PROVIDER POLICIES & PROCEDURES

HOSPITAL BEDS AND RELATED ACCESSORIES

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 hospital beds and related accessories. 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 carethey need as quickly as possible.

A hospital bed is a bed with specific features for individuals who need to be in certain positions because of their medical diagnosis(es) and/or condition(s) and can include beds that are fixed-height; variable-height; semi-electric; total electric; heavy-duty; and hospital cribs and hospital beds for infants and children. A hospital bed is considered durable medical equipment and is useful in the home only to an individual with a medical condition. Accessories for a hospital bed are items that are also considered durable medical equipment and are used in conjunction with a hospital bed. They can include side rails, trapeze bars, traction equipment, fracture frames, mattresses, mattress overlays, and bed cradles.

Prior Authorization Requirements

- Prior authorization is required for all hospital beds, including pediatric hospital beds and cribs
- Prior authorization is required for pressure-reducing air mattresses (powered and non-powered) and powered mattress overlays
- Prior authorization is not required for:
  - standard mattresses (E0271, E0272)
  - bed cradles (E0280)
  - side rails (E0305, E0310)
  - trapeze bars (E0910, E0911, E0912, E0940)
  - traction equipment (E0840, E0870, E0890)
  - fracture frames (E0920, E0946, E0947, E0948)

  However, if an individual requires a rental or purchase of these items above what is allowed on the DSS DME Fee Schedule (e.g., rental greater than one month), prior authorization is required.

CLINICAL GUIDELINE

Coverage guidelines for hospital beds and related accessories 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:

Hospital Beds

HUSKY Health primarily uses Change Healthcare's InterQual® Criteria when reviewing prior authorization requests for coverage of most hospital beds. HUSKY Health will use this policy to review requests for hospital beds for which InterQual® Criteria are not available.

A hospital bed may be considered medically necessary for an individual when they have a medical condition that:

A. Requires frequent positioning of the body to alleviate pain, prevent contractures, avoid respiratory infections, or to promote good body alignment; or
B. Requires special attachments, i.e., traction equipment, that can only be used with a hospital bed; or
C. Makes it difficult to transfer from a standard bed to a chair, wheelchair, or to stand; or
D. Requires positioning of the body that is not feasible with an ordinary bed, e.g., elevation of head > than 30 degrees.

Bed Accessories

HUSKY Health primarily uses Change Healthcare's InterQual® Criteria when reviewing prior authorization requests for coverage of most hospital bed accessories. HUSKY Health will use this policy to review requests for hospital bed accessories for which InterQual® Criteria are not available.

The following accessories are considered medically necessary for individuals who meet the following criteria:

A. Traction equipment:
    1. *Criteria for Hospital Bed* is met; and
    2. The individual has a musculoskeletal or neurological impairment requiring traction equipment; and
    3. The individual and caregiver(s) has demonstrated the appropriate use and tolerance of the traction equipment.
B. Fracture frames (e.g. Balkan frame):
    1. Criteria for *Hospital Bed* is met; and
    2. The individual has an orthopedic condition (i.e., broken bone or fractured bone) requiring a fracture frame; and
    3. The individual and caregiver(s) has demonstrated the appropriate use and tolerance of the fracture frame.

Non-Covered

The following items are typically considered investigational and therefore not medically necessary as there is a lack of published, controlled trials evaluating their safety and efficacy for use in the home:

- Lateral rotational therapy beds
- Kinetic therapy beds
- Oscillating beds
- Stryker frame beds
- Weighted blanket or specialized mattress technology as treatment for disrupted sleep

The following items typically do not meet the definition of durable medical equipment and are therefore not medically necessary:

- Bed alarms

Repair, Adjustment, and Replacement of Parts and Accessories

Repairs, adjustments, and replacement of parts and accessories necessary for the normal and effective functioning of a hospital bed are typically covered when the above criteria are met. Repairs, adjustments, and replacement of parts and accessories not meeting the above criteria may be considered medically necessary based on an assessment of the individual and his or her unique needs. An updated evaluation may be requested if it is determined that the individual's medical condition(s) or diagnosis(es) has changed since receiving the current hospital bed.

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 health care 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 hospital beds and accessories is required. Requests for coverage will be reviewed in accordance with procedures in place for reviewing requests for durable medical equipment. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

<u>The following information is needed to review requests for a bed and/or accessories:</u>

1. Fully completed authorization request via web portal;
2. A signed prescription from a licensed physician, APRN, or PA enrolled in the Connecticut Medical Assistance Program (CMAP) written within the past twelve (12) months;
3. Clinical documentation from the ordering physician, APRN, or PA that includes the following:
    a. Height and weight;
    b. Medical evaluation by the ordering physician, APRN, or PA, including a history and physical examination and/or subsequent progress notes that address the need for the requested bed and/or accessories within the last twelve (12) months of this request;
    c. Description of the medical condition and the clinical need for a hospital bed and/or accessories; and
4. A home evaluation with recommendations from a Connecticut licensed occupational therapist or physical therapist, performed within three (3) months prior to the submission of the prior authorization request, which meets the criteria in the above Clinical Guideline. The clinical documentation should include the following:
    a. Individual's medical condition and the clinical need for the specific bed and/or accessories;
    b. A comparative evaluation of various beds that explains the clinical need and rationale for the requested bed;
    c. Documentation demonstrating the caregiver(s) were provided education on the bed and/or accessories; and
5. For beds and accessories that are manually priced - a detailed product description including manufacturer, model/part number, product description, HCPCS code and unit(s). Actual

Acquisition Cost (AAC) and Manufacturer's Suggested Retail Pricing (MSRP), including documentation disclosing any and all discounts per *DSS Pricing Policy for Meds Items*.

