5101:3-10-18 **Hospital beds ~~and~~, pressure-reducing support surfaces and accessories.**

(A) Hospital beds.

~~Generally~~Unless otherwise stated, coverage of hospital beds will be limited to ~~patients~~ consumers who meet the following criteria.

(1) Variable height hospital bed.

A "variable height" hospital bed is one with manual height, head and leg elevation adjustments. A request for prior authorization must include accompanying documentation signed by the ~~prescribing physician~~ prescriber which specifies the medical condition, severity and frequency of symptoms and the estimated duration of need and documents that:

(a) The ~~patient's~~ consumer's diagnosis/condition (including but not limited to the weight of the ~~patient~~consumer) warrants the consistent need for a variable height hospital bed in ways not feasible with an ordinary bed in order to provide elevation in excess of thirty degrees to the consumer due to congestive heart failure, chronic pulmonary disease, or documented problems with aspiration. Pillows or wedges must have been considered and ruled out as elevation of the head or upper body at less than thirty degrees does not require the use of a hospital bed ~~(e.g., a variable height hospital bed is required to position the body in ways not feasible with an ordinary bed)~~, or

(b) The ~~patient~~ consumer requires traction equipment which can only be attached to a hospital bed, or

(c) The bed is required to assist the ~~patient~~consumer with mobility and/or transfers (e.g., to a chair, wheelchair or standing position), or

(d) The bed is required to facilitate frequent interventions by a care giver in order to alleviate pain and prevent bed sores (e.g., turning the ~~patient~~ consumer every two hours).

(2) Semi-electric bed.

A "semi-electric" bed is one with manual height adjustment and with electric head and leg elevation adjustments. A semi-electric hospital bed may be approved with supporting documentation when the ~~patient~~consumer meets the general requirements in paragraph (A)(1) of this rule and requires frequent changes in body position and has an immediate need for a change in body

positon ~~there is documentation that the specific medical needs of the patient cannot be met in any other way~~.

(3) Total electric bed.

A "total electric" bed is one with electric height, head and leg elevation adjustments. Total electric beds and other institutional type beds are not ~~ordinarily~~ covered by the medicaid program.

(4) A heavy duty extra wide hospital bed is covered if the consumer meets the general requirements in paragraph (A)(1) of this rule and the consumer's weight is more than three hundred fifty pounds, but does not exceed six hundred pounds.

(5) An extra heavy duty hospital bed is covered if the consumer meets the general requirements in paragraph (A)(1) of this rule and the consumer's weight exceeds six hundred pounds.

(B) Bed accessories.

(1) Trapeze equipment is covered if the consumer needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

(2) Heavy duty trapeze equipment is covered if the consumer meets the criteria in paragraph (B)(1) of this rule and the consumer's weight is more than two hundred fifty pounds.

(3) Side rails are covered when they are required by the consumer's condition and they are an integral part of, or an accessory to, a covered hospital bed.

(4) A replacement innerspring mattress or foam rubber mattress is covered for a consumer-owned hospital bed if a consumer's condition requires it.

(C) Hospital beds, accessories or support surfaces are not separately reimbursed for consumers in LTCFs (long term care facilities) as this equipment is reimbursed to the specific facility through the facility's cost report.

(D) Any prescription for hospital beds, accessories or support surfaces must be prescribed by a prescriber actively involved in managing the consumer's medical condition as defined in paragraph (A) (2) of rule 5101-3-10-05 of the Administrative Code and should be treating the consumer under a comprehensive plan of care which addresses the underlying medical need for any equipment referenced in this rule.

~~(B)~~(E) Pressure-reducing support surfaces.

