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PURPOSE

The purpose of this policy is to describe the health plan's process for the prior authorization decision-making conditions in which Hospital Beds, Mattresses and Lifts may be authorized according to the directives from state of Louisiana Medicaid.

SCOPE

The scope of this policy applies to the Louisiana Prior Authorization staff and all colleagues processing Louisiana authorization requests for Hospital beds, Mattresses[IG1][KL2] and Lifts and Ma.

POLICY

It is the policy of the Plan that specific state directives, in addition to MCG® criteria are used when processing authorization requests for Hospital Beds, Mattresses and Lifts. Louisiana state qualifications, authorization and documentation requirements must be met. Louisiana Medicaid covers Hospital beds, Mattresses and Lifts. It defines additional Louisiana state qualifications and authorization and documentation requirements.

STANDARD

Coverage of Hospital Beds, Mattresses and Lifts requires prior authorization. All Providers (both facility and ordering physicians) must be registered in the state and the health plan's registry. The provider should be a preferred provider for the health plan.

Member Criteria and Prior Authorization Requirements[1]

Hospital beds and lifts do require prior authorization. Hospital bed mattresses are included with the hospital bed. Any specialty mattress requires authorization. To be eligible for a hospital bed, members must meet the following criteria[IG3]:[2]

- **The member's condition requires positioning of the body to alleviate pain, promote good body alignment, prevent contractures, or avoid aspiration or respiratory infections that is not feasible in a regular bed with pillow support**
- **The member's condition requires special attachments such as traction equipment that can only be attached to a hospital bed and cannot be fixed and used on an ordinary bed**
- **The member requires the head of the bed to be elevated more than 30 degrees most of the**

[1] **2023 Louisiana Medicaid Service Manual Chapter 18.2.23 Durable Medical Equipment: Hospital beds p. 3 of 8**

[2] Aetna Better Health Clinical Policy Bulletin 0543

time due to congestive heart failure, chronic pulmonary disease or problems with aspiration that pillows, or wedges have been considered but deemed inadequate.

- Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed.

Mattresses[3]

A hospital bed mattress is considered part of the hospital bed rental. If a replacement mattress is required, it is part of the rental agreement and should not be charged but may be charged and considered medically necessary of a member owned hospital bed.

Pressure support Surface Mattresses or overlays are considered medically necessary if:

- **Group 1 Support Mattresses:**
  - **The member is completely immobile and cannot make changes in body position without assistance;**
  - **Limited Mobility – cannot independently make changes in body position significant enough to alleviate pressure**
  - **Any stage pressure ulcer on the trunk or pelvis**
  - **Impaired nutritional status**
  - **Fecal or urinary incontinence**
  - **Altered sensory perception**
  - **Compromised circulatory status.**
- **Group 2 Pressure Reducing Support Surface Mattresses:**
  - **The member has multiple stage ii (partial thickness skin loss)pressure ulcers located on the trunk or pelvis**
  - **The member has been on a comprehensive ulcer treatment program for at least the past month with has included the use of an appropriate group 1 support mattress.**
  - **The member's ulcers have worsened or remained the save of the past month.**
  - **The member has large or multiple stage iii (full thickness tissue loss) or stable l V (deep tissue destruction) Pressure ulcers on the trunk or pelvis.**
  - **The member has ha a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery with the past sixty (60) days)**
  - **The member has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility with the past thirty (30) days.**
- **Group 3 Pressure Reducing Support Surfaces or Air-Fluidized Beds (Bead Beds)(all criteria must be met)**

[3] Aetna Better Health Clinical Policy Bulletin 0430 p. 1

- The member has a stage lll (full thickness tissue loss) or stage ~~IV~~l V (deep tissue destruction pressure ulcer
  - Does not include a foot ulcer as the foot can be elevated on its own.
  - If the ulcer is less than 8 square centimeters or is in an area other than the posterior trunk or pelvis, the attending physician must document why an alternative support surface would not be medically effective.
- The member is ~~bedridden~~bedridden, or chair bound as a result of severely limited mobility
- Without the air-fluidized bed, the member would require institutionalization
- The air-fluidized bed is ordered in writing by the attending physician based on a comprehensive assessment and evaluation after conservative treatment has been unsuccessful.
- A trained adult Caregiver is available to assist with activities of daily living and bed management
- The physician re-evaluated the home treatment regimen and recertifies the need for the air-fluidized bed monthly.
- Other alternative equipment has been considered and ruled out.
- The air fluidized beds are considered medically necessary until the ulcer is healed or if healing does not continue there is documentation to show modifications of the plan of care to promote healing and documentation that the use of the bed is medically necessary for wound management~~—~~.

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Standard 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:

- **The member 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;**
- **The member 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**
- **The member 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.**

Hospital Beds, Fixed and Variable Height (More specific criteria may apply as described for[IG4] each covered hospital bed type).

- **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 member 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.**
- **Variable height bed must document that the member 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:**
    - **The member has tried multiple means of transfer and can only transfer with a total electric bed; and**

- **2. The member has a caregiver with a documented medical condition stating an inability to use a crank on a semi-electric bed.**

Pediatric Hospital Beds[IG5]

Pediatric Hospital Beds may be authorized as manual, semi-electric or fully electric adjustment to the head and leg elevation. With one full side rail. [4][IG6] **A pediatric hospital bed without an added safety enclosure is covered when ALL of the following criteria are met:**

The pediatric member must have documentation that:

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

Pediatric hospital beds are not covered when:

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. **The bed is an ordinary bed, typically sold as furniture, which consists of a frame, box spring, and mattress;**
4. **The bed is an Institutional type of hospital beds (e.g., oscillating beds, spring-base beds, circulating beds, continuous lateral rotation beds, and Stryker frame beds);**
5. **The enclosed bed is for a member with 24-hour care from caregivers who are required to be awake and actively caring for the child;**
6. **The enclosed bed systems ~~is~~are not approved by the FDA (e.g., Vail Enclosure Bed, Posey Bed Enclosure System); and**

[4] 2023 Louisiana Medicaid Service Manual Chapter 18.2.23 Durable Medical Equipment: Hospital beds p. 4 of 8

7. **The hospital bed has a manufacturer that is not registered and cleared to market with the FDA.**

Trapeze accessory [5]

Trapeze bare[IG7][KL8] **may be authorized but require documentation of need for assistance to sit up in bed ~~and~~**[HG9][KL10] **because of a respiratory condition or a need to change body positions for other medical reasons.**

Patient Lifts[6]

Patient lifts are approved if the following conditions are met. Hydraulic lifts are a covered benefit, but electric lifts are not covered.. Lift slings or seats (either canvas or nylon) are considered part of the lift and are only covered as replacement items.

1. **The member is confined to bed, chair or room and is unable to transfer or unable to achieve needed movement with or without assistance;**
2. **Caregivers are unable without the use of the lift, to provide periodic movement necessary to arrest or retard deterioration of the member's condition, thus affecting improvement in rehabilitation; and**
3. **Caregivers are unable to transfer the member from chair to bed or bath because of member's size or weight.**

Documentation Requirements[7]

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

1. Prior Authorization form ~~(PA-01 Form~~[HG11][KL12][KL13]**~~);~~**
2. Physician prescription;
3. Therapy notes are helpful in describing the functional deficit requiring a hospital bed, why an electric bed may be needed, as well as documenting the hospital bed is suitable for the home. This information is sometimes found in the physician notes.~~.~~.
~~3. Louisiana Medicaid Pediatric Hospital Bed Evaluation (BHSF-PHB-Form 1~~[HG14][KL15][KL16]**~~)~~**
~~completed by a Louisiana State licensed physician and physical or occupational therapist in its entirety (see Appendix G~~[HG17][KL18][KL19]**~~); and~~**
~~4. Original manufacturer's price.~~

[5] **2023 Louisiana Medicaid Service Manual Chapter 18.2.24 Durable Medical Equipment: Trapeze. 1 of 1**
[6] **2023 Louisiana Medicaid Service Manual Chapter 18.2.23.2 Durable Medical Equipment: Patient Lift p. 8 of 8**
[7] **2023 Louisiana Medicaid Service Manual Chapter 18.2.23 Durable Medical Equipment: Hospital beds p. 7 of 8**

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. Pressure relieving air mattresses must be ordered and authorized separately.

