BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH

In the Matter of	)	
	)	
DAVID D. **	)	OAH No. 24-0129-MDX
	)	Agency No. 24-HCS-0073

DECISION

I. Introduction

David D. is a minor who receives Medicaid benefits from the State of Alaska. Beth D. and Kyle D., David's guardians, requested that the Medicaid program authorize payment for an enclosed bed. The Division of Health Care Services (Division) denied that request. David's guardians requested a hearing to challenge that denial.

David's hearing was held on April 8, 2024 and May 2, 2024. Ms. D. represented David in the hearing and testified on his behalf. Laura Baldwin, a Fair Hearing Representative for the Division, represented the Division. Karen Benson, a Medicaid Program Specialist 4, who oversees the Medicaid Durable Medical Equipment program, testified for the Division.

David had the burden of proof to establish that the enclosed bed was medically necessary. The evidence in this case shows that the Cubby Bed is medically necessary in David's case. Consequently, the Division's denial of David's request for a Cubby Bed is reversed.

II. Facts

David is an energetic four-year-old with multiple diagnoses: autism spectrum disorder, attention deficit hyperactivity disorder, Wiedemann-Steiner syndrome, insomnia, global developmental delay, incontinence, and anxiety.[1]

David underwent a sleep study where he was diagnosed with insomnia.[2] To treat the insomnia, he was proscribed melatonin and gabapentin.[3] With medication and modifications to sleep hygiene routines, David is able to get an average of 6-7 hours of sleep a night.[4] While that

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1 Ex. E, pp. 4-7.
2 David's Ex. C.
3 David's Ex. C.
4 David's Ex. A, *See also* Testimony of Ms. D.

[**OAH publication note: pseudonyms have been used for publication.]

amount is sufficient for some adults, it is below the recommended 10-13 hours of sleep for his age group.[5] David's dosage of gabapentin cannot be increased.[6]

David exhibits multiple concerning night behaviors. These include a fixation with repeatedly slamming doors that has led to an injury to his pinky figure which required medical treatment;[7] head-banging significant enough to leave bumps described as "goose-eggs";[8] hyperactive nighttime movements during which he seeks a hard object to bounce himself off of;[9] and a history of eloping.[10] David has also managed to circumvent gates and unlock doors.[11] David's history of elopement includes an incident when he managed to acquire the keys to the family van, exit the home, and places the keys in the ignition.[12] In another incident David simply walked out of the home and was returned by a neighbor who is a police officer.[13] As David's room is on the second floor, nighttime elopement places him at significant risk of falling down the stairs.[14] In addition to insomnia and nighttime waking, David's conditions make him very sensitive to stimuli like lighting and noise.[15]

David's parents attempted numerous behavior modifications, sleeping training, and assistive devices.[16] David has been receiving therapy since he was eight months old.[17] That therapy has always included a goal of improving his sleep hygiene. As a part of that therapy David has been receiving applied behavior analysis (ABA) therapy from Amy Lacher-Thompson, a board-certified behavioral analyst, for two years.[18] That therapy was focused on addressing elopement, increasing safety skills, and reducing aggressive behaviors.[19] Despite two years of therapy, David still exhibits nighttime elopement, self-injurious behavior, and aggressive behaviors.

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5 David's Ex. A.
6 Testimony of Ms. D.
7 David's Ex. G
8 Testimony of Ms. D.
9 David's Ex. A.
10 Testimony of Ms. D.
11 Ex. E, p. 5.
12 Testimony of Ms. D.
13 David's Ex. G.
14 Ex. E, p. 5. *See also* Testimony of Ms. D.
15 Ex. E. *See also* Letter from Nathan Busbee. *See also* Testimony of Ms. D.
16 David's Ex. A.
17 Testimony of Ms. D.
18 Letter from Amy Lacher-Thompson BCBA
19 Letter from Amy Lacher-Thompson BCBA

