
CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.2: SPECIFIC COVERAGE CRITERIA**PAGE(S) 8**

18.2.23 Hospital Beds, Lifts, and Trapeze Bar**18.2.23.1 Hospital Beds**

Standard hospital beds are approved if the beneficiary is confined to a bed and their condition necessitates positioning the body in a way that is not possible in an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed.

Prior authorization requests for all covered hospital beds (as described in this section) must include the following:

1. The beneficiary requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition that is expected to last for at least one month;
2. The beneficiary requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed; and
3. The beneficiary has a condition that requires special attachments (such as a trapeze, foot board, or traction equipment) that cannot be fixed and used on an ordinary home bed.

NOTE: More specific criteria may apply as described for each covered hospital bed type.

Hospital Beds, Fixed and Variable Height

A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment. A variable height hospital bed is one with manual height adjustment and manual head and leg elevation adjustments.

In addition to the required documentation for PA requests as described under Hospital Beds above, the request must also include that the beneficiary has a condition that requires special attachments (such as a trapeze, foot board, or traction equipment) that cannot be fixed and used on an ordinary home bed.

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.2: SPECIFIC COVERAGE CRITERIA**PAGE(S) 8**

Furthermore, requests for a variable height bed must document that the beneficiary requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care.

Hospital Bed, Semi-Electric

A semi-electric hospital bed is one with manual height adjustment and electric head and leg elevation adjustments.

In addition to the required documentation as previously listed under Hospital Beds, the PA request must document that the beneficiary requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care. The PA request must also include that the beneficiary is alone for extended periods of time, requires frequent and immediate changes in body position and can operate the bed controls independently.

Hospital Bed, Total Electric

A total electric hospital bed is one with electric height adjustment and electric head and leg elevation adjustments.

In addition to the required documentation as previously listed under Hospital Beds, the PA request must document that the beneficiary requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care. The PA request must also include that the beneficiary is alone for extended periods of time, requires frequent and immediate changes in body position and can operate the bed controls independently.

Documentation submitted on the PA request must also indicate one of the following:

1. The beneficiary has tried multiple means of transfer and can only transfer with a total electric bed; and
2. The beneficiary has a care-giver with a documented medical condition stating an inability to use a crank on a semi-electric bed.

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.2: SPECIFIC COVERAGE CRITERIA**PAGE(S) 8**

Hospital Bed Mattresses

Hospital bed mattresses are considered part of the hospital bed and will only be approved to replace mattresses that are no longer functional, when the beneficiary meets the criteria to receive a hospital bed.

Egg-Crate Mattresses & Alternating Air Pressure Mattresses/Pads

Egg-crate mattresses and alternating air pressure mattresses/pads are devices used to relieve pressure and prevent the occurrence of decubitus ulcers. The pads include: gel, air, dry and water pressure pads for mattresses, and mattress-size pads.

The PA request must include:

1. Documentation on the lesions, the beneficiary's condition, positioning, nutritional status (including serum albumen and total protein levels with the initial request), and detailed descriptions of prior treatments used and the outcomes of the treatments;
2. Documentation showing the presence of stage three or stage four decubitus ulcers affecting at least two pressure bearing surfaces; and
3. For subsequent PA requests, documentation must show signs of healing. The presence of new decubitus must be explained and may be a basis for denial without extenuating circumstances.

Sheepskins

Sheepskins are approved if the beneficiary's skin condition necessitates use.

Side Rails

Side rails for beds other than hospital beds are approved only if the beneficiary's medical condition necessitates use of rails on a regular bed.

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.2: SPECIFIC COVERAGE CRITERIA**PAGE(S) 8**

Hospital Bed, Pediatric

A pediatric hospital bed allows for the manual, semi-electric, or fully electric adjustment to the head and leg elevation. A pediatric hospital bed is:

1. One with a full side rail (360 degrees, up to 24 inches high above the mattress) enclosure; and
2. May be manual, semi-electric, or total electric.

Specific Criteria**Hospital Bed, Pediatric without Safety Enclosure**

A pediatric hospital bed without an added safety enclosure is covered when **all** of the following criteria are met.

The beneficiary must:

1. Be under 21 years of age;
2. Meet the criteria for a hospital bed (see Hospital Bed Criteria in this section);
3. Have a medical condition that prevents the use of a standard size hospital bed and is best met by a pediatric sized hospital bed;
4. Have a medical condition that requires positioning of the body ordered by the physician so that the head of the bed elevation is greater than 30 degrees, or have documented problems with aspirations; and
5. 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.

