LOUISIANA DEPARTMENT OF HEALTH

# State of Louisiana
# Louisiana Department of Health
# Pediatric Hospital Bed Evaluation

*Instructions: Complete all required forms below and submit along with required documentation to obtain prior authorization for a pediatric hospital bed.*

- PA-01 and Pediatric Hospital Bed Evaluation form are required with all requests.
- Writing must be legible.
- All sections must be completed by the appropriate professional and signed. Enter N/A for items/sections that do not apply. DO NOT skip or leave sections blank.
- Please attach physician prescription and original manufacturer invoice sheets.
- The provider, physician, and provider must sign the Attestation page.

Acronyms List:

| | | | |
|---|---|---|---|
| AFO – ankle foot orthosis<br>Asst – assistive<br>DOB – date of birth<br>ER – external rotation | LE – lower extremity<br>Max A – maximal assistance<br>Min A – minimal assistance | Mod A – moderate assistance<br>Mod I – modified independent<br>N/A – not applicable | ROM – range of motion<br>SPV – supervision<br>UE - upper extremity<br>WFL – within functional limits |

## *To be completed by DME PROVIDER*

| | |
|---|---|
| Date of Evaluation: | |
| Recipient Name: | DOB: |
| Medicaid ID #: | Other Insurance: |
| Recipient's Address: | |
| Recipient's Height: | Recipient's Weight: |

***PRESENT PEDIATRIC HOSPITAL BED***

| | |
|---|---|
| Does the recipient currently own any type of hospital bed? ☐ Yes ☐ No | |
| If yes, please provide the following information: | |
| Serial #: | Age: |
| Model: | Size: |
| Price: | Funding Source: |
| Can the hospital bed be repaired? ☐ Yes ☐ No<br>If yes, please explain: | |

Why is the current hospital bed not meeting the recipient's needs?

_____

Provider (Print Name)

_____ _____

Provider's Signature/Credentials Date

## *To be completed by PRESCRIBING PHYSICIAN:*

| |
|---|
| Physician Name: |
| Recipient Name: |
| Diagnosis: |
| Age at diagnosis: Prognosis: |
| Summary of medical condition to warrant a pediatric hospital bed: |
| Estimated length of need for pediatric hospital bed: |

_____

Physician (Print Name)

_____ _____

Physician's Signature/Credentials Date

# *To be completed by THERAPIST:*

*Please select the item that best describes the recipient:*

**HOME ENVIRONMENT:**

☐ Home ☐ Apartment ☐ Mobile Home ☐ Asst. Living ☐ Alone ☐ With family/caregivers

Is the caregiver available 24 hours a day? ☐ Yes ☐ No

If no, how many hours a day is the caregiver available?

Will the home environment accommodate the recommended pediatric hospital bed? ☐ Yes ☐ No

If no, will the home be modified? ☐ Yes ☐ No

Comments:

**COGNITION:**

| | Intact | Impaired |
|---|---|---|
| Memory | | |
| Problem solving | | |
| Attention/Concentration | | |
| Vision | | |
| Hearing | | |
| Judgment | | |

Comments:

**COMMUNICATION:**

☐ Verbal ☐ Non Verbal ☐ Sign Language ☐ Gestures ☐ Communication Device

**SENSATION**:
☐ Intact ☐ Impaired ☐ Absent
**History of pressure sores:** ☐ Yes ☐ No
If yes, provide location and stage:

**Current pressure sores:** ☐ Yes ☐ No
If yes, provide location and stage:

**BOWEL MANAGEMENT:** ☐ Continent ☐ Incontinent

**BLADDER MANAGEMENT:** ☐ Continent ☐ Incontinent

**PATHOLOGICAL REFLEXES:**

☐ Asymmetrical tonic neck reflex ☐ Tonic labyrinthine reflex supine
☐ Symmetrical tonic neck reflex ☐ Tonic labyrinthine reflex prone
☐ Extensor tone ☐ Startle
☐ Positive ☐ Supporting
☐ Other: _____
Comments:

**MOBILITY:**

- ***Bed Mobility:*** ☐ Independent ☐ Mod I ☐ SPV ☐ Min A ☐ Mod A ☐ Max A ☐ Dependent

- ***Transfers:*** ☐ Independent ☐ Mod I ☐ SPV ☐ Min A ☐ Mod A ☐ Max A ☐ Dependent
  **Method:** ☐ Stand Pivot ☐ Squat Pivot ☐ Scoot Pivot ☐ Sliding Board ☐ Lift

