Hospital Bed/Patient Lift/Commode

A Semi-Electric Hospital Bed is covered if:

One of criteria 1-4 is met; AND
Criteria 5 AND 6 are met. (E0260)

1. Patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed; **OR**
2. Patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, **OR**
3. Patient 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. Pillows and wedges have been considered and ruled out. **OR**
4. Patient requires traction equipment, which can only be attached to a hospital bed. **AND**
5. Patient requires a variable bed height to permit transfers to a chair, wheelchair or standing position, **AND**
6. Patient requires frequent changes in body position and/or has an immediate need for a change in body position.

Patient Lift (E0630)

A patient lift is covered if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the patient would be bed confined.

Bedside Commode (E0163)

A commode is covered when the patient is physically incapable of utilizing regular toilet facilities. This would occur in the following situations:

1. The patient is confined to a single room, or
2. The patient is confined to one level of the home environment and there is no toilet on that level, or
3. The patient is confined to the home and there are no toilet facilities in the home

An Extra Wide/Heavy Duty Commode Chair (E0168) is covered for a patient who weighs 300 pounds or more. If an extra wide commode is ordered and the patient does not weigh more than 300 pounds, it will be denied as not reasonable and necessary.

A Commode Chair with Detachable Arms (E0165) is covered if the detachable arms feature is necessary to facilitate transferring the patient **OR** if the **patient has a body configuration that requires extra width**.

Support Surfaces – Group 1 WOPD is required prior to delivery

- **Alternating pump and pad (E0181)**
- **Foam mattress (E0184)**
- **Gel Overlay (E0185)**

A **Group 1 Mattress Overlay or Mattress** is covered if **one** of the following three criteria are met:
1. The patient is completely immobile - i.e., patient cannot make changes in body position without assistance, **OR**
2. The patient has limited mobility - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, **OR**
3. The patient has any stage pressure ulcer on the trunk or pelvis and at least one of conditions A-D below

Conditions for criteria 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

Support Surfaces – Group 2 WOPD is required prior to delivery

- **Low Air Loss Mattress (E0277)**
- **Roho Mattress (E0371)**

A group 2 support surface is covered if the patient meets:
a. Criterion 1 and 2 and 3, **OR**
b. Criterion 4, **OR**
c. Criterion 5 and 6.

1) The patient has multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02 -707.05), **AND**
2) Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface, **AND**
3) The ulcers have worsened or remained the same over the past month, **OR**
4) The patient has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.00 -707.01), **OR**

The comprehensive ulcer treatment described in #2 above should generally include:

- Education of the patient and caregiver on the prevention and/or management of pressure ulcers
- Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer).
- Appropriate turning and positioning
- Appropriate wound care (for a stage II, III, or IV ulcer)
- Appropriate management of moisture/incontinence
- Nutritional assessment and intervention consistent with the overall plan of care
- If the patient is on a group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements.

RELATED CLINICAL INFORMATION:
Patients needing pressure reducing support surfaces should have a care plan which has been established by the patient's physician or home care nurse, which is documented in the patient's medical records, and which generally should include the following:
1. Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
2. Regular assessment by a nurse, physician, or other licensed healthcare practitioner
3. Appropriate turning and positioning
4. Appropriate wound care (for a stage II, III, or IV ulcer)
5. Appropriate management of moisture/incontinence
6. Nutritional assessment and intervention consistent with the overall plan of care

The Staging of Pressure Ulcers used in this policy is as follows:

Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.
Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.