Clear Form

Minnesota Department of **Human Services**

DHS-4370-ENG 8-11

Minnesota Health Care Programs (MHCP)

Enclosed Medical Bed Authorization Form

ASSIGNED NUMBER FROM MN–ITS

Use this form in addition to the MN–ITS Authorization Request transaction or the Authorization Form (DHS-4695) to request authorization for an enclosed medical bed. Fax this form with any additional or required documentation to the medical review agent.

If more space is needed, continue answer on separate sheet and indicate question you are answering.

Enclosed Medical Bed Criteria

MHCP will consider medical necessity of an enclosed medical bed only in the most extreme condition, due in part to:

- Restrictive nature of the enclosed bed
- The confinement the bed entails
- The high cost of the enclosed bed

A confining enclosed bed is **not** for dealing with seizures or behaviors such as head banging, rocking, balance problems, etc.

Consider issues of sensory deprivation and the potential for over-use.

- Recipient must be mobile
- Recipient must be cognitively impaired
- Recipient sustains injuries due to unrestricted, unsupervised mobility (include documentation)

Provider Information

PROVIDER NAME	NPI/UMPI
CONTACT NAME	PHONE NUMBER ( )

Recipient Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MHCP ID NUMBER

DIAGNOSIS CODE	DESCRIPTION

RECIPIENT MUST HAVE ONE OF THE FOLLOWING (check all that apply)

☐ TBI ☐ CP ☐ Seizure disorder ☐ DD (cognitive impairment) ☐ Severe behavioral disorder

HEIGHT	WEIGHT	OTHER RELEVANT INFORMATION ABOUT SIZE/STATURE

DESCRIBE RECIPIENT'S COGNITIVE AND COMMUNICATION IMPAIRMENT

LIVING ARRANGEMENT

☐ Home alone ☐ Home w/caregiver (who is caregiver _____)

☐ Nursing home ☐ Group home ☐ Assisted Living ☐ ICF/DD

ADL ASSISTANCE

☐ Totally dependant ☐ Partially dependant ☐ Independent

DESCRIBE ANY NEEDED ASSISTANCE

Recipient has PCA services. ☐ Yes ☐ No Number of hours/days: _____

Recipient is in school or day care. ☐ Yes ☐ No Number of hours/days: _____

Recipient receives skilled nursing care. ☐ Yes ☐ No Number of hours/days: _____

RECIPIENT CAN WALK ☐ Yes ☐ No	IF NO, EXPLAIN

Documentation of medical necessity for the following must be included.

RECIPIENT HAS SEIZURES ☐ Yes ☐ No	IF YES, TYPE	FREQUENCY OF SEIZURES
RECIPIENT TAKES SEIZURE MEDICATION ☐ Yes ☐ No	LIST	
SEIZURES COMPROMISE RESPIRATORY STATUS ☐ Yes ☐ No	IF YES, DESCRIBE	
POTENTIAL EXISTS FOR INJURY WITH SEIZURE ☐ Yes ☐ No	IF YES, DESCRIBE	

UNCONTROLLED PERPETUAL MOVEMENT RELATED TO DIAGNOSIS

Recipient requires special positioning not feasible with a standard bed ☐ Yes ☐ No

Recipient requires frequent and/or rapid positioning changes ☐ Yes ☐ No

IF YES, RELATED TO

☐ Respiratory ☐ Cardiac ☐ GI ☐ Orthopedic ☐ Swallowing problems

EXPLAIN

RECIPIENT HAS ABNORMAL MUSCLE TONE ☐ Yes ☐ No	IF YES, DESCRIBE

RECIPIENT HAS PROPER COORDINATION AND PROTECTIVE RESPONSES ☐ Yes ☐ No	RECIPIENT CAN SIT INDEPENDENTLY ☐ Yes ☐ No	RECIPIENT CAN PULL TO KNEES ☐ Yes ☐ No

RECIPIENT CAN PULL TO A STAND ☐ Yes ☐ No	RECIPIENT CAN SAFELY RESUME TO A SITTING POSITION ONCE STANDING ☐ Yes ☐ No	RECIPIENT IS ATOXIC OR LOSES BALANCE EASILY ☐ Yes ☐ No

EVIDENCE OF NEED DUE TO A PROVEN SAFETY RISK; HISTORY OF INJURIES THAT HAVE OCCURRED UPON THIS REQUEST

DOCUMENTED EVIDENCE OF MOBILITY (CLIMBING OUT OF BED, NOT JUST STANDING AT THE SIDE OF THE BED). MUST INCLUDE MOBILITY THAT WILL PUT THEM AT RISK FOR SERIOUS INJURY, NOT JUST A POSSIBILITY OF INJURY