- ***Ambulatory Status:*** ☐ Independent ☐ Mod I ☐ SPV ☐ Min A ☐ Mod A ☐ Max A ☐ Dependent ☐ Non-ambulatory
  **Distance:** ☐ < 25 feet ☐ 25 – 50 feet ☐ 50- 100 feet ☐ 100-150 feet ☐ >150 feet
  **Device:** ☐ Straight Cane ☐ Quad Cane ☐ Crutches ☐ Forearm Crutches ☐ Walker ☐ Gait Trainer ☐ None ☐ Other:_____

- ***Wheelchair mobility:*** ☐ Independent ☐ Mod I ☐ SPV ☐ Min A ☐ Mod A ☐ Max A ☐ Dependent

**PEDIATRIC HOSPITAL BED TRIAL AND CONSIDERATIONS:**

Does the recipient have seizures? ☐ Yes ☐ No

If yes, please provide how often seizures occur with medications:

Is the desired medical benefit attainable by the use of an ordinary bed? ☐ Yes ☐ No

If no, please explain:

Can an ordinary bed be modified or adapted by commercially available items to meet the medical needs? ☐ Yes ☐ No

If no, please explain:

Please document how the recipient's current bed has failed to protect the recipient.

Does the recipient have a medical condition that is expected to last greater than 6 months which requires positioning of the body in ways that are not feasible with an ordinary bed or hospital bed?

☐ Yes ☐ No

Does the recipient require the head of the bed to be elevated more than 30 degrees due to a medical condition or documented problems with aspiration? ☐ Yes ☐ No

Have pillows or wedges been considered and ruled out? ☐ Yes ☐ No

Does the recipient have a history of behavior involving unsafe mobility (ex: climbing out of bed)?

☐ Yes ☐ No

If yes, please explain:

Does the recipient have any documented injuries while in an ordinary bed or standard hospital bed?

☐ Yes ☐ No

If yes, please explain:

Please document whether all least costly alternatives were tried and unsuccessful. Please provide comments on why each item was unsuccessful:

- rail protectors ☐ Yes ☐ No
- putting a mattress on the floor ☐ Yes ☐ No
- medications to address seizures and/or behaviors ☐ Yes ☐ No
- helmets for head banging ☐ Yes ☐ No
- removing safety hazards from the recipient's room/child protection devices – on door knob, baby gate to prevent child from leaving room ☐ Yes ☐ No
- baby monitors and bed alarm systems ☐ Yes ☐ No
- behavior modification strategies ☐ Yes ☐ No
- ruled out physical and environmental factors for behavior – hunger, thirst, toileting, pain, restlessness, fatigue due to sleep deprivation, acute physical illness, temperature, noise levels, lighting, medication side effects, over/under stimulation, or a change in caregivers or routine. ☐ Yes ☐ No
- patient would be institutionalized without the bed ☐ Yes ☐ No

Comments on Pediatric Hospital Bed Trial and Considerations:

**POSTURE: (note if assessment done in sitting or supine)**

- **Head Posture:** ☐ WFL ☐ Flexed ☐ Extended ☐ Rotated ☐ Laterally flexed
  ☐ Cervical hyperextension
- **Head Control:** ☐ Normal ☐ Good ☐ Fair ☐ Poor ☐ Absent
- **Trunk Posture:** ☐ WFL ☐ Thoracic kyphosis ☐ Lumbar lordosis
  ☐ Scoliosis: ☐ left ☐ right ☐ C curve ☐ S curve
  ☐ Rotation: ☐ left ☐ right
- **Trunk Tone:** ☐ Hypertonia ☐ Normal ☐ Hypertonia ☐ Spasticity ☐ Rigidity
  ☐ Athetosis ☐ Ataxia ☐ Tremors
  **Severity:** ☐ Mild ☐ Moderate ☐ Severe
- **Pelvis:** ☐ Neutral ☐ Posterior ☐ Anterior ☐ Subluxation ☐ Dislocation ☐ Fracture
  ☐ Obliquity: ☐ left ☐ right
  ☐ Rotation: ☐ left ☐ right
  ☐ Windswept**:** ☐ left ☐ right

**UPPER EXTREMITY:**
General UE and Strength:

Shoulders: ☐ WFL
☐ Elevated/Depressed: ☐ Fixed ☐ Partially flexible ☐ Flexible
☐ Protracted/Retracted: ☐ Fixed ☐ Partially flexible ☐ Flexible
☐ Subluxed

