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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, E0291, and E0328) **may be considered medically necessary** if one or more of the following criteria are met:

1. The individual 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 individual requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or

a) 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, or

b) The individual requires traction equipment, which can only be attached to a hospital bed.

A variable height hospital bed (HCPCS codes E0255, E0256, E0292, and E0293) **may be considered medically necessary** if the individual meets one 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.

A semi-electric hospital bed (HCPCS codes E0260, E0261, E0294, E0295, or E0329) **may be considered medically necessary** if the individual 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 (HCPCS codes E0301 or E0303) **may be considered medically necessary** if the individual meets 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 (HCPCS codes E0302 or E0304) **may be considered medically necessary** if the individual meets one of the criteria for a hospital bed and the individual's weight exceeds 600 pounds.

A total electric hospital bed (HCPCS codes E0265, E0266, E0296, and E0297) is not covered; the height adjustment feature is a convenience feature. Total electric beds will be denied as **not medically necessary**.

For any of the above hospital beds (plus those coded E1399), if documentation does not justify the medical need of the type of bed billed, payment will be denied as **not medically necessary**.

If the individual does not meet any of the coverage criteria for any type of hospital bed it will be denied as **not medically necessary**.

ACCESSORIES: (2)
Trapeze equipment (E0910, E0940) **may be considered medically necessary** if the individual 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) **may be considered medically necessary** if the individual meets the criteria for regular trapeze equipment and the beneficiary's weight is more than 250 pounds.

Trapeze bars attached to a bed (E0910, E0911) **are considered not medically necessary** when used on an ordinary bed.

A bed cradle (E0280) **may be considered medically necessary** when it is necessary to prevent contact with the bed coverings.

Side rails (E0305, E0310) or safety enclosures (E0316) **may be considered medically necessary** when they are required by the individual's condition and they are an integral part of, or an accessory to, a covered hospital bed.

If an individual's condition requires a replacement innerspring mattress (E0271) or foam rubber mattress (E0272) it **may be considered medically necessary** for an individual owned hospital bed.

Pressure Reducing Support Surfaces

Group 1 Support Surfaces (HCPCS codes A4640, E0181, E0182, E0184, E0185, E0186, E0187, E0188, E0189, E0196, E0197, E0198, or E0199)

A Group 1 mattress overlay/underlay, or mattress **may be considered medically necessary** if the individual meets one of the three following criteria:
1. The individual is completely immobile – (i.e., individual cannot make changes in body position without assistance); or
2. The individual has limited mobility – (i.e., individual cannot independently make changes in body position significant enough to alleviate pressure and at least one of the conditions A-D below), or
3. The individual has any stage pressure ulcer on the trunk or pelvis and at least one of conditions A-D below.

Conditional criteria for 2 and 3 (in each case the medical record must document the severity of the condition sufficiently to demonstrate the medical necessity for a pressure reducing support surface):
a. Impaired nutritional status;
b. Fecal or urinary incontinence;
c. Altered sensory perception;
d. Compromised circulatory status.

When the coverage criteria for a Group 1 mattress overlay or mattress are not met, it will be **considered not medically necessary.**

Group 2 Support Surface (HCPCS codes E0193, E0277, E0371, E0372, E0373, E1399)

A Group 2 support surface **may be considered medically necessary** if the individual meets at least one of the following three criteria (1, 2, or 3):

1. The individual has multiple stage 2 pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the individual has been on a comprehensive ulcer treatment program including each of the following:
   a. Use of an appropriate group 1 support surface, and
   b. Regular assessment by a nurse, practitioner, or other licensed healthcare practitioner, and
   c. Appropriate turning and positioning, and
   d. Appropriate wound care, and
   e. Appropriate management of moisture/incontinence, and
   f. Nutritional assessment and intervention consistent with the overall plan of care.
2. The individual has large or multiple stage 3 or 4 pressure ulcer(s) on the trunk or pelvis,
3. The individual had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.

If the individual is on a group 2 surface, there should be a care plan established by the treating practitioner or home care nurse which includes the above elements. The support surface provided for the individual should be one in which the individual does not "bottom out".

When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

When the stated coverage criteria for a group 2 mattress or bed are not met, a claim will be denied as **not medically necessary.**

A support surface which does not meet the characteristics specified in the Policy Guidelines section will be denied as **not medically necessary.**

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: 1) other aspects of the care plan are being modified to promote healing, or 2) the use of the group 2 support surface is reasonable and necessary for wound management.

Group 3 Support Surface (HCPCS code E0194)
An air-fluidized bed **may be considered medically necessary** only if **all** of the following criteria are met:
1. The individual has a stage 3 (full thickness tissue loss) or stage 4 (deep tissue destruction) pressure ulcer.
2. The individual is bedridden, or chair bound as a result of severely limited mobility.
3. In the absence of an air-fluidized bed, the individual would require institutionalization.

4. The air-fluidized bed is ordered in writing by the individual's treating practitioner based upon a comprehensive assessment and evaluation of the individual after completion of a course of conservative treatment designed to optimize conditions that promote wound healing. The evaluation generally must be performed within one month prior to initiation of therapy with the air-fluidized bed.
5. 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 available to verify that the necessary conservative treatment was rendered. Conservative treatment must include:
    a. Frequent repositioning of the beneficiary with particular attention to relief of pressure over bony prominences (usually every 2 hours); and
    b. Use of a Group 2 support surface to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation; and
    c. Necessary treatment to resolve any wound infection; and
    d. Optimization of nutrition status to promote wound healing; and
    e. Debridement by any means, including wet-to-dry gauze dressings, to remove devitalized tissue from the wound bed; and
    f. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals.

