

BEDS, SUPPORT SURFACES DