Clinical Criteria – Cubby Bed; HCPCS E1399

Subject: Cubby Bed; HCPCS E1399	**Renewed Effective:** 10/31/25
	Review Schedule: Annual

Clinical coverage criteria — Cubby / enclosed ("safety") bed (HCPCS E1399)

Summary: An enclosed/specialty "cubby" bed (billed to E1399 when no specific HCPCS applies) is covered only when clear medical necessity is documented: the child has a diagnosed condition that creates a significant risk of injury or harm from leaving the bed unsafely, the member cannot safely use less-restrictive alternatives, and the request is supported by objective functional and incident evidence and by a treating prescriber and (preferably) a therapist evaluation.

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1) Coverage rule

A cubby or enclosed bed is a form of durable medical equipment (DME). Coverage is allowed only when documentation demonstrates that the item is medically necessary to prevent injury or to allow safe care in the home, and when less-restrictive, reasonable alternatives have been tried and shown ineffective or are clinically inappropriate. Use of unlisted code E1399 is acceptable when no more specific HCPCS code describes the device.

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2) Required *medical necessity* criteria — ***ALL of the following must be present***

1. Prescription / Order
    - Written prescription from an MD/DO, nurse practitioner, or physician assistant stating the item requested (e.g., "Cubby safety/enclosed bed" or equivalent), the diagnosis, and the rationale why the bed is necessary for safety.
2. Treating clinician assessment (must be included)
    - A recent clinical note (within 90 days of request) from the prescribing clinician describing the member's diagnosis, current functional status, cognition/awareness, and specific safety risks related to sleeping/bed egress (e.g., frequent unsupervised elopement from bed, high fall risk, self-injurious behavior during sleep, uncontrolled seizures with history of injury during or immediately after seizure, profound cognitive impairment with repeated unsafe bed exits).
3. Therapist evaluation
    - Occupational therapy (OT) or physical therapy (PT) assessment demonstrating: safety deficits, inability to use standard bed modifications, and justification for the specific features of the requested enclosed bed (sizing, padding, alarms, camera/monitoring hubs, etc.). If OT/PT is unavailable, the prescribing clinician must provide equivalent functional justification.
4. Objective evidence of risk *and* prior incidents
    - Clear documentation of prior incidents (date-stamped incident/behavioral reports, ED visits, documented injuries, school/guardian incident logs) showing danger

from exiting or being in a standard bed. Statements like “parent worried” alone are insufficient.

5. Documented trial and failure of less-restrictive alternatives (dates, duration, and outcome)
    - Examples: lower bed on floor; bed rails/rail covers; door/room locks; bed alarms; increased supervised sleep checks; environmental modifications; behavioral interventions; medication optimization/psychiatric treatment as appropriate. Provider must document what was tried, for how long, and why it failed or was not safe/feasible. Payer reviewers will expect this information before approving an enclosed bed.
6. Home safety assessment
    - A home safety evaluation (by OT, home health clinician, or supplier) stating that the home environment cannot be made safe by other means and that the enclosed bed is appropriate for the home layout and caregiver capacity.
7. Plan of care & review
    - A brief plan describing how the enclosed bed will be used, who will supervise, plans to re-assess for desensitization/transition to less restrictive sleep arrangements, and expected duration of need.

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3) Acceptable diagnoses / clinical scenarios (examples)
Coverage is commonly appropriate when there is clinical documentation of one or more of the following ***and*** other criteria above are met:

- Severe developmental disability with elopement/unsafe egress.
- Seizure disorder with uncontrolled seizures or seizure episodes with prior injury when out of bed.
- Severe cognitive impairment / disorientation (traumatic brain injury, severe intellectual disability) with repeated unsafe exits from bed.
- Severe behavioral or psychiatric disorder with documented night-time self-injury or aggression.
- Neuromuscular condition with frequent injurious falls from bed and inability to comply with less restrictive measures.

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4) Documentation checklist for prior authorization (submit all)

- Prescription/order (itemized).
- Recent clinician note (90 days) with diagnosis and safety rationale.
- OT/PT evaluation or therapy note describing function and justification.
- Home safety assessment.
- Incident reports / ED/hospital notes / dated caregiver incident logs showing harms or near-misses.
- Documentation of less-restrictive alternatives tried (dates and outcomes).

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6) Exclusions & typical denial reasons

- No objective evidence of unsafe egress, injuries, or incidents.
- No documentation that less-restrictive alternatives were tried or why they're inappropriate.
- Device requested for convenience, family preference, or purely behavioral/sleep training without safety risk.
- Item is primarily adaptive/comfort furniture (ordinary bed) rather than DME meeting the payer's definition.

Helpful references (examples)

- CMS — Hospital beds & accessories (policy article / coding guidance; E1399 use). Centers for Medicare & Medicaid Services
- Anthem clinical policy — enclosed crib/bed medical necessity examples & requirement to try less restrictive options. Anthem
- Excellus BCBS — specialty enclosure bed systems policy (pediatric). Excellus Prospect
- CubbyBeds — LMN templates / guidance for providers & suppliers (useful for clinicians writing supporting documentation). Cubby Beds
- MEDDMEW / review of enclosed bed evidence and policy challenges — notes limited evidence base and recommends consistent documentation requirements. Center for Evidence-based Policy