

## Therapy Evaluation for Bed Transfer / Positioning Devices (Typically Bed or Side Rails)

**Note:** A Physical Therapist or Occupational Therapist must complete this form to determine a recommendation for bed rails or side rails and does not guarantee payment for the device. Return the completed form to the client's primary healthcare provider and the client's caseworker. Do not alter this form in any way.

| <b>Section 1. Client Information (to be completed by Caseworker)</b>  |  |  |
|---|--|--|
| CLIENT'S NAME   |  |  |
| CLIENT'S TELEPHONE NUMBER (WITH AREA CODE)  | CLIENT ID (PROVIDER ONE NUMBER)                                    | DATE OF REQUEST                          |
| CASEWORKER'S NAME   | CASEWORKER'S TELEPHONE NUMBER (WITH AREA CODE)                     | CASEWORKER'S FAX NUMBER (WITH AREA CODE) |
| CASE WORKER'S EMAIL   |  |  |
| What is the diagnosis / medical condition for which the use of bed rails or side rails is being considered? (Do not use ICD10 codes for the diagnosis.)   |  |  |
| Indicate if client resides in one of the following (or plans to admit in the near future):<br><input type="checkbox"/> Adult Family Home <input type="checkbox"/> Assisted Living Facility (including ARC / EARC)<br>If client is, or will be in an in-home setting, how many hours a day is a caregiver available (average): |  |  |
| CLIENT'S PRIMARY HEALTHCARE PROVIDER'S NAME   |  |  |
| CLIENT'S PRIMARY HEALTHCARE PROVIDER'S TELEPHONE NUMBER (WITH AREA CODE)  | CLIENT'S PRIMARY HEALTHCARE PROVIDER'S FAX NUMBER (WITH AREA CODE) |  |
| <b>Section 2. Evaluation (to be completed by OT or PT)</b>  |  |  |
| What is the specific medical or functional need for the bed rails or side rails requested, including all related accessories and modifications?   |  |  |
| What other alternatives to bed rails or side rails have been tried? What were the results of the trials?  |  |  |
| If no alternatives have been tried, please explain.   |  |  |
| Does the client already own similar equipment? If yes, why does it not meet their current medical or functional needs? Please include if this evaluation is due to a change in the client's condition or setting.   |  |  |

|  |                                 |   |
|--|---------------------------------|---|
| CLIENT NAME  | CLIENT ID (PROVIDER ONE NUMBER) | DATE OF REQUEST                         |
| <p>Would the transfer / positioning device be used with a hospital bed or standard bed? <input type="checkbox"/> Hospital <input type="checkbox"/> Standard</p> <p>What is the client's ability to raise and lower rails? <input type="checkbox"/> Independent <input type="checkbox"/> Requires assistance</p> <p>What is the client's cognitive ability? <input type="checkbox"/> Consistently makes needs known <input type="checkbox"/> Not able to make needs known<br/> <input type="checkbox"/> Cognitively intact <input type="checkbox"/> Cognitively impaired</p> <p>Does client have a history of falls from bed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What is the client's transfer ability? <input type="checkbox"/> Full assist <input type="checkbox"/> Moderate assist <input type="checkbox"/> No assist</p>   |                                 |   |
| ADDITIONAL COMMENTS  |                                 |   |
| <b>Section 3. Recommendation</b>   |                                 |   |
| <p>1. Are rails recommended to assist with transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are rails recommended to assist with bed positioning? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is the purchase of bed rails or side rails recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>a. If "Yes," type of rails recommended:<br/> <input type="checkbox"/> Half rails <input type="checkbox"/> Full rails<br/> <input type="checkbox"/> Other, including quarter-length or eighth-length bed rails, aka bed canes, stander bars, etc.;</p> <p style="padding-left: 40px;">Please describe "Other" recommendation in detail:</p> <p>b. If "No," do you recommend an alternative device or equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If "Yes," what do you recommend?</p> |                                 |   |
| <b>Section 4. Signature</b>  |                                 |   |
| THERAPIST'S SIGNATURE  | DATE                            | PRINTED NAME                            |
| THERAPIST'S TELEPHONE NUMBER (WITH AREA CODE)  |                                 | THERAPIST'S FAX NUMBER (WITH AREA CODE) |

## Bed Transfer / Positioning Device Instructions and Work Flow

1. After the expedited prior authorization for the bed transfer / positioning device evaluation is approved by the client's Apple Health (AH) medical plan, the therapist contacts the client's caseworker.
  - a. See the [AH Outpatient Rehabilitation billing guide](#) for information for fee-for-service AH.
  - b. Follow established authorization and billing protocols for AH managed care plans.
  - c. If client is in-patient at an acute care setting or a resident of a skilled nursing facility, an in-house OT / PT can complete this form prior to discharge to a community setting.
2. The Department of Social and Health Services / Area Agency on Aging (AAA) case worker initiates the request for a bed transfer / positioning device therapy evaluation by completing Section 1 of this form with client demographics, date of request, case worker name and contact information, average caregiving hours/day, and primary healthcare provider information (if known).
3. The Bed Transfer / Positioning Device evaluation form is sent to the therapist for completion.
4. The therapist completes the evaluation using generally accepted standards of practice which will typically be an in-person evaluation, and uses this form to document their determination whether a device is recommended and if so, what style of device and their use. The therapist should document alternative devices recommended, if applicable.
5. The therapist returns the completed form to the caseworker and sends a copy to the client's primary healthcare provider, regardless of recommendation outcome. The caseworker should provide a copy to the client's residential provider, when applicable.