



**BlueCross BlueShield
of Illinois**

Blue Cross and Blue Shield of Illinois Provider Manual

HMO Scope of Benefits Section

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Hospital Beds

Benefit

Hospital beds are covered as durable medical equipment for bed-confined members if determined medically necessary by the Primary Care Physician (PCP).

Interpretation

Hospital beds must be medically necessary as determined by the physician. Typically:

- The member requires positioning not feasible in an ordinary bed (e.g., to alleviate pain, prevent aspiration or treat decubitus ulcers) or
- The member needs special attachments that cannot be affixed to and used on an ordinary bed.

The physician should document the member's medical condition. The severity and frequency of symptoms pertinent to use of a hospital bed for positioning must be described. Special attachments must be medically necessary, and documentation of this necessity should be as specific as possible.

Electric powered hospital beds are covered only when frequent or immediate changes in body position are necessary, and when no delay in such repositioning is tolerable. Also, the member must be able to operate the controls and cause the adjustments.

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Coverage Variation

Note: All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Benefit coverage and/or exclusions may vary for certain employer groups. To ensure current member benefit determination, please refer to the BCBS Benefit Matrix and/or contact customer service to confirm member coverage.

Note: Blue Precision HMOSM and BlueCare DirectSM have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”