Hospital Beds
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Hospital Beds		
MNG #: 077	☒ CCA Senior Care Options (HMO D-SNP) (MA) ☒ CCA One Care (Medicare-Medicaid) (MA)	**Prior Authorization Needed?** ☒ **Yes (always required)** ☐ **Yes (only in certain situations. See this MNG for details)** ☐ **No**
Benefit Type: ☒ **Medicare** ☒ **Medicaid**	**Original Approval Date:** 7/1/2021	**Effective Date:** 9/28/2021; 9/30/2024; 10/1/2025
Last Revised Date: 6/13/24; 3/13/2025	**Next Annual Review Date:** 7/1/2022; 6/13/25	**Retire Date:**

OVERVIEW: A hospital bed is a bed specially designed to meet the medically necessary needs of an individual, including positioning or safety, that cannot be provided by an ordinary bed. Common features of a hospital bed include adjustable height for the entire bed, head and/or the foot adjustment, and adjustable side rails. A hospital bed may accommodate or support special attachments (e.g., traction equipment) that cannot be used on an ordinary bed. An ordinary bed is typically sold as a furniture item and does not meet the definition of a hospital bed or durable medical equipment.

DECISION GUIDELINES:

CCA follows applicable Local Coverage Determinations (LCD) L33820 Hospital Beds and Accessories and related Policy Article A52508. Refer to LCD and related Policy Article for Coverage Indications, Limitations, and Documentation requirements.

Prior authorization is required for hospital beds **E0301, E0302, E0303, E0304 and E0328:**

Clinical Coverage Criteria:

1. A standard written order (SWO)/prescription from the treating practitioner; and
2. Face to face note- A practitioner [Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM), Physician's Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS)] has had a face-to-face examination with the member within the six months prior to the written order. If the face-to-face note does not provide the medical necessity information, a Letter of Medical Necessity (LMN) should be included in the submitted documentation (including continued need/use if applicable); and
3. Hospital beds E0301, E0302, E0303 and E0304 may be authorized when the following criteria are met:
   a) Positioning needs of the member cannot be accomplished by the use of an ordinary bed. These needs include but are not limited to:
      - Head or foot elevation
      - Frequent position changes
      - Changes in height of bed for safe transfers or for members who have a history of falls in/out of bed
      - Member requires traction or other equipment that can be attached only to a hospital bed;

   Or

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4. A hospital bed is required to enable caregiver(s) to provide necessary care to the member; and
5. Heavy duty-extra wide hospital bed (**E0301, E0303**) is covered when the above criteria 1 or 2 are met and one of the following criteria are met:
   a) Member's weight is greater than 350 pounds, but does not exceed 600 pounds; or
   b) Member requires additional surface area to accommodate their body habitus;

   Or
6. Extra heavy-duty, extra wide hospital bed (**E0302, E0304**) is covered when the above criteria 1 through 3 are met and one of the following criteria are met:
   a. Member's weight exceeds 600 pounds; or
   b. Member requires additional surface area to accommodate their body habitus; or
   c. Members' needs cannot be met by the E0301 or E0303;
7. Pediatric hospital bed E0328 may be authorized when the following criteria are met:
   a. Member is at risk of falling out of an ordinary bed or a hospital bed; or
   b. Member has a condition (e.g., history of seizures, spasms, cognitive impairment, behavior disorder) which puts member at risk of serious injury while in an ordinary bed or a hospital bed; or
   c. Member has a history of behavior involving unsafe mobility (e.g., climbing out of bed) that puts the member at risk of serious injury while in an ordinary bed or a hospital bed;

   And
   d. Less costly alternatives (e.g., side rails, wearing a protective helmet) have been tried and were unsuccessful or are contraindicated.

LIMITATIONS/EXCLUSIONS:

CCA does not cover a hospital bed in any of the following scenarios:

1. Member can be adequately positioned in a regular bed, with or without additional pillows or wedges.
2. Member already has equipment that serves the same purpose, and is able to meet their need(s).
3. Member is able to use less costly equipment to meet their need(s).
4. Use of a hospital bed is not reasonably expected to provide a meaningful contribution to the treatment of a member's illness or injury.
5. There is insufficient documentation to establish medical necessity for use of a hospital bed for the treatment of a member's illness or injury.

CODING:

When applicable, a list(s) of codes requiring prior authorization is provided. This list is for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment.

CPT/HCPCS CODE	CODE DESCRIPTION
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

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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
E0304	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with 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

Disclaimer:

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual© criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

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. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

This Medical Necessity Guideline is not a rigid rule. As with all CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity [supporting literature (full text preferred) should be attached to the request], or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

REFERENCES:

1. Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD): Hospital Beds and Accessories (L33820). Accessed February 25, 2025. https://www.cms.gov/medicare-coverage- https://www.cms.gov/medicare-coverage-

database/view/lcd.aspx?lcdid=33820&ver=21&keyword=Hospital%20bed&keywordType=starts&areaId=s24&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

2. Centers for Medicare & Medicaid Services (CMS). Hospital Beds and Accessories-Policy Article (A52508). Accessed February 25, 2025. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52508&ver=39&keyword=Hospital%20bed&keywordType=starts&areaId=s24&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1
3. Massachusetts Executive Office of Health and Human Services; MassHealth. Guidelines for Medical Necessity Determination for Hospital Beds. Accessed February 25, 2025. file:///M:/MNGs%20in%20progress/May%202024/Hospital%20Beds/mg-hospitalbeds.pdf
4. Massachusetts Executive Office of Health and Human Services; MassHealth. 130 CMR 409.00: Durable medical equipment services. Accessed February 25, 2025. https://www.mass.gov/doc/130-cmr-409-durable-medical-equipment-services-emergency-regulation/download
5. Massachusetts Executive Office of Health and Human Services; MassHealth.130 CMR 450.00: Administrative and billing regulations. Accessed February 25, 2025. https://www.mass.gov/doc/130-cmr-450-administrative-and-billing-regulations/download

REVISION LOG:

REVISION DATE	DESCRIPTION
3/13/2025	Template update; removed Auth Doc Requirements – placed "Face to face note" and LMN language in Clinical Criteria; removed "standard" hospital bed throughout; removed MAPD product language; revised code E0238 to E0328 x1. Editorial updates.
6/25/2024	Utilization Management Committee approval
5/9/24	Template update. Applicable to CA and MI products. Separate sections for MAPD (refers to applicable LCD) and SCO/One Care products. Added clinical coverage criteria for pediatric bed. "Insufficient documentation to establish medical necessity for using a hospital bed for the treatment of a member's illness or injury" added to limitations section.
12/31/23	Utilization Management Committee approval

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APPROVALS:

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