David has also worked with Nathan Busbee, a licensed occupational therapist.[20] For more than 6 months David engaged in aquatic therapy aimed at reducing his tactile and auditory sensitivities and improving self-regulation.[21] Despite progress on some of David's therapy goals, he still experiences issues with his sensory sensitivity. These issues remain significant enough that David cannot tolerate a helmet or headphones.[22]

In addition to therapy and medication, David's parents have tried numerous other products. David cannot utilize a standard hospital bed as he is physically capable of climbing barriers which increases his fall risk, injury risk, and entrapment risk.[23] In November of 2021 a bed tent, as recommended by David's occupational therapists, was purchased to create an enclosed safe sleep area.[24] David's bed was placed directly on the floor inside of this tent.[25] In January 2022, after a sleep training to encourage David to use this bed, a carabineer was added to the outside of the primary access door of the tent to allow David to be enclosed in the tent at night.[26] This method was effective for five months until David started tearing at the bed tent at night to get out.[27] Despite repair attempts, since July of 2022 David has destroyed two bed tents by tearing through the tent to create his own exits and thrashing against the sides of the bed tent with enough force to bend the tent poles beyond repair.[28] Additionally, while placing the mattress on the floor prevented falls, it did not prevent David from banging his head or body against hard surfaces in the tent or in the room.[29]

David's parents have also tried a variety of locks and alarms. While alarms are sometimes disengaged by the other children in the home, the evidence presented shows that David has learned how to circumvent door locks on his own.[30] Additionally, while his parents have tried a mattress alarm, they stopped using a mattress alarm after consultation with David's medical team.[31] The mattress alarm was not effective at improving David's sleep hygiene and

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20 Letter from Nathan Busbee.
21 Letter from Nathan Busbee.
22 Letter from Nathan Busbee.
23 Ex. E, p. 7
24 Testimony of Ms. D.
25 David's Ex. A.
26 David's Ex. A.
27 Testimony of Ms. D.
28 David's Ex. A.
29 Testimony of Ms. D.
30 Testimony of Ms. D.
31 Testimony of Ms. D.

as he is sensitive to auditory stimuli, the alarm was counterproductive.[32] Free standing sound machines, aroma therapy devices, and dim lights have been tried as ways of regulating David's sensory inputs.[33] David's parents have also tried baby monitors and video monitors to monitor David's bedroom. Unfortunately, David has been able to manipulate and tamper with these devices.[34] Additionally, as David has a habit of chewing through cords, standalone devices that plug in present their own safety risk.[35]

After testing the above discussed methods, David's parents requested that Medicaid pay for a Cubby Bed for David on December 10, 2023.[36] The Cubby Bed is a completely enclosed low mattress on lockable wheels.[37] The canopy completely encloses the mattress and has zippers that prevents the occupant from leaving the bed. [38] It also has padding which protects an occupant from injuring themselves inside the enclosure, and enclosure panels that limit the amount of sensory input an occupant receives.[39]

The authorization request included a "Physical Therapy Mobility Assistive Equipment Letter of Medical Necessity" from Providence Alaska Children's Hospital.[40] That Letter of Medical Necessity was signed by Jeff Brand MD.[41] The request also contained a letter signed by both Dr. Brand and by Hyun-Mi Abrahams Kaiser, PT, DPT, ATP which reads in pertinent part:

> [David] has developmental and cognitive delay with behavioral impairments due to his autism. He is unsafe and very active at night and requires 24/7 supervision at this time. He requires an enclosed bed to improve his safety and limit stimulation that he is receiving that increases his agitation. This recommended enclosed bed has the ability to limit his movements during the night and also maintain his safety. It has zippered enclosures that have safety measures preventing his ability to escape and move about the house at night. It has padding [that prevents] his ability to be entrapped or to suffocate. This padding is also necessary given [David's] self harming behaviors which include him banging his head against walls and hard surfaces. The enclosure panels limit noise, night, and visual stimulus which decreases the amount of sensory input he gets which helps calm him. His family has tried other options that are of lesser cost but this has not provided any benefit and [he] continues to elope at night, through doors, windows, and

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32 Testimony of Ms. D.
33 Ex. E, p. 5.
34 Ex. E, p. 5.
35 Testimony of Ms. D.
36 Ex. E, p. 1.
37 Ex. E, p. 7.
38 Ex. E, p. 7.
39 David's Ex. J.
40 Ex. E, p
41 Ex. E, p. 8.