In addition, conservative treatment should generally include:

    g. Education of the beneficiary and caregiver on the prevention and management of pressure ulcers; and
    h. Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly, and
    i. Appropriate management of moisture/incontinence.

An occlusive barrier is required, when necessary, to maintain a moist wound-healing environment that may otherwise be compromised by the drying action of airflow generated by air-fluidized therapy. If moist dressings are NOT required because of the wound characteristics (e.g., heavily exudative wound, etc.), the occlusive barrier is not required as a condition for reimbursement.

Wet-to-dry dressings when used for debridement do not require an occlusive dressing. Use of wet-to-dry dressings for wound debridement, begun during the period of conservative treatment and which continue beyond 30 days will not preclude coverage of an air-fluidized bed. Should additional debridement again become necessary while a beneficiary is using an air-fluidized bed (after the first 30-day course of conservative treatment) that will not cause the air-fluidized bed to be denied.

6. 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 its problems such as leakage.
7. A treating practitioner directs the home treatment regimen and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis.
8. All other alternative equipment has been considered and ruled out.

An air-fluidized bed **is considered not medically necessary** under any of the following circumstances:
1. The individual has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions);
2. The individual requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material;
3. The caregiver is unwilling or unable to provide the type of care required by the individual on an air-fluidized bed;
4. Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1600 pounds or more);
5. Electrical system is insufficient for the anticipated increase in energy consumption; or
6. Other known contraindications exist.

Payment is **not** included for the caregiver or for architectural adjustments such as electrical or structural improvement.

The continued coverage of an air-fluidized bed as **medically necessary** must be documented by the treating practitioner every month. Continued use of an air fluidized bed is covered until the ulcer is healed or, if healing does not continue, there is documentation to show that: 1) other aspects of the care plan are being modified to promote healing, or 2) the use of the bed is reasonable and necessary for wound management.

If the stated coverage criteria for an air-fluidized bed are not met, the claim will be denied as **not medically necessary**.

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

NOTE 2: For further information related to durable medical equipment including repairs and replacements, and for information on nonhospital or safety beds (e.g., the SleepSafe Beds®, Cubby Beds), see DME101.000 Durable Medical Equipment Reference List.

Policy Guidelines

A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment. (3)

A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments.

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

A total electric bed is one with electric height adjustment and with electric head and leg elevation adjustments.

An ordinary bed is one that 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.

E0301 and E0303 are hospital beds that are capable of supporting a beneficiary who weighs more than 350 pounds, but no more than 600 pounds.

E0302 and E0304 are hospital beds that are capable of supporting a beneficiary who weighs more than 600 pounds.

E0316 is a safety enclosure used to prevent a beneficiary from leaving the bed.

E1399 should be used for products not described by the specific HCPCS codes above.

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. (2) In contrast, an ordinary bed is one that 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.

The following are descriptions of various types of hospital beds:

- A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment;
- A variable height hospital bed is one with a manual height adjustment and with electric head and leg elevation adjustments;

- A semi electric bed is one with manual height adjustment and with electric head and leg adjustments;
- A total electric bed is one with electric height adjustment and with electric head and leg adjustments.
- A heavy duty extra wide hospital bed is capable of supporting an individual who weights more than 350 pounds, but not more than 600 pounds.
- An extra heavy-duty hospital bed is capable of supporting an individual who weights more than 600 pounds.
- An air fluidized bed uses warm air under pressure to set small ceramic beads in motion which simulate the movement of fluid. When the individual is placed in the bed, their body weight is evenly distributed over a large surface area which crease a sensation of "floating".

Pressure Reducing Support Surfaces

Pressure relieving support surfaces are designed to prevent or promote the healing of pressure ulcers by reducing or eliminating tissue interface pressure. (4) Most of the 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 circumscribed location.

Pressure relieving 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 circumscribed site.

Group 1 pressure reducing support surface include: pressure pads for mattresses, non-powered pressure reducing mattresses and powered pressure reducing mattress overlay 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; and

    - 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; and
    - Foam with a density and other qualities that provide adequate pressure reduction; and
    - 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; and
    - 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; and
- 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.

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.

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. (6)

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 or total 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 individual 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.

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 (6)
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

Stage	Description
Stage 1 Pressure Injury: Non-blanchable erythema of intact skin	Non-blanchable erythema of intact skin, which may appear differently in darkly pigmented 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 including incontinence associated dermatitis, intertriginous dermatitis, medical adhesive related skin injury, 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: 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.

Rationale

This policy is based on a review of coverage guidance from the Centers for Medicare and Medicaid Services (CMS) specific to Hospital Beds, Air Fluidized Bed, and Pressure Reducing Support Services. (1-9)

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®) ©2025 American Medical Association: Chicago, IL.

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Centers for Medicare and Medicaid Services

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 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 cms.hhs.gov.

Policy History/Revision

Date	Description of Change
5/7/2026	New medical document. Hospital beds and related equipment may be considered medically necessary when criteria in Coverage are met.