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.2: SPECIFIC COVERAGE CRITERIA**PAGE(S) 8**

In addition, the following criteria must be met:

1. The desired medical benefit is not attainable by the use of an ordinary bed. All alternative methods have been tried and failed;
2. An ordinary bed cannot be modified or adapted by commercially available items to meet the medical needs; and
3. Pillows and wedges must have been considered and ruled out.

Hospital Bed, Pediatric with Safety Enclosure

A pediatric hospital bed with an added safety enclosure is covered when **all** of the following criteria are met. The absence of a pediatric hospital bed with safety enclosure would result in the beneficiary being institutionalized.

The beneficiary must:

1. Be under 21 years of age;
2. Have one of the following diagnoses: brain injury, moderate to severe cerebral palsy, seizure disorder (with daily seizure activity taking anti-seizure medication), developmental disability, or severe behavior disorder (this list is not all inclusive);
3. Meet the criteria for a hospital bed (see Hospital Bed Criteria in this section);
4. Have a medical condition that puts them at risk for falling off of or seriously injuring himself/herself while in an ordinary bed, standard size hospital bed, or a pediatric sized hospital bed;
5. Have a history of behavior involving unsafe mobility (climbing out of bed - more than standing at the side of the bed) that puts the beneficiary at risk for serious injury while in an ordinary bed, standard hospital bed, or pediatric hospital bed;
6. Be cognitively impaired and have communication impairments. The beneficiary is mobile and their unrestricted mobility has resulted in documented injuries; and

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.2: SPECIFIC COVERAGE CRITERIA**PAGE(S) 8**

7. Have tried less costly alternatives which were unsuccessful, including any of the following (not all inclusive):
 - a. Rail protectors;
 - b. Medications to address seizures and/or behaviors;
 - c. Helmets for head banging;
 - d. Baby monitors and bed alarm systems;
 - e. Behavior modification strategies;
 - f. Removal of safety hazards and installation of child protection devices (e.g. baby gate, safety door knob) in the beneficiary's room;
 - g. Placement of mattress on the floor; and
 - h. Physical and environmental factors for behavior have been eliminated. These include, but are not limited to, 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.

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.2: SPECIFIC COVERAGE CRITERIA**PAGE(S) 8**

Exclusion Criteria

Non-coverage of the pediatric hospital bed includes, but is not limited to the following:

1. Lack of caregiver monitoring of beneficiary's safety;
2. The safety enclosure frames are used as a restraint or for the convenience of family or caregiver;
3. An ordinary bed, typically sold as furniture, which consists of a frame, box spring, and mattress;
4. Institutional type hospital beds (e.g. oscillating beds, spring-base beds, circulating beds, continuous lateral rotation beds, and Stryker frame beds);
5. Enclosed beds for beneficiaries with 24-hour care from caregivers who are required to be awake and actively caring for the child;
6. Enclosed bed systems that are not approved by the FDA (e.g. Vail Enclosure Bed, Posey Bed Enclosure System); and
7. The hospital beds where manufacturer is not registered and cleared to market with the FDA.

Documentation Requirements

The following documentation must be submitted to support the medical necessity for this equipment:

1. Prior Authorization form – (PA-01 Form);
2. Physician prescription;
3. Louisiana Medicaid Pediatric Hospital Bed Evaluation (BHSF-PHB-Form 1) completed by a Louisiana State licensed physician and physical or occupational therapist in its entirety (see Appendix G); and
4. Original manufacturer's price.

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

SECTION 18.2: SPECIFIC COVERAGE CRITERIA**PAGE(S) 8**

18.2.23.2 Patient Lifts

Lifts are approved only if all of the following conditions are met:

1. Beneficiary is confined to bed, chair or room and is unable to transfer or unable to achieve needed movement with or without assistance;
2. Caregiver is unable without the use of a lift to provide periodic movement necessary to arrest or retard deterioration in the beneficiary's condition, thus affecting improvement in rehabilitation; and
3. Caregiver is unable to transfer beneficiary from chair to bed or bath (or vice versa) e.g., because of beneficiary's size or weight.

Medicaid covers hydraulic lifts. **Electric lifts are not covered.**

Lift Slings

Lift slings or seats, either canvas or nylon, are considered part of the lift and are only covered as replacement items.