P R O V I D E R B U L L E T I N

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To: **All Indiana Health Coverage Programs Durable Medical Equipment Providers, Home Health Care Providers, Hospitals, Medical Clinics, and Physicians**

Subject: **Hospital Beds and Specialty Beds**

Note: The information in this bulletin is not directed to those providers rendering services in the risk-based managed care delivery system.

Overview

Indiana Health Coverage Programs (IHCP) has established a policy for hospital beds and specialty beds effective August 1, 2000. The IHCP will provide coverage for hospital beds and specialty beds when they are medically necessary in a non-institutional setting, there is a written physician's order, and they have been prior authorized. The purpose for these policies is to decrease variation in utilization management by providing a guide for determining the medical necessity of hospital beds and specialty beds.

For purposes of the IHCP, the term *hospital beds* refers to variable height, semi-electric, and total electric beds. The term *specialty beds* refers to enclosed beds, or pediatric hospital beds. This bulletin identifies the new local codes for specialty beds and the criteria required for prior authorization approval.

A medical clearance form was developed to assist in establishing medical necessity and maintenance of documentation that supports medical necessity of hospital beds and specialty beds. Beds will be reimbursed as capped rental items. A copy of the new medical clearance form is included with this bulletin. You may copy it and use it as needed. Prior authorization is required for all types of hospital beds and specialty beds. Coverage criteria, Health Care Financing

Administration's Common Procedure Coding System (HCPCS) codes, and billing instructions for beds are given in this bulletin.

Coverage Criteria for Hospital Beds

The IHCP has approved the following criteria for hospital beds:

A hospital bed is considered medically necessary if one or more of the following conditions are met:

- Positioning of the body that is ordered by the physician, in ways not feasible with an ordinary bed due to a medical condition, which is expected to last at least one month. Elevation of the head and upper body greater than 30 degrees.
- Positioning of the body that is ordered by the physician in ways to alleviate pain that are not possible in an ordinary bed.
- Positioning of the body ordered by the physician that requires head elevation greater than 30 degrees most of the time related to a medical condition, such as congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed.
- A physician orders traction that requires traction equipment that can only be attached to a hospital bed.

A variable height hospital bed is covered if, in addition to meeting one or more of the criteria for a hospital bed, the following condition is met:

- The physician orders a bed height different than a fixed height hospital bed to accommodate transfers to a chair, wheelchair, or standing position.

A semi-electric hospital bed is covered if, in addition to meeting one or more of the criteria for a hospital bed, the following condition is met:

- The physician orders frequent changes in body positioning and/or has an immediate need for a change in body position.

Coverage Criteria for Specialty beds

The IHCP has approved the following criteria for specialty beds:

An enclosed bed or cubicle bed is considered medically necessary when all the following criteria are met:

- The patient has an appropriate diagnosis which could include, but is not limited to, the following:
  - 343.8 – Other specified infantile cerebral palsy
  - 343.9 – Infantile cerebral palsy
  - 318.1 – Severe mental retardation
  - 318.2 – Profound mental retardation
  - 780.3 – Convulsions
  - 345.1 – Generalized convulsive epilepsy
  - 345.3 – Grand mal status
  - 330.0 – Leukodystrophy
  - 331.1 – Picks disease
  - 331.4 – Obstructive hydrocephalus
  - 348.1 – Anoxic brain damage
  - 854 – Intracranial injury of other and unspecified nature
- Documentation of medical necessity must include **at least one** of the following:
  - Daily seizure activity
  - Uncontrolled perpetual movement related to diagnosis
  - Self-injurious behavior such as uncontrolled head banging activity
- Documentation of safety factors tried and failed including, but not limited to, the following:
  - Chest restraints
  - Side rails
  - A mattress on the floor
  - Protective helmet
- Supporting documentation must include secondary diagnoses and pertinent history:
  - History of injuries or falls
  - High risk for fractures due to osteoporosis
  - At risk for hemorrhage due to thrombocytopenia
  - Frequent upper respiratory infections and or other complications related to aspiration
  - Respiratory complications related to positioning. Requires elevation of the head and upper body greater than 30 degrees
  - Requires frequent positional changes
- A signed physician's order for the enclosed bed or cubicle bed
- A Medical Clearance Form completed and signed by the physician
- Verification that the primary caregiver is willing and able to clean and maintain the mesh canopy per the manufacturer recommendations. The IHCP will not pay for laundering the mesh canopy.