> giving access to other objects that pose a safety risk to him...Standard beds with rails have risk of entrapment. This bed has safety sheets that zipper into place preventing entrapment/injury. The tension canopy of this enclosed bed has the ability to resist his strength and high speed variable movements.

The Letter of Medical Necessity further provides that:

> Based on the evaluation today, the recommendation is for [David] to have a Cubby Bed that provide him with a safe enclosed space that will also decrease stimulation and contain him to prevent any injury to himself or others. This will decrease the burden of care on family during the night and improve the sleep hygiene for both [David] and his family.[42]

The Letter of Medical Necessity concludes with a "Recommendation" that states that David needs the Cubby Bed "to keep him from eloping during the night."[43]

As part of her exhibits Ms. D. provided a 2022 study titled, "Sleep disturbances correlate with behavioral problems among individuals with Wiedemann-Steiner syndrome."[44] Wiedemann-Steiner syndrome (WSS) is a rare genetic disorder, and this study was limited to a small sample size. While the sample size was small, over 80% of the sample exceed a clinical cut-off for risk of sleep disturbance. Overall, the study found "extremely high rates of sleep programs that are largely behavioral in nature" in individuals with WSS.[45] The study also found that dysfunctional sleep behaviors, including nighttime waking and hyperactivity, are part of the "neurobehavioral phenotype" of Wiedemann-Steiner syndrome. Of those respondents who reported night waking 40.9% reported that night waking lasted over an hour. Unlike many of the subjects in the study, David has had the benefit of therapy.[46]

Ms. D. also submitted letters of support from: David's behavioral analyst, Ms. Lacher-Thompson; David's Occupational therapist, Nathan Busbee; and David's Pediatric Developmental Neurologist, Dr. Cathleen Marshall. As other attempts to modify David's behaviors were unsuccessful, Ms. Lacher-Thompson recommends a safety bed.[47] Ms. Lacher-

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42 Ex. E, p. 7.
43 Ex. E, p. 6.
44 Collins Ex. D, pp. 30-52
45 Ex. D, R 44
46 "Notably, the number of participants in our sample with a history of behavioral intervention is disproportionately low, relative to the rate of those with problem behaviors. It is possible that psychotropic medication use, which was not inquired in our study, was favored by these families as a primary therapeutic approach for externalizing and affective problems. It is also possible that the impact of these problematic behaviors is under-recognized and individuals are not receiving proper and adequate intervention" David's Ex. D.
47 Letter from Amy Lacher-Thompson BCBA

Thompson believes a safety bed is needed to ensure that David is safe and secure and provide David with a safe and comfortable sleeping environment.[48] As David cannot tolerate protective headgear, Mr. Busbee believes that the Cubby bed is necessary to increase David's safety at night and assist David with sensory regulation.[49] Finally, Dr. Marshall believes the Cubby Bed is medically necessary to ensure David is safe at night and reduce elopement.[50]

III. Discussion

The Cubby Bed consists of a mattress with a secure padded enclosure, electronic monitoring equipment, and sensory control devices. In David's case it has four articulated purposes: to prevent injury to David; to decrease his sensory input; to contain him to prevent elopement; and to improve his sleep hygiene. Unlike some other categories of durable medical equipment (DME) the Division does not have a regulation or local coverage determinations (LCD) directly on point. The Division instead provided Medicare LCD for hospital beds.[51] However, the Cubby bed is not best evaluated strictly as a hospital bed.[52] A hospital bed is generally designed to assist those who struggle with the activity of daily living (ADL) of bed mobility, such as turning in bed and transitioning from laying down to sitting up in bed. Here the Cubby bed, as requested, does not assist with the ADL of bed mobility as it does not appear to raise, lower, or articulate the mattress in anyway.