Hands: ☐ WFL ☐ Fisting ☐ Other: _____

UE Tone: ☐ Flaccid ☐ Hypotonia ☐ Normal ☐ Hypertonia ☐ Spasticity ☐ Rigidity

Comments on the recipient's UE:

**LOWER EXTREMITY:**
General LE and Strength:

Hip position: ☐ Neutral
☐ Hip Abduction: ☐ Fixed ☐ Partially fixed ☐ Flexible
☐ Hip Adduction: ☐ Fixed ☐ Partially fixed ☐ Flexible
☐ Subluxed
☐ Dislocated
☐ Leg length discrepancy
☐ Windswept: ☐ Right ☐ Left
☐ Fixed ☐ Partially fixed ☐ Flexible

Does the recipient wear AFO's? ☐ Yes ☐ No
LE Tone: ☐ Flaccid ☐ Hypotonia ☐ Normal ☐ Hypertonia ☐ Spasticity ☐ Rigidity

Comments on recipient's LE:

| **BALANCE:** | | | | | |
|---|---|---|---|---|---|
| | Normal | Good | Fair | Poor | Absent |
| Sitting Balance | | | | | |
| Static: | | | | | |
| Dynamic: | | | | | |
| Standing Balance | | | | | |
| Static: | | | | | |
| Dynamic: | | | | | |

Comments:

**PAIN AND EDEMA: (reworked)**

*Pain:* ☐ Yes ☐ No

If yes, please state, severity (using the visual analog scale 0-10), location, and how often (daily, weekly, monthly).

Is the recipient on pain medication? ☐ Yes ☐ No

If yes, please list medication.

Does pain medication alleviate the recipient's pain?

*Edema:* ☐ Yes ☐ No

If yes, please state severity, location, and how often (daily, weekly, monthly).

## RECOMMENDED PEDIATRIC HOSPITAL BED AND NON-STANDARD PARTS

- *Please provide the original manufacturer invoice.*
- *Please describe the medical necessity for the requested equipment.*
- *Please justify the pediatric hospital bed size being recommended.*
- *Medically justify each non-standard part on the pediatric hospital bed.*
- *List the pediatric hospital bed parts in order of the manufacture price sheet.*
- *Stamp signatures are not accepted.*
- *The provider can assist with all pediatric hospital bed part justifications.*

Pediatric Hospital Bed Model:

Justification:

Pediatric Hospital Bed size requested:

Justification:

| |
|---|
| Non-standard part on Pediatric Hospital Bed:<br><br>Justification: |
| Non-standard part on Pediatric Hospital Bed:<br><br>Justification: |
| Non-standard part on Pediatric Hospital Bed:<br><br>Justification: |
| Non-standard part on Pediatric Hospital Bed:<br><br>Justification: |
| Non-standard part on Pediatric Hospital Bed:<br><br>Justification: |
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| Non-standard part on Pediatric Hospital Bed:<br><br>Justification: |
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| Non-standard part on Pediatric Hospital Bed:<br><br>Justification: |
| Non-standard part on Pediatric Hospital Bed:<br><br>Justification: |

Non-standard part on Pediatric Hospital Bed:

Justification:

_____

Therapist (Print Name)

_____ _____

Therapist's Signature/Credentials Date

LOUISIANA DEPARTMENT OF HEALTH

# ATTESTATION FORM

**Note:** Completion of this page is required. Failure to submit a completed attestation form will result in missing documentation and possible denial of the prior authorization.

**A. I, _____ (print therapist's name), was present and participated in this evaluation, have personally completed this evaluation, and agree that the above Pediatric Hospital Bed and all the non-standard parts recommended are medically necessary for the above patient.**

_____ _____

**Therapist (Print Name)** **Contact Number**

_____ _____

**Therapist's Signature/Credentials** **Date**

**B. I, _____ (print physician's name), have read this evaluation, completed the physician's portion of the evaluation, and agree that the above Pediatric Hospital Bed and all the non-standard parts recommended are medically necessary for the above patient.**

_____ _____

**Physician (Print Name)** **Contact Number**

_____ _____

**Physician's Signature/Credentials** **Date**

**C. I, _____ (print provider's name), have read this evaluation, completed the provider's portion of this evaluation, and agree that the above Pediatric Hospital Bed and all the non-standard parts recommended are medically necessary for the above patient.**

_____ _____

**Provider (Print Name)** **Contact Number**

_____ _____

**Provider's Signature/Credentials** **Date**