APPLICABLE ~~CPT~~[IG20][KL21]- HCPCS CODES

This policy applies the additional definitions, qualifications, criteria and documentation requirements to the procedure codes listed below. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply. All codes listed on the DMEPOS fee schedule will be covered.

HCPCS[IG22][KL23]	Description
A4640	Replacement pad of use with medically necessary alternating pressure pad owned by patient
E0181	Powered pressure reducing mattress overlay/pad, alternating with pump includes heavy duty
E0182	Replacement pump or alternating pressure pad
E0184	Dry pressure mattress
E0185	Gel or gel-like pressure pad for mattress, standard length and width
E0186	Air pressure mattress
E0187	Water pressure mattress
E0188	Synthetic Sheep Skin pad
E0189	Lambswool, sheepskin pad
E0194	Air Fluidized Bed
E0196	Gel pressure mattress (nonpowered)
E0197	Air pressure pad for mattress
E0198	Eggcrate type pad for mattress
E0250	Hospital Bed – fixed height, with any side rails and mattress
E0251	Hospital Bed – with side rails , fixed
E0255	Hospital Bed – with side rail variable
E0256	Hospital Bed – Variable height, HI LO with any type siderails, without mattress

E0260	Hospital Bed – Semi electric (head and food adjustment)with any side rails and mattress; manual height adjustment
E0261	Hospital Bed – Semi electric (head and foot adjustment) with any ~~type~~type of side rails without mattress.
E0265	Hospital Bed – total electric (head, foot, height adjustments) with any siderails and mattress
E0266	Hospital Bed – Total electric (head, foot and height adjustment) any side rails without mattress
E0271	Mattress - Innerspring
E0272	Mattress – Foam Rubber
E0290	Hospital Bed – fixed height, with no side rails and with mattress
E0291	Hospital Bed – fixed height with no side rails, no mattress; short term rental
E0292	Hospital Bed – variable height, hi-lo, without siderails with mattress
E0293	Hospital Bed – variable height , hi-lo, without rails; without mattress
E0294	Hospital Bed - Semi electric (head and foot) without siderails; with mattress
E0295	Hospital Bed - Semi electric (head and foot) without siderails; without mattress
E0296	Hospital Bed – Total electric (head, foot height) without side rails, with mattresss
E0297	Hospital Bed – Total electric (head, foot, height) without side rials or mattress
E0300	Hospital Bed – Pediatric crib, hospital grade, fully enclosed, with or without top enclosure
E0301	Hospital Bed – Heavy duty; extra wide; bed capacity over 350 lbs. But less than 600 lbs.; with any type of side rails and without mattress
E0302	Hospital Bed – Heavy duty; extra wide; bed capacity greater than 600 lbs.; with any type of side rails and without mattress
E0303	Hospital Bed – Heavy duty; extra wide; bed capacity greater than350 lbs. But less 600 lbs.; with any type of side rails and with mattress
E0304	Hospital Bed – Heavy duty; extra wide; bed capacity greater than 600 lbs.; with any type of side rails and with mattress
E0305	Bedside rails half length
E0310	Bedside rails full length
E0315	Bed accessory- board table or support device any type

E0316	Safety enclosure frame/canopy for use with hospital bed
E0328	Hospital bed, pediatric; manual; 360o side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress
E0329	Hospital bed, pediatric; electric or semi electric; 360o side enclosures, topo headboard, footboard and side rails up to 24 inches above the spring, includes mattress
E0621	Sling or seat, patient lift, canvas or nylon
E 0630	Member lift, hydraulic or mechanical, includes any seat, sling, strap or pad.
~~E0635~~	~~Member lift, electric with seat of sling~~[KL24]~~.~~
~~E0639~~	~~Member lift, moveable from room to room with disassembly and reassembly, includes all components/accessories.~~
E0910	Trapeze Bar; Full -length , 2 posts
E0940	Trapeze Bar – Free standing, complete

DEFINITIONS:

Lift	A mechanical device that helps caregivers move dependent patients from place to place with minimal strain.
MCG ®	A set of nationally standardized criteria used to make medical necessity determinations for authorization requests.
Prior Authorization (PA)	Approval from the health plan that is required before receiving a service in order for the service to be covered
Trapeze	A triangular metal device that hangs from above the hospital bed. It allows patient to grab the device and move or lift themselves in the bed.

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