The Cubby bed in this matter was billed under E1399, the Medicaid code for DME- miscellaneous,[53] and can more accurately be described as a: specialty bed; safety bed; or enclosed bed. The Division takes the position that enclosed beds, like the Cubby bed, can be considered medically necessary based on safety risks but only in the most extreme cases, with a significant history of injury, and only after other available methods have been tried.[54]

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48 Letter from Amy Lacher-Thompson BCBA

49 Letter from Nathan Busbee.

50 Letter from Dr. Cathleen Marshall.

51 Ex. B, pp 31 – 80.

52 Additionally, it is noted that this is not a Medicare case. While Medicare and Medicaid do have some overlapping regulations, they do not share definitions in every area. Additionally, various federal courts have held that LCDs do not hold the force of law. *Erringer v. Thompson*, 371 F. 3d 625, 644 n.10 (9th Cir. 2004) "Even if the LCDs themselves were the subject of our concern, they are only binding in the initial adjudication and during the preliminary appeals stages. They do not bind ALJs or the federal courts."

53 Ex. 1.

54 Testimony of Ms. Benson.

Much of the testimony during the two days of hearing was devoted to trying to determine what constitutes the most extreme case, and what alternative methods should have been tried in David's case. At the close of the hearing the Division maintained the position that while circumstances may exist that would justify the approval of an enclosed bed based on safety concerns, they have yet to see a case with sufficiently severe circumstance.[55]

The Division's approach presents significant issues as it does not create an objective criterion that can be easily applied. Nor is the Division's argument, that the safety issues can meet medical necessity but only in the most extreme circumstances, codified in any statute, regulation, or policy statement. Instead, in reviewing the denial of the request for the Cubby Bed, the critical question is whether it is medically necessary. This is because the Alaska Medicaid regulations explicitly state that Medicaid will only pay for medically necessary services and items[56] and will not pay for items and services that are:

> 1) not reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system, as determined upon review by the department, or that is not identified in a screening required under 7 AAC 110.205;
>
> (2) not properly prescribed or medically necessary in accordance with criteria established under 7 AAC 105 - 7 AAC 160 or by standards of practice applicable to the prescribing provider;[57]

Therefore, what David must prove is that the Cubby bed is medically necessary; that it is reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system; and it was properly described.

While the Division has not published further coverage guidance for determining the medical necessity of enclosed beds, multiple other states have.[58] While the guidance

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55 Testimony of Ms. Benson.

56 7 AAC 105.100(5).

57 7 AAC 105.110.

58 Publicly available criteria for the approval of enclosed beds, safety beds, specialty beds, or similar products exist in: **California** *See* Durable Medical Equipment (DME): Other DME Equipment, p. 8 (Available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/58152677-9614-44AB-AA0A-1F3F04123E7D/duraother.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO); **Illinois**, *See* Pediatric Specialty Beds Criteria (Available at: https://hfs.illinois.gov/medicalproviders/mpac/psbcriteria.html); **Iowa**, *See* Safety Beds DME-016, p. 2 (Available at: https://hhs.iowa.gov/media/323/download?inline=#:~:text=IAC%2078.10(2)d%20cross,results%20in%20risk%20to%20safety.); **Indiana**, *See* Provider Bulletin BT200026, pp 2-3 (Available at: https://provider.indianamedicaid.com/ihcp/bulletins/bt200026.pdf); **Minnesota** *See* Hospital Beds (Available at: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_152895); **Rhode Island** *See* Coverage Guidelines for Durable Medical Equipment: Hospital Beds (Available at:

from other states is not binding on the Division, it is instructive. In general, published guidance from other states supports the Division's position that a generalized safety risk alone is not enough to meet medical necessity. That is also a position that has been adopted by the Commissioner.[59] While enclosed beds are not medically necessary in every case with a generalized safety risk, guidance from other states provides a clear and objective test defining when an enclosed bed is medically necessary. In Iowa, for example, that test is: [60]