Pediatric hospital beds are considered medically necessary when all the following criteria are met:

- Has a medically necessary diagnosis. Diagnoses could include, but are not limited to, the following:
  - V55.0 – Tracheostomy
  - V55.1 – Gastrostomy
  - 428.0 – Heart Failure
  - 511.8 – Other specified forms of effusion, except tuberculous
  - 511.9 – Unspecified pleural effusion
  - 518.81 – Respiratory failure
  - 518.82 – Other pulmonary insufficiency, not elsewhere classified
  - 518.89 – Other disease of the lung, not elsewhere classified
  - 519.1 – Other disease of trachea and bronchus, not elsewhere classified
  - 769.0 – Respiratory distress syndrome
  - 770.8 – Other respiratory problems after birth
  - 786.9 – Other
- **Mandatory criteria** for prior authorization:
  - A physician's order for a multi-positional bed related to frequent positioning changes that are required
  - Elevation of upper body and head greater than 30 degrees is required
  - Written documentation why a standard crib is not appropriate and what alternative methods have been tried and failed is required
  - A medical clearance form completed and signed by the physician
- **Recommended criteria** (patient must meet at least one of the following criteria):
  - Documentation that indicates there is a risk for aspiration pneumonitis and/or gastric reflux related to disease processes is present
  - Documentation of a history of aspiration pneumonitis is present

Billing Instructions

Table 1.1 – Level II and Level III HCPCS Codes for hospital and specialty beds and accessories

Fixed height beds	
Code	**Description**
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
Variable height beds	
Code	**Description**
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	
Code	**Description**
E0260	Hospital bed, semi-electric (head and foot adjustments), with any type side rails, with mattress
E0294	Hospital bed, semi-electric (head and foot adjustments), without side rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustments), without side rails, without mattress
Total electric beds	
Code	**Description**
E0265	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress
E0296	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress
Specialty beds	
Code	**Description**
Z5101	Enclosed bed with mattress, all accessories included
Z5102	Cubicle bed with mattress, all accessories included
Z5103	Pediatric hospital bed with mattress, all accessories included

Table 1.1 – Level II and Level III HCPCS Codes for hospital and specialty beds and accessories

Trapeze bars and other bed accessories	
Code	**Description**
E0271	Mattress, innerspring
E0272	Mattress, foam rubber
E0273	Bed board
E0274	Over-bed table
E0280	Bed cradle, any type
E0305	Bedside rails, half length
E0310	Bedside rails full length
E0315	Bed accessories: boards or tables, any type
E0910	Trapeze bars, patient helper, attached to bed, with grab bar
E0940	Trapeze bar, free standing, complete with grab bar

Providers are to bill their usual and customary charge for the equipment and will be reimbursed the lesser of the submitted charges for the equipment or the maximum fee amount. The equipment is to be billed on a HCFA-1500 claim form using a DME provider number. The provider is obligated to provide repairs and maintenance for the first 15 months or until the item is purchased. After 15 months, repairs and maintenance are billed using E1399 for replacement parts and E1340 for labor charges.

Further Information

Questions about this bulletin may be directed to the Health Care Excel (HCE) Medical Policy Department at (317) 347-4500. Questions about the billing procedures referenced in this bulletin may be directed to EDS Customer Service at (317) 655-3240 in the Indianapolis local area or 1-800 577-1278.

Indiana Health Coverage Programs

MEDICAL CLEARANCE FORM

HOSPITAL AND SPECIALTY BEDS

Section A		
Certification Date: Initial: __/__/__		Revised: __/__/__
Patient Name: _____ Address: _____		Supplier Name: _____ Address: _____
Phone Number: _____ RID Number:		Phone Number: _____ Provider Number:
Place of Service: _____ Name and address of facility (if applicable)	HCPCS Code:	PT DOB____/___/___/; Sex___(M/F) HT_____(IN); WT_____(LBS) Physician Name: Address: Physician UPIN Number: _____ Physician Phone Number: ( ) _____

Section B **Information in this section may not be completed by the supplier of the items or supplies*	
Estimated. length of need (number of months_____) Years_____ Lifetime_____	DX codes (ICD-9) _____ _____ _____ _____

Circle Y for Yes, N for No, or NA for Not Applicable for the following questions:			
1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?	Y	N	NA
2. Does the patient require, for the relief of pain, positioning of the body in ways not feasible in an ordinary bed?	Y	N	NA
3. Does the patient require the head of the bed elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or aspiration?	Y	N	NA
4. Does the patient require traction that can only be attached to a hospital bed?	Y	N	NA
5. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position?	Y	N	NA
6. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?	Y	N	NA

Section C **Narrative description of equipment and cost*			
(1) Narrative description of all items, accessories, and options ordered; and (2) supplier's charges:			
Section D **Complete this section if you are supplying or ordering a specialty bed. If supplying or providing a hospital bed, skip to Section E.*			
What diagnosis qualifies this patient for a specialty bed?			ICD-9 code:
Does this patient have seizures?	Y N NA	If yes, what type?	
Date of last seizure:	How often do seizures occur?		
Has patient sustained injury related to seizure activity?	Y N NA	If yes, what type of injury?	
List three safety factors that have been tried and why they failed?			
Does this patient have a history of behavior problems that may result in injury, or a history of falls, respiratory problems, cardiac problems or gastrointestinal problems?			Y N NA
If yes, document all that apply.			
Section E: Physician Signature, Attestation, and Date			
I certify that I am the physician listed in section A of this form. I have received sections A through E of the certificate of medical necessity (including charges for items ordered). Any statement on my letterhead, attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is Section B is true, accurate and complete to the best of my knowledge, and I understand falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.			
Physician's Signature:		**Date:**	