Coverage of pressure-reducing support surfaces is ~~generally~~ limited to those group 1, group 2, and group 3 codes specified on the medicaid supply list found in appendix A ~~of~~ to rule 5101:3-10-03 of the Administrative Code. A support surface must have a group 1, group 2 or group 3 healthcare common procedure coding system (HCPCS) ~~HCPCS~~ code as defined in rule 5101:3-1-19.3 of the Administrative Code ~~assigned by the medicare statistical analysis durable medical equipment regional carrier (SADMERC)~~ in order to be considered for coverage. Prior authorization is required for all group 2 and group 3 surfaces. ~~Refer to the medicaid supply list found in appendix A of rule 5101:3-10-03 of the Administrative Code, for prior authorization requirements for group 1 surfaces.~~

(1) Group 1.

(a) Definition.

"Group 1" pressure reducing support surfaces are typically defined as non-powered pressure reducing mattress overlays. These devices are designed to be placed on top of an ordinary hospital bed or home mattress. Group-1 pressure reducing support surfaces may be, but are not limited to, gel or gel-like overlays, air pressure or dry pressure, synthetic sheepskin, or lambswool sheepskin overlays. Group 1 may also include some powered pressure reducing mattress overlay systems (alternating pressure or low air loss), which are not included in group 2 pressure reducing support surfaces.

(b) Coverage criteria.

A group 1 mattress overlay or mattress is covered if ~~the patient has~~ any of the following apply:~~limited mobility, i.e., patient cannot independently make changes in body position significant enough to alleviate pressure. For those group 1 surfaces that do not require prior authorization, the provider must maintain on file the physician prescription documenting the patient's mobility limitations. If prior authorization is required, the physician prescription documenting the patient's mobility limitations must be submitted with the prior authorization form (JFS 03142).~~

(i) Consumer is completely immobile, i.e., cannot make changes in body position without assistance, or

(ii) Consumer has limited mobility, i.e., cannot independently make changes in body position significant enough to alleviate pressure, or

(iii) Consumer has any stage pressure ulcer on the trunk or pelvis, or

(iv) The consumer has compromised circulatory status.

Any support surface or bed provided by the department will be one in which the consumer does not "bottom out." Bottoming out is the finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the consumer's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion will be tested by the provider with the consumer in the supine position with their head flat, in the supine position and their head slightly elevated (no more than thirty degrees), and in the side-lying position.

(2) Group 2.

(a) Definition.

"Group 2" pressure reducing support surfaces are typically defined as: a powered air floatation bed (low air loss therapy); a powered pressure-reducing air mattress; a nonpowered advanced pressure reducing overlay for a mattress of standard length and width; a powered air overlay for a mattress of standard length and width; or a nonpowered advanced pressure reducing mattress. ~~A "low air loss bed" is defined as a hospital bed with a fully integrated power pressure reducing mattress which has all of the following characteristics:~~

A "low air loss bed" is defined as a hospital bed with a fully integrated power pressure reducing mattress which has all of the following characteristics:

(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;

(ii) Air cells with an inflated ~~Inflated~~ cell height ~~of the air cells~~ through which the air being circulated of ~~is~~ five inches or greater;

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out;

(iv) A surface designed to reduce friction and shear; and,

(v) Can be placed directly on a hospital bed frame or ordinary bed frame.

(b) Coverage criteria.

Generally, a group 2 support surface (i.e., an air-floatation bed) for use by an eligible ~~recipient~~consumer in a private residence ~~or a long-term care facility (LTCF)~~ may be prior-authorized when the ~~patient~~consumer has:

(i) Pressure sore(s) in stage III or stage IV of tissue breakdown, as defined in appendix A ~~of~~ to this rule, located on the trunk, or

(ii) Burns of third degree with or without graft sites, or

(iii) Multiple wounds at stage II, or

(iv) Had a recent surgical procedure (within sixty days prior to the date of the authorization request) of wound closure involving skin grafts and/or skin flaps. (Note: for the first thirty days following a skin graft and/or a skin flap procedure, an original copy of a ~~physician's~~provider's prescription shall be considered sufficient documentation for medical necessity. Subsequent approvals must meet the requirements of this rule.)

(3) Group 3.

(a) Definition.