RECIPIENT ATTEMPTS TO WANDER AT NIGHT ☐ Yes ☐ No	POTENTIAL PROBLEMS EXIST BECAUSE OF WANDERING ☐ Yes ☐ No	EXPLAIN
RECIPIENT RECOGNIZES DANGER ☐ Yes ☐ No	RECIPIENT HAS BEEN FOUND IN DANGEROUS SITUATIONS ☐ Yes ☐ No	EXPLAIN
RECIPIENT HAS SUSTAINED INJURIES WHILE WANDERING ☐ Yes ☐ No	LIST INJURIES	
RECIPIENT IS SELF ABUSIVE ☐ Yes ☐ No	IF YES, EXPLAIN AND DESCRIBE THE INJURIES SUSTAINED	
MEDICATIONS HAVE BEEN TRIED TO REDUCE THIS BEHAVIOR ☐ Yes ☐ No	IF YES, LIST	
BEHAVIOR MODIFICATIONS HAVE BEEN TRIED ☐ Yes ☐ No	IF YES, DESCRIBE	
RECIPIENT EXHIBITS PICA BEHAVIOR (eat/chew/swallow inedible objects ☐ Yes ☐ No	IF YES, DESCRIBE	
RECIPIENT TOLERATES CONFINED AREAS ☐ Yes ☐ No	EXPLAIN	
RECIPIENT HAS SLEEP DISTURBANCES ☐ Yes ☐ No	IF YES, AVERAGE AMOUNT OF SLEEP PER NIGHT	LIST MEDICATIONS TRIED TO INDUCE SLEEP
SLEEP DEPRIVATION AFFECTS THE RECIPIENT'S HEALTH AND BEHAVIOR ☐ Yes ☐ No	LIST BEHAVIOR MODIFICATIONS TRIED	

Bed Requested	MAKE	MODEL

RECIPIENT IS IN A ☐ Hospital ☐ Nursing Facility ☐ Board and Care	DESCRIBE SPECIFIC DISCHARGE PLAN OR UNUSUAL MEDICAL NEED

RECIPIENT USED THIS OR SIMILAR EQUIPMENT ☐ Yes ☐ No	IF YES, DESCRIBE LENGTH OF TIME, RECIPIENT RESPONSE, ENVIRONMENT OF TRIAL
RECIPIENT CURRENTLY SLEEPING ON	EXPLAIN REASON NO LONGER APPROPRIATE

Other types of beds exist that have bumper pads, removable tops, adult sized cribs, etc. Many recipients have been hospitalized and used an enclosed bed system, but have not tried any other options.

Type	**Outcome**
BED WITH SIDE RAILS ☐ Yes ☐ No	
HOSPITAL CRIB ☐ Yes ☐ No	
BUMPER PADS ☐ Yes ☐ No	
OTHER TYPE OF RESTRAINTS ☐ Yes ☐ No	

Type	Outcome
MATTRESS ON FLOOR/INSIDE SMALL PORTABLE TENT ☐ Yes ☐ No	
PADDING AROUND REGULAR OR HOSPITAL BED ☐ Yes ☐ No	
CRIB WITH PADDING ☐ Yes ☐ No	
MEDICATIONS TO PREVENT SEIZURES OR CORRECT BEHAVIOR ☐ Yes ☐ No	
HELMET FOR HEAD BANGING ☐ Yes ☐ No	
REMOVAL OF ALL SAFETY HAZARDS FROM RECIPIENT'S ROOM, USING CHILD PROTECTION DEVICE ON DOOR KNOB OR GATES ACROSS DOORWAYS ☐ Yes ☐ No	
BABY MONITORS TO LISTEN TO RECIPIENT ACTIVITY ☐ Yes ☐ No	

LIST OTHER, LESS COSTLY ALTERNATIVES AND WHY THEY DID NOT MEET RECIPIENT'S MEDICAL NEEDS
ADDITIONAL ENVIRONMENTAL FACTORS TO CONSIDER
NUMBER OF HOURS BED WILL BE USED DURING A 24-HOUR PERIOD
EXPLAIN HOW THIS IS DIFFERENT THAN WHAT OTHER PARENTS NORMALLY DEAL WITH WHEN THEIR CHILDREN (OF SIMILAR AGE) CLIMB OUT OF BED AND WANDER
VERIFY THAT THE PRIMARY CAREGIVER IS WILLING AND ABLE TO CLEAN THE MESH CANOPY PER THE MANUFACTURER'S RECOMMENDATIONS
APPROXIMATE LENGTH OF TIME NEEDED ☐ Purchase ☐ Rental

SIGNATURE OF EQUIPMENT SPECIALIST	DATE
SIGNATURE OF PT/OT/OTHER PROFESSIONAL INVOLVED IN EVALUATION/CREDENTIALS	DATE
SIGNATURE OF PHYSICIAN VERIFYING INFORMATION	DATE