfaces below) to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation; and
3. Necessary treatment to resolve any wound infection; and
4. Optimization of nutrition status to promote wound healing; and
5. Debridement by any means, including wet to dry gauze dressings, to remove devitalized tissue from the wound bed; and
6. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressing protected by an occlusive covering, while the wound heals; and
7. Education of the individual/caregiver in the prevention and management of pressure ulcers; and
8. Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly; and
9. Appropriate management of moisture/incontinence; AND

- The availability of a trained adult caregiver to assist with activities of daily living, repositioning, skin care, fluid balance, dry skin care, 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
- Physician directed home treatment regimen with ongoing physician directed assessment; AND
- All other alternative equipment has been considered and ruled out.

Home use of the air-fluidized bed **is considered not medically necessary** in the following circumstances:

- Presence of coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions); or
- Requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or occlusive material; or
- Other known contraindications exist.

NOTE 2: Coverage for the air-fluidized bed is limited to the equipment itself, and does not include reimbursement for the caregiver or, architectural adjustments such as electrical or structural improvements.

Continued coverage of an air-fluidized bed **may be considered medically necessary** until the ulcer is healed, or, if healing does not continue, there is documentation to show that:

- Other aspects of the care plan are being modified to promote healing; or
- The use of the bed is necessary for wound management.

NOTE 3: Air-fluidized beds are classified as a Group 3 Pressure Reducing Support Surface by The Centers for Medicare and Medicaid Services.

Pressure Reducing Support Surfaces

Group 1 Support Surfaces (as Defined in the Description) (HCPCS codes A4640, E0181, E0182, E0183, E0184, E0185, E0186, E0187, E0188, E0189, E0196, E0197, E0198, E0199 or E0272)

A Group 1 mattress overlay/underlay, or mattress **may be considered medically necessary** if the individual meets:

- Criterion 1, **or**
- Criterion 2 or 3 **and** at least one of criteria 4-7:
  1. Completely immobile – that is, individual cannot make changes in body position without assistance;
  2. Limited mobility – that is, individual cannot independently make changes in body position significant enough to alleviate pressure;
  3. Any stage pressure ulcer on the trunk or pelvis;
  4. Impaired nutritional status;
  5. Fecal or urinary incontinence;
  6. Altered sensory perception;
  7. Compromised circulatory status.

A Group 1 support surface **is considered not medically necessary** when the criteria listed above are not met.

Group 2 Support Surfaces (as Defined in the Description) (HCPCS codes E0193, E0277, E0371, E0372, E0373)

A Group 2 support surface **may be considered medically necessary** if the individual meets:

- Criteria 1 **and** 2 **and** 3, **or**
- Criterion 4, **or**
- Criteria 5 **and** 6
  1. Multiple stage II pressure ulcers located on the trunk or pelvis;
  2. Individual has been on a comprehensive ulcer treatment program (see **NOTE 4**) for at least the past 30 days that has included the use of an appropriate group 1 support surface;
  3. The ulcers have worsened or remained the same over the past month;
  4. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis;
  5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days);
  6. The individual has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

NOTE 4: The comprehensive ulcer treatment program described above should generally include:

- Education of the individual and caregiver on the prevention and/or management of pressure ulcers; AND
- Regular assessment by a nurse, physician or other licensed healthcare practitioner (usually at least weekly for an individual with a stage III or IV ulcer); AND
- Appropriate turning and positioning; AND
- Appropriate wound care (for a stage II, III or IV ulcer); AND
- Appropriate management of moisture/incontinence; AND
- Nutritional assessment and intervention consistent with the overall plan of care.

Continued use of a group 2 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:
- Other aspects of the care plan are being modified to promote healing; or
- The use of the group 2 support surface is medically necessary for wound management.

When a group 2 pressure reducing support surface is prescribed following a myocutaneous flap or skin graft, continued use **may be considered medically necessary** for up to 60 days from the date of surgery.

INSTITUTIONAL BEDS: (HCPCS code E0270)
Beds in this category may include, but are not limited to, Stryker Frame™, Circulo-Electric™, Oscillatory bed and the Progressa bed system. These beds **are considered not medically necessary** as they are considered institutional equipment and inappropriate for home use.