1. There is a diagnosis-related cognitive or communication impairment that results in a safety risk
2. There is a risk of injury due to the member's mobility
3. At least one of the following are documented
    a. An active seizure disorder
    b. Uncontrolled movements related to a diagnosis that places the member at risk for injury
    c. Self-injurious behavior that would be expected to improve through use of the requested bed
4. Documentation that at least two safety measures have been considered and either ruled out as contraindicated or tried and failed, including but not limited to:
    a. Side rails
    b. A mattress on the floor
    c. Protective helmet
    d. Posey vest
    e. Weighted blanket
5. Supporting documentation must include secondary diagnoses and pertinent history of at least one of the following
    a. Risk of entrapment in a regular hospital bed
    b. History of injuries or falls
    c. High risk of fractures
    d. At risk for hemorrhage due
    e. Frequent upper respiratory infections or other complications related to aspiration
    f. Respiratory complications related to positioning. Requires elevation of the head and upper body great than 30 degrees
    g. Requires frequent position changes
6. A signed physician's order and documentation that the member has been assessed for appropriateness of the bed and has no contraindications.

https://eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/DME/CoverageGuidelinesforDurableMedicalEquipment.aspx).

[59] *In Re* R.W., OAH No. 23-0694-MDX (Commissioner of Health 2024).

[60] Iowa Medicaid Program, Clinical Criteria – DME-016- Safety Beds, p 2.

While the test itself is not binding, it does provide a useful roadmap to understand how to apply the term, medically necessary, to an enclosed bed. The facts in David's case meet this road map.

It is undisputed that David has a diagnosis that results in a cognitive and communication impairment.[61] David's guardians have provided ample evidence that this diagnosis results in significant safety risks and risk of injury, either by elopement or self-harming behaviors. David's Autism and WSS diagnoses are directly connected to his hyperactive night-time mobility and self-harming behaviors, which creates this safety risk. The risk of harm created by David's behavior would be greatly diminished by the Cubby bed as it would keep David contained and away from surfaces where he could harm himself.

His guardians also submitted ample evidence that placing the mattress on the floor, using a bed tent, and bedside rails were all ineffective at reducing the safety risks. Additionally, David's guardians submitted records from his physical therapist showing, despite months of therapy, David cannot tolerate a helmet.[62] David's medical records and the testimony of Ms. D. also established that he has a history of injuries and is at risk of entrapment in a hospital bed. Finally, David's treating physician's opinion is that the Cubby Bed is medically necessary. Again, while the Division is in no way bound by the regulations of another state's program, these metrics provide a helpful framework for determining what constitutes medical necessity for an enclosed bed.

Unlike some other cases, David's risk of injury does not come from falling out of bed, which could be addressed by placing the bed on the floor, but from injuring himself on the bed or other solid surfaces in the home. While the Division suggested that a mattress alarm would be effective, David has already tried a mattress alarm and its use was discontinued after consultation with David's medical team. Use of the mattress alarm was discontinued because David has a well-documented history of sensitivity to lights and loud noises. A safety measure that creates the very stimuli that David responds negatively to is, at best, counterproductive.

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61 David's Ex. E.

62 Letter from Nathan Busbee.

Additionally, as David has a habit of chewing through cords, which presents its own risk of injury, an alarm with an exposed cord is not helpful.[63]

The Division also suggested that a lock or an alarm on the bedroom door would be effective to meet David's needs. However, the record is clear that David has a history of injuring himself by headbanging and rocking, including against bare walls in his bedroom.[64] A lock or alarm on the door would not prevent this and therefore would not be effective.

The Division next suggested that David could wear a helmet to address his risk of injury from self-injurious behavior. The hearing was continued to allow Ms. D. additional time to submit documentation that David cannot tolerate a helmet. Through her testimony and the exhibits she provided, Ms. D. proved that David had undergone at least six months of occupational therapy around learning to tolerate any contact with his head – including helmets. Despite this David's occupational therapist wrote, "…we have not made significant progress with continuously tolerating objects on his head."[65] Further, David's occupational therapist provided his opinion that "Due to his inability to tolerate items on his head, [David] will benefit from the Cubby safe sleep bed to assist with his sensory regulation and improve his safety at night."[66] Therefore, a helmet would not be effective at preventing David's injury.

