

## CHAMPVA POLICY MANUAL

**CHAPTER:** 2  
**SECTION:** 17.9  
**TITLE:** AIR FLUIDIZED BED

---

---

**AUTHORITY:** 38 USC 1713; 38 CFR 17.270(a) and 17.272(a)

**RELATED AUTHORITY:** 32 CFR 199.4(d)(3)(ii)

---

---

### I. EFFECTIVE DATE

April 20, 1989

### II. PROCEDURE CODE(S)

HCPCS Level II Code E0194

### III. DESCRIPTION

The air-fluidized bed is a rectangular box containing 1,800-2,000 pounds of glass beads covered with a closely woven monofilament polyester sheet. Warm pressured air circulates through the beads causing the polyester sheet to float. The pressure relief system is used to treat bedsores or to aid in circulation. This bed is also called a bead bed. Two well-known trade names are Clinitron or KinAir.

### IV. POLICY

Food and Drug Administration (FDA) approved air fluidized beds are covered as durable medical equipment when ordered by a physician for bedridden or chairbound patients.

### V. POLICY CONSIDERATIONS

A. Claims which indicate a patient has been on the air fluidized bed for more than 60 days, or the care is not being monitored by a physician, or the physician is not seeing the patient at least monthly, should be referred for third level review to determine if the care is medically necessary and appropriate.

B. Charges related to institutional use of air fluidized beds are included in the DRG charge. For DRG exempt institutions, charges will normally be billed separately; however, they may also be included in the billed room and board charge.

## VI. LIMITATIONS

Coverage of air fluidized beds for home use is limited to the following:

1. The bed must be ordered by a physician.
2. The home treatment must be supervised by a physician.
3. The patient:
  - a. is bedridden or chairbound,
  - b. has stage III or stage IV pressure sores,
  - c. is afebrile, nonseptic and does not have any other contraindications to the bed therapy (i.e., no coexisting pulmonary conditions, or is being treated with moist wound dressing therapy, etc.),
  - d. would otherwise require continued hospitalization,
  - e. has tried all other medical/surgical treatments and these treatments were unsuccessful, and
  - f. has a person available to assist him/her in managing and maintaining the bed.
4. The rental of the bed only (see EXCLUSIONS below).
5. Skilled nursing visits when determined to be medically necessary. If the patient's condition is custodial, the skilled nursing visits are limited to one hour per day.

## VII. EXCLUSIONS

The following costs and services are excluded from coverage:

1. Structural or electrical changes necessary to accommodate home use of the air fluidized bed.
2. Any increases in monthly home utility charges (i.e., gas or electric, etc.).
3. Bed maintenance costs (these costs should already be included in the monthly rental rate).
4. All education, training or instruction related to use and operation of the bed.

TRANSMITTAL #: 35  
DATE: 02/26/2001  
TRICARE CHANGE #: N/A

5. Nursing/caregiver services for respite care or primarily for activities of daily living (i.e., turning, bathing, feeding, bed management).

**\*END OF POLICY\***