MATTRESS REPLACEMENT:
The replacement of an innerspring or foam rubber mattress for a medically necessary hospital bed **may be considered medically necessary.** See Note 5.

RELATED EQUIPMENT:
Bed Side Rails (HCPCS codes E0305, E0310)
Bed side rails **may be considered medically necessary** if required by the individual's condition and are integral parts of, or an accessory to a hospital bed. Some indications include but are not limited to:
- Confusion/disorientation;
- Vertigo(dizziness);
- Seizures; or
- Senile dementia or psychosis.

Bed Cradle (HCPCS code E0280)
Bed cradles **may be considered medically necessary** to prevent contact with bed coverings. Some indications include but are not limited to:
- Burns;
- Gangrene of the feet; and

- Impaired circulation in the feet.

Trapeze Bars (HCPCS codes E0910, E0911, E0912, E0940)
A trapeze bar **may be considered medically necessary** when an individual needs this device to sit up because of a respiratory condition, to change body position for other medical conditions, or to get in or out of bed.

Bed Boards and Over the Bed Tables (HCPCS codes E0273, E0274, E0315)
These items **are considered not medically necessary** as they are considered convenience items.

Safety Net Enclosure (HCPCS code E0316)
The use of safety netting placed over a hospital bed frame or canopy, to prevent falls, **is considered not medically necessary.** These devices are intended for institutional use only.

NOTE 5: For further information related to durable medical equipment (DME) including repairs and replacements, and for information on nonhospital or safety beds (e.g., the SleepSafe Beds®, Cubby Beds), see DME101.000 DME Introduction.

Policy Guidelines

None.

Description

Hospital beds allow the individual's position to be changed at the head and foot of the bed. In addition, the distance of the bed from the floor can be adjusted. In contrast, an ordinary bed has a fixed height from the floor and has no head or leg elevation adjustment.

The following are descriptions of various types of hospital beds:
- Fixed height beds have manual head and leg elevation adjustments but not bed height adjustment;
- Variable height beds have manual height adjustments and with electric head and leg elevation adjustments;
- Semi electric beds have manual height adjustment and electric head and leg adjustments;
- Total electric beds have electric height adjustments and electric head and leg adjustments; these additional features allow for motorized adjustment of the height of the bed frame from the floor and are strictly for the convenience of the caregiver. The caregiver may have physical limitations in his/her ability to care for the individual;
- A heavy duty extra wide hospital bed is capable of supporting an individual weight between 350 and 600 pounds;
- An extra heavy-duty bed is a bed able to support individual weight of more than 600 pounds;
- An air fluidized therapy bed is a device employing the circulation of filtered air through

silicone coated ceramic beads creating the characteristics of fluid. Uses include treatment and/or prevention of decubitus ulcers, management of severe or extensive burns, and to aid the circulation of blood;
- A powered flotation therapy bed is a semi-electric or totally-electric hospital bed with a fully integrated powered pressure reducing mattress, containing a large volume of constantly moving water, air or sand. Uses include treatment and/or prevention of decubitus ulcers, management of severe or extensive burns, and to aid in the circulation of blood. (1)

Miscellaneous beds:
Oscillatory beds were designed to assist with repositioning needs of the critically ill. Using a programmed unit, the bed shifts the position of the individual with minimal stimulation therefore reducing the oxygen demands needed for recuperation.

Beds used in the treatment of spinal cord injuries (e.g., Circulo-Electric™, Stryker Frame™ or the Progress Smart Bed System), are found in facilities such as hospitals. The Progessa Smart Bed System® is an institutional bed that features dining chair and full chair positions along with an in-bed scale and three mode bed exit alarm. It is also available with different mattresses for prevention, therapy and pulmonary conditions. (9)

Pressure Reducing Support Surfaces
Pressure reducing support surfaces are designed to prevent or promote the healing of pressure ulcers by reducing or eliminating tissue interface pressure. Most of these devices reduce interface pressure by conforming to the contours of the body so that pressure is distributed over a larger surface area rather than concentrated on a more restricted site. Pressure reducing support surfaces that contain multiple components are categorized according to the clinically predominant component, which is usually the topmost layer of a multi-layer product.

Group 1 pressure reducing support surface include: pressure pads for mattresses, non-powered pressure reducing mattresses and powered pressure reducing mattress overlay/underlay systems.

Pressure pads for mattresses describe non-powered pressure reducing mattress overlays. These devices are designed to be placed on top of a standard hospital or home mattress. These include:
- A gel or gel-like mattress overlay is characterized by a gel or gel-like layer with a height of 2 inches or greater.
- An air mattress overlay is characterized by interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump.
- A water mattress overlay is characterized by a filled height of 3 inches or greater.
- A foam mattress overlay is characterized by **all** of the following:
    - Base thickness of 2 inches or greater and peak height of 3 inches or greater if it is a convoluted overlay (e.g., egg crate) or an overall height of at least 3 inches if it is a non-convoluted overlay;
    - Foam with a density and other qualities that provide adequate pressure reduction;

and
    - Durable, waterproof cover.

Non-powered pressure reducing mattresses include:

- A foam mattress characterized by **all** of the following:
    - Foam height of 5 inches or greater;
    - Foam with a density and other qualities that provide adequate pressure reduction;
    - Durable, waterproof cover; and
    - Can be placed directly on a hospital bed frame.
- An air, water or gel mattress characterized by all of the following:
    - Height of 5 inches or greater of the air, water or gel layer;
    - Durable, waterproof cover; and
    - Can be placed directly on a hospital bed frame.

Powered pressure reducing mattress overlay systems (alternating pressure or low air loss) are characterized by **all** of the following:

- An air pump or blower that provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay;
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater; and
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate member lift, reduce pressure and prevent bottoming out.

Group 2 pressure reducing support surface include powered pressure reducing mattresses, semi-electric hospital beds with powered pressure reducing mattresses, powered pressure reducing mattress overlays, advanced non-powered pressure reducing mattresses and advanced non-powered pressure reducing mattress overlays.

A powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) is characterized by **all** of the following:

- An air pump or blower that provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress; AND
- Inflated cell height of the air cells through which air is being circulated is 5 inches or greater; AND
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate member lift, reduce pressure, and prevent bottoming out; AND
- A surface designed to reduce friction and shear; AND
- Can be place directly on a hospital bed frame.

A semi-electric hospital bed with a fully integrated powered pressure reducing mattress that has all the characteristics defined above is considered a group 2 pressure reducing support surface.

An advanced non-powered pressure reducing mattress overlay is characterized by **all** of the following:

- Height and design of individual cells provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out; AND
- Total height of 3 inches or greater; AND
- A surface designed to reduce friction and shear; AND
- Documented evidence to substantiate that the product is effective for the treatment of condition described by the coverage criteria for group 2 support surfaces.

A powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) is characterized by **all** of the following:

- An air pump or blower that provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay; AND
- Inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater; AND
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate member lift, reduce pressure, and prevent bottoming out; AND
- A surface designed to reduce friction and shear.

An advanced non-powered pressure reducing mattress is characterized by **all** of the following:

- Height and design of individual cells provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out; AND
- Total height of 5 inches or greater; AND
- A surface designed to reduce friction and shear; AND
- Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces; AND
- Can be placed directly on a hospital bed frame.

For all types of support surfaces, the support surface provided should be one in which the individual does not “bottom out.” Bottoming out is the finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the individual’s bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the individual 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.

Pressure reducing support surfaces that contain multiple components are categorized according to the clinically predominant component, which is usually the topmost layer of a

multi-layer product. For example, a product with 3-inch powered air cells on top of a 3-inch foam base would be categorized as a powered overlay not as a powered mattress.

Pressure Injury Stages

A pressure injury is localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities, and condition of the soft tissue.

Table 1: Pressure Injury Stages (8)

Stage	Description
Stage 1 Pressure Injury: Non-blanchable erythema of intact skin	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 2 Pressure Injury: Partial-thickness skin loss with exposed dermis	Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or 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 (MARSI), or traumatic wounds (skin tears, burns, abrasions).
Stage 3 Pressure Injury: Full-thickness skin loss	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 this is an unstageable pressure injury.
Stage 4 Pressure Injury: Full-thickness skin and tissue loss	Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. 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 this is an unstageable pressure injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss	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, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration	Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.
Mucosal Membrane Pressure Injury	Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. These ulcers cannot be staged.

Rationale

This policy was originally developed in 1990 and has been routinely updated with new information from the Centers for Medicare and Medicaid Services National Coverage Determinations and any Local Coverage Determinations available. This policy is based in large part on the Centers for Medicare and Medicaid Services National and Local Coverage Determinations on Hospital Beds and Pressure Reducing Support Services. The most recent literature review is through March 2024.

Coverage for hospital beds must be reasonable and necessary for the treatment of the individual patient. A physician must provide a certificate of medical necessity for the appropriate equipment needed. Medical necessity information should include the diagnosis, a narrative description of the individual's condition, abilities, and limitations and the length of need of the item prescribed. The medical records may include physician’s office records, hospital records, nursing home records, home health agency records, and/or records from other healthcare professionals.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	None
HCPCS Codes	A4640, E0181, E0182, E0183, E0184, E0185, E0186, E0187, E0188, E0189, E0193, E0194, E0196, E0197, E0198, E0199, E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0271, E0272, E0273, E0274, E0277, E0280, E0290, E0291, E0292, E0293, E0294, E0295, E0296, E0297, E0300, E0301, E0302, E0303, E0304, E0305, E0310, E0315, E0316, E0328, E0329, E0371, E0372, E0373, E0910, E0911, E0912, E0940

*Current Procedural Terminology (CPT®) ©2023 American Medical Association: Chicago, IL.

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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <http://www.cms.hhs.gov>.

Policy History/Revision	
Date	**Description of Change**
11/15/2024	Document updated with literature review. The following changes were made to Coverage: 1) Moved content related to "Nonhospital beds such as the Craftmatic® Adjustable bed, the Sleep Number® bed by Select Comfort Corporation and the Self Adjusting Technology (SAT™) Bed, the SleepSafe Beds®, Cubby Beds, waterbeds and beds considered safety or sensory-friendly safe spaces" to DME101.000; and 2) Amended Note 5 to state: For further information related to durable medical equipment (DME) including repairs and replacements, and for information on non-hospital or safety beds (e.g., the SleepSafe Beds®, Cubby Beds) see DME101.000 DME Introduction. Some references removed.
05/15/2024	Document updated with literature review. The following change was made to Coverage: under 'Miscellaneous Beds' added Cubby Bed as not medically necessary. References 11-14 added, others updated.
04/15/2023	Document updated with literature review. Coverage unchanged. References updated.
10/01/2022	Document updated. The following change was made to Coverage: Added language for mattress underlay (E0183) to Pressure Reducing Support Surfaces section. No new references added.
05/15/2022	Reviewed. No changes.
04/01/2021	Document updated with literature review. Coverage unchanged. No new references added.
01/15/2021	Document updated with literature review. The following change was made to Coverage: Added Progessa Smart Bed System® as an example of an institutional bed. Reference 10 added.
10/15/2019	Reviewed. No changes.
01/15/2019	Document updated with literature review. Coverage unchanged. References revised; added references 7-9.
04/01/2017	Reviewed. No changes.
04/01/2016	Document updated with literature review. Coverage unchanged.
07/01/2015	Reviewed. No changes.
05/15/2014	Document updated with literature review. The following example was added to the MISCELLANEOUS BEDS statement: SleepSafe Beds®. The wording was changed to include "considered not medically necessary" to the following coverage sections "Bed Boards and Over the Bed Tables" and "Safety Net Enclosure". CPT/HCPCS code(s) updated.

10/01/2008	CPT/HCPCS code(s) updated
04/15/2008	Policy reviewed without literature review; new review date only. This policy is no longer scheduled for routine literature review and update.
01/01/2008	CPT/HCPCS code(s) updated, medical policy unchanged
10/01/2006	Revised/updated entire document
02/01/2004	Revised/updated entire document
08/01/2002	Revised/updated entire document
09/01/1999	Revised/updated entire document
05/01/1996	Revised/updated entire document
06/01/1991	Revised/updated entire document
05/01/1990	New medical document