"Group 3" pressure reducing support surfaces are typically defined as air-fluidized beds. An "air-fluidized bed" is a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid. It is utilized for the treatment of a patient who has stage III or stage IV pressure sores.

(b) Coverage criteria.

A group 3 support surface (i.e., an air-fluidized bed) may be prior authorized when the patient has a stage III wound or a stage IV wound.

The department's prior authorization unit will review the request and determine if an alternative support surface, such as a group 2 support surface, may be more appropriate.

~~(C)~~(F) Pressure reducing support surfaces and hospital beds - medical necessity documentation requirements.

The following current (within the last thirty days), signed and dated documentation must be submitted to the department with ~~the~~a fully completed ~~prior authorization~~medical necessity form: ~~(JFS 03142) for all group 2 and group 3 support surfaces, except for surfaces prescribed for the first thirty days after skin graft/skin flap surgery, as per paragraph (B)(2)(b)(iv) of this rule. Each piece of documentation must be labeled with the resident's name.~~

(1) JFS 02904 (4/2009),"Certificate of Medical Necessity/Prescription Decubitus Care Equipment (Pressure Reducing Support Surfaces)" (CMN) appendix B to this rule for all group 2 and group 3 support surfaces except for support surfaces prescribed for the first thirty days after skin graft/skin flap surgery, as per paragraph (E)(2)(b)(iv) of this rule; or

(2) JFS 02190 (4/2009),"Certificate of Medical Necessity/Prescription Hospital beds" (CMN) appendix C to this rule for all hospital beds.

Each additional piece of documentation submitted to the department as an attachment to the CMN must be labeled clearly and legibly with the consumer's name and medicaid identification number.

~~(1)~~(3) A current ~~physician's~~prescriber's prescription or order for the support surface or hospital bed; and~~.~~

~~(2)~~(4) A current ~~physician's~~prescriber's prescription or order for treatment of wounds for a support surface; and~~.~~

~~(3)~~(5) The ~~patient's~~consumer's current diagnosis for a support surface or hospital bed; and~~.~~

~~(4)~~(6) The ~~patient's~~consumer's weight history for at least sixty days prior and up to the request for a support surface; and~~.~~

~~(5)~~(7) The ~~patient's~~consumer's current comprehensive nutritional assessment by a licensed/registered dietitian for a support surface; and~~.~~

~~(6)~~(8) Laboratory reports of blood tests, performed within twenty one days prior to

submission of the authorization request for a support surface, showing, at a minimum:

(a) Serum protein,

(b) Serum albumin/prealbumin,

(c) Hemoglobin, and

(d) Hematocrit.

~~(7)~~(9) ~~The patient's~~A detailed current wound description of the consumer's with a comprehensive ~~current wound descriptions and~~ history describing wound appearance, length, width, depth, and location, prepared by a licensed ~~nurse~~health practitioner, and describing wound stage as defined in appendix A ~~of~~ to this rule if applicable for a support surface.

~~(8) Photograph(s) taken of the patient's wound(s), within twenty-one days prior to the submission of the authorization request. Each photograph should be labeled as follows:~~

~~(a) Patient's name;~~

~~(b) Date the photograph was taken; and,~~

~~(c) Wound location(s).~~

~~(9) A statement from the LTCF which specifies the end date of the patient's medicare part A benefits must be submitted for patients who are eligible for medicare.~~

~~(D)~~(G) When the medical necessity for the pressure-reducing support surface or hospital bed has been established, the ~~patient's~~consumer's overall health status and any complicating conditions will be considered when authorizing the most appropriate and cost-effective support surface (air-fluidized or low air loss) or hospital bed.

~~(E)~~(H) For those support surfaces requiring prior authorization, the initial and any subsequent periods of coverage will be authorized at the discretion of the department.

(I) Hospital beds, accessories or support surfaces are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge, whichever is

less.

Effective:

R.C. 119.032 review dates: 01/13/2009

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Certification

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Date

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