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

LIMITATIONS
N/A

CODES:

Codes Reviewed Using Policy:

Code	Description
E0840*	Traction frame, attached to headboard, cervical traction
E0870*	Traction frame, attached to footboard, extremity traction (e.g. buck's)
E0890*	Traction frame, attached to footboard, pelvic traction
E0920*	Fracture frame, attached to bed, includes weights
E0946*	Fracture frame, dual with cross bars, attached to bed (e.g. balken 4 poster)
E0947*	Fracture frame, attachments for complex pelvic traction
E0948*	Fracture frame, attachments for complex cervical traction
E1399	Durable medical equipment, miscellaneous

*Prior authorization is required for this item only if the individual needs an amount or a rental period greater than what is allowed on the DSS DME Fee Schedule

Codes Reviewed Using InterQual Criteria:

Code	Description
E0250	Hospital bed, fixed height, with any type of side rails, with mattress
E0251	Hospital bed, fixed height with any type of side rails, without mattress
E0255	Hospital bed, variable height, with any type of side rails, with mattress
E0256	Hospital bed, variable height with any type of side rails, without mattress
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type of side rails, with mattress
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type of side rails, without mattress
E0265	Hospital bed, total-electric (head, foot, and height adjustment), with any type of side rails, with mattress
E0266	Hospital bed, total-electric (head, foot, and height adjustment), with any type of side rails, without mattress
E0271*	Mattress, innerspring
E0272*	Mattress, foam rubber
E2077	Powered pressure-reducing air mattress

E0280*	Bed cradle, any type
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height without side rails, without mattress
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
E0296	Hospital bed, total-electric (head, foot, and height adjustments), without side rails, with mattress
E0297	Hospital bed, total-electric (head, foot, and height adjustments), without side rails, without mattress
E0300	Pediatric crib, hospital grade, fully enclosed
E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
E0302	Hospital bed, heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
E0303	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type of side rails, with mattress
E0304	Hospital bed, heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type of side rails, with mattress
E0305*	Bed side rails, half length
E0310*	Bed side rails, full length
E0328	Pediatric hospital bed, manual, with 360 degree side enclosures
E0329	Pediatric hospital bed, electric, with 360 degree side enclosures
E0371	Nonpowered advanced pressure reducing overlay for standard mattress, length and width
E0372	Powered air overlay for standard mattress, length and width
E0373	Nonpowered advanced pressure reducing mattress
E0910*	Trapeze bars, attached to bed, with grab bar
E0911*	Trapeze bar, heavy duty, for patient with weight capacity greater than 250 pounds, attached to bed
E0912*	Trapeze bar, heavy duty, for patient with weight capacity greater than 250 pounds, freestanding
E0940*	Trapeze bar, free standing, complete with grab bar

***Prior authorization is required for this item only if the individual needs an amount or a rental period greater than what is allowed on the DSS DME Fee Schedule

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 & Medical Services. Local Coverage Determination (LCD)-Cervical Traction Devices. Last revised 01/01/2020. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33823&ver=26&keyword=Cervical%20Traction%20Devices&keywordType=starts&areaId=s46&docType=F,P&contractOption=all&sortBy=relevance&bc=1
- 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
- DSS Pricing Policy for Medical Equipment, Device, and Supplies (MEDS) Items. Available at: https://www.huskyhealthct.org/provider/policies_procedures.html
- U.S. Food and Drug Administration (FDA), Center for Devices and Radiological Health (CDRH). Medical Devices. Hospital beds. August 23, 2018. Available at: https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/default.htm.
- Williams Buckley A, Hirtz D, Oskoui M, Armstrong MJ, Batra A, et al. Practice guideline: Treatment for insomnia and disrupted sleep behavior in children and adolescents with autism spectrum disorder: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology. 2020 Mar 3;94(9):392-404. doi:10.1212/WNL.0000000000009033

PUBLICATION HISTORY

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Original Publication	January 2024	Approved at the January 10, 2024 Medical Reviewer meeting. Approved at the CHNCT Clinical Quality Subcommittee on March 18, 2024. Approved by DSS on March 28, 2024.
Updated	February 2025	Introduction updated to define accessories. Prior authorization requirements were added. Clinical Guideline updated to clarify when policy criteria will be used. Accessories without IQ criteria added. Non-covered section simplified. Procedure section updated to specify prescription from ordering provider needs to be signed. Changes approved at the February 12, 2025 CHNCT Medical Reviewer meeting. Approved at the March 17, 2025 CHNCT Clinical Quality Subcommittee meeting. Approved by DSS on April 3, 2025.