Bed and Mattress, Non-HCPCS Coded Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Bed and Mattress, Non-HCPCS Coded		
MNG #: 103	☒ CCA Senior Care Options (HMO D-SNP) (MA) ☒ CCA One Care (Medicare-Medicaid) (MA) ☐ CCA Medicare Preferred (PPO) (MA & RI) ☐ CCA Medicare Value (PPO) (MA & RI) ☐ CCA Medicare Maximum (HMO D-SNP) (RI) ☐ CCA Medicare Excel (HMO POS) (MI) ☐ CCA Medicare Maximum (HMO D-SNP) (MI) ☐ CCA Medicare Excel (HMO) (CA)	**Prior Authorization Needed?** ☒ **Yes (always required)** ☐ **Yes (only in certain situations. See this MNG for details)** ☐ **No**
Benefit Type: ☐ **Medicare** ☒ **Medicaid**	**Approval Date:** 3/3/2022	**Effective Date:** 8/23/2022
Last Revised Date: 4/11/2024	**Next Annual Review Date:** 3/3/2023; 4/11/2025	**Retire Date:**

OVERVIEW: Non-HCPCS coded beds (e.g. adjustable flex bed) and mattresses (e.g. memory foam) may provide a substitute when member's need(s) cannot be met by a hospital bed or mattress or a HCPCS coded support surface. HPHCS coded mattresses include foam mattress, air mattress, water mattress, gel mattress, powered-pressure reducing mattress and non-powered advanced pressure reducing mattress.

DECISION GUIDELINES:

Clinical Coverage Criteria:

CCA may cover a non-HCPCS coded bed and/or mattress when the following criteria are met:

1. Documentation of one or more of the following;
   a. Member has a medical condition or injury including, but not limited to pain, numbness, insomnia, altered sensation, impaired bed mobility or a need of keeping head or legs elevated while in bed; **or**
   b. Member's body habitus cannot be accommodated by a hospital bed and/or hospital bed mattress; **or**
   c. An increased bed surface area is required for member's care; **and**
2. Documentation by a physical therapist or occupation therapist includes the following:
   a. Why member's need(s) cannot be met by a hospital bed, a hospital bed mattress or a HCPCS coded support surface; **and**

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b. Member's trial of HCPCS coded hospital bed, hospital bed mattress or support surface was unsuccessful; **and**

c. Requested bed/mattress is reasonable and medically necessary:
   i. Safe and effective; and
   ii. Furnished in accordance with accepted standards of medical practice for the treatment of the member's condition or to improve the function of a malformed body member; and
   iii. Meets, but does not exceed, the member's medical need; and
   iv. Is at least as beneficial, comparable in effect/availability/suitability, and is no more costly as an existing and available medically appropriate alternative.

LIMITATIONS/EXCLUSIONS:

CCA will not cover a non-HCPCS codes bed or mattress when:

- The member already has a bed and/or mattress that is able to meet their needs and is in good working order.
- The member's needs could be met with a less costly alternative.
- The requested bed/mattress cannot reasonably be expected to make a meaningful contribution to the treatment of a member's illness or injury.
- Bed and/or mattress is for comfort and/or convenience purposes only.

Limitation:

- The non-HCPCS coded bed, mattress must be provided by a CCA contracted provider.

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
E1399	Durable medical equipment, miscellaneous (when used for non-HCPCS coded bed/mattress)

Documentation Requirements:

- Standard Written Order (SWO)
- Letter of Medical Necessity (LMN)
- Manufactures Invoice

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.

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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.

RELATED REFERENCES:

1. Commonwealth of Massachusetts Executive Office of Health and Human Services. Durable Medical Equipment Manual for MassHealth Providers; Provider Regulations Subchapter 4: Durable Medical Equipment Provider Regulations. Accessed March 1, 2024. https://www.mass.gov/lists/durable-medical-equipment-manual-for-masshealth-providers#subchapter-4:-durable-medical-equipment-providers-regulations-
2. Commonwealth of Massachusetts Executive Office of Health and Human Services. 130 CMR 450.00: Administrative and billing regulations. Accessed March 1, 2024. https://www.mass.gov/regulations/130-CMR-45000-administrative-and-billing-regulations
3. U.S. Congress. United States Code: Social Security Act § 1862(a)(1)(A)

REVISION LOG:

REVISION DATE	DESCRIPTION
4/11/2024	Title update, MNG applies to non-HCPCS coded beds. Template update. Removed Determination of Need and Clinical Eligibility sections. Added reasonable and medically necessary documentation criteria. Added Bed, mattress is for comfort and/or convenience purposes only to limitations section.

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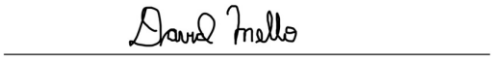
APPROVALS:

David Mello	Senior Medical Director Utilization Review and Medical Policy
CCA Senior Clinical Lead [Print]	**Title [Print]**
	4/11/2024
Signature	**Date**
Click here to enter text.	
CCA Senior Operational Lead [Print]	**Title [Print]**
Signature	**Date**
Nazlim Hagmann	Chief Medical Officer
CCA CMO or Designee [Print]	**Title [Print]** 4/11/2024
	
Signature	**Date**