



PRIOR AUTHORIZATION CRITERIA GUIDELINE	
Criteria Guideline Name: DDD - Enclosed/Restraint Beds	PA Number: PAGL DD1018 DDD P&P 1018
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**PURPOSE:**

To provide criteria for the evaluation and authorization for enclosed/restraint beds.

**POLICY:**

The request for enclosed/restraint beds must be made by the PCP (Primary Care Provider), or other provider with PCP referral, citing clear medical risks and safety issues for the member requesting the equipment.

**PROCEDURE:**

The following information must be documented and considered for request:

- A. Documentation from PCP or other provider must include specific medical conditions and safety concerns which meet the following criteria for medical necessity:
  - a. Uncontrolled seizure disorder or
  - b. Bleeding Dyscrasia, or
  - c. Spasticity secondary to Cerebral Palsy that has resulted in injury from a fall or hospitalization or
  - d. Other medical diagnosis requiring enclosed/restraint environment.
  
- B. And the goal is to:
  - a. Prevent injury from fall, or
  - b. Prevent dislodgement of tubes, catheters, etc.,
  - c. Prevent injuries from uncontrolled movement
  - d. Prevent or in lieu of hospitalization
  
- C. And all other alternatives considered were determined inappropriate or tried unsuccessfully (for example, a mattress on the floor or other bed systems) and appropriate care cannot be provided cost-effectively utilizing other resources.



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D. Not covered for:

- a. Caregiver convenience
- b. Punitive confinement
- c. Safety only – including risks of wandering away from home
- d. As a replacement for appropriate adult supervision
- e. As a restraint only

E. All requests for enclosed/restraint beds shall require approval by the Division's Medical Director.



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Reviewed by: QM/UM Committee Date: 9/17/2009

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