Next the Division suggested that before resorting to DME additional therapy should be tried. The Division argued that this was particularly important because David has made improvements through therapy.[67] The Division is correct that David has made some positive gains in therapy. However, David has been in therapy since he was 8 months old, and good sleep hygiene has always been a part of David's therapy.[68] Crucially, the same providers who noted David's improvements from therapy, also recommended the Cubby bed for David. Amy Lacher-Thompson, David's behavioral analyst, wrote "While these interventions have shown promising results during clinic sessions, [David] continues to exhibit elopement behaviors at night. As a result, he meets medical necessity criteria for safety equipment such as a safety bed to provide an additional layer of safety and support for [David]."[69] In short, despite testing a

63 Testimony of Ms. D.
64 Testimony of Ms. D.
65 Letter from Nathan Busbee.
66 Letter from Nathan Busbee.
67 Testimony of Ms. Benson.
68 Testimony of Ms. D.
69 Letter from Amy Lacher-Thompson, BCBA

multitude of alternative means to address David's nighttime issues, none of these alternative methods appear to be effective for David. In part, this is why David's care team universally recommends the Cubby Bed.

Federal courts have held that an individual's physician's opinion regarding whether a treatment is medically necessary is presumed to be correct:

> The Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.[70]

In general, more weight is given to a treating physician's opinion than the opinions of those who do not treat a claimant.[71] An administrative law judge must provide "clear and convincing" reasons for rejecting the uncontradicted opinion of either a treating or examining physician.[72] Even when a treating or examining physician's opinion is contradicted, that opinion "can only be rejected for specific and legitimate reasons that are supported by substantial evidence in the record."[73] "The opinion of a nonexamining physician cannot by itself constitute substantial evidence that justifies the rejection of the opinion of either an examining physician *or* a treating physician."[74]

To reject the uncontradicted medical necessity opinion of a treating physician, which Dr. Brand is, there must be "clear and convincing evidence" that the Cubby Bed is not medically necessary. As recited above, the evidence supports a conclusion that the Cubby bed is medically necessary to treat the safety concerns and sleep hygiene issues that flow directly from David's diagnoses. That conclusion is supported by the recommendation of David's Occupational therapist, Behavioral therapist, and Pediatric Neurologist. The record is clear that David's parents have tried all other practical methods to treat the safety concerns and sleep hygiene issues, and none of these alternative methods proved effective or appropriate. Therefore, there is not clear and convincing evidence to reject the cohesive opinions of David's care team. As David has established his request for the Cubby bed is medically necessary, it must be approved.

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70 *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989).
71 *Lester v. Chater*, 81 F.3d 821, 830 (9th Cir. 1996).
72 *Lester* at 830 – 831.
73 *Lester* at 830 – 831.
74 *Lester* at 831.

IV. Conclusion

While an enclosed bed will not be medically necessary in every case where there are safety risks related to a cognitive impairment, medical necessity is determined on a case-by-case basis. David's treating providers universally recommended the Cubby Bed after the trial and failure of a multiple other methods. As their recommendations were well supported in the record, there is not clear and convincing evidence to reject their shared opinion that the Cubby Bed is medically necessary. Therefore, David's parents satisfied his burden and proved by a preponderance of the evidence that the Cubby Bed, including the accessories in his prior authorization request, is medically necessary for him due to his autism spectrum disorder, Wiedemann-Steiner syndrome, insomnia, and related safety and behavioral issues. The Division's denial of David's prior authorization request for the Cubby Bed device is REVERSED.

Dated: May 31, 2024

[signature redacted]

Eric M. Salinger
Administrative Law Judge

Adoption

The undersigned, by delegation from the Commissioner of Health, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 3rd day of July, 2024.

Daniel R. Phelps II
Process Improvement Manager

[OAH Publication Note: This Decision has been redacted for publication.]