PROVIDER POLICIES & PROCEDURES

ENCLOSED NON-HOSPITAL BEDS

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for enclosed non-hospital beds. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

An enclosed non-hospital bed is a commercially available, specialized bed that has been manufactured or customized with additional enclosure components.

Technology features associated with enclosed non-hospial beds will be reviewed using the HUSKY Health Medical Devices with Integrated Technology policy.

CLINICAL GUIDELINE

Coverage guidelines for enclosed non-hospital beds are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines only. Coverage determinations are based on an assessment of the individual and his or her unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

The use of an enclosed non-hospital bed in a home setting is considered **investigational and therefore not medically necessary** based on the following:

A. There is insufficient published, scientific evidence in peer-reviewed medical literature supporting an enclosed non-hospital bed as being safe, without evidence of causing entrapment, injuries, and death;
B. There is insufficient published, scientific evidence in peer-reviewed medical literature to support that an enclosed non-hospital bed has been shown effective in preventing elopement, improving sleep, or preventing injury;
C. These items can be locked/secured from the outside and do not permit independent exit, restricting direct access for the individual to safely evacuate in an emergency, and delay direct access for the caregiver to the individual during an environmental or medical emergency; and
D. They are not appropriate as a substitute for caregiver supervision when an individual is experiencing behavioral and/or sleep challenges.

EPSDT Special Provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary to correct or

ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Prior authorization of enclosed non-hospital beds is required for coverage and will be reviewed in accordance with procedures in place for durable medical equipment. Coverage determinations will be based upon a review of requested and submitted case-specific information.

EFFECTIVE DATE
This Policy is effective for prior authorization requests for enclosed non-hospital beds for individuals covered under the HUSKY Health Program beginning November 01, 2024.

LIMITATIONS
N/A

CODES
N/A

DEFINITIONS
1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is

generally recognized by the relevant medical community, (B)recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

- Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD)- Hospital Beds and Accessories. Last revised 01/01/2020. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33820
- Huang PP, Durbin DR. Promoting safety in children with disabilities. In: UpToDate. Augustyn M, Tehrani N (Eds.). Update March 12, 2025.
- Moon RY, Carlin RF, Hand I; TASK FORCE ON SUDDEN INFANT DEATH SYNDROME AND THE COMMITTEE ON FETUS AND NEWBORN. Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. Pediatrics. 2022;150(1):e2022057990. doi:10.1542/peds.2022-057990
- Sherburne E, Snethen JA, Kelber S. Safety Profile of Children in an Enclosure Bed. *Clin Nurse Spec*. 2017;31(1):36-44. doi:10.1097/NUR.0000000000000261
- U.S. Food and Drug Administration (FDA), Center for Devices and Radiological Health (CDRH). Medical Devices. Class 1 Device Recall Cubby Bed. April 14, 2022. Available at: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRes/res.cfm?ID=192277
- U.S. Food and Drug Administration (FDA), Center for Devices and Radiological Health (CDRH). MAUDE Adverse Event Report: Cubby Bed/Better Sleep Designs LLC. Cubby Bed; Bed, Manual. June 15, 2021. Available at: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfmaude/detail.cfm?mdrfoi__id=12318404&pc=FNJ&device_sequence_no=1
- U.S. Food and Drug Administration (FDA). Center for Devices and Radiological Health (CDRH). Class 1 Device Recall. Vail 500 Enclosed Bed System. Vail 1000 Enclosed Bed System. Jun 30, 2005. Available at: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfres/res.cfm?id=39027
- Maude Alerts by Innolitics. Available at: Reports for Product Code OYS. 2016-2020

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	July 2024	Approved at the July 10, 2024 Medical Reviewer meeting. Approved at the CHNCT Clinical Quality Subcommittee on September 16, 2024. Approved by DSS on September 27, 2024.
Updated	June 2025	Reference to "Change Healthcare InterQual®" updated to "InterQual®" to reflect new branding. Changes reviewed and approved at the June 11, 2025, CHNCT Medical Reviewer

		meeting. Approved by the CHNCT Clinical Quality Subcommittee on June 16, 2025. Approved by DSS on July 9, 2025.
Update	June 2026	Changed title to Enclosed Non-Hospital Beds and edited throughout policy to reflect change. Edited the description in the Introduction. Added Note that any technology feature associated with enclosed beds will be reviewed using the Medical Devices with Integrated Technology. *Clinical Guideline* • Added language that there is lack of peer-reviewed evidence supporting safety and efficacy in preventing elopement, improving sleep, or preventing injury. • Language added that enclosed beds delay access to individuals during an environmental or medical emergency. Removed Codes in section. References updated. Changes reviewed and approved at the June 10, 2026, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on June 17, 2026. Approved by DSS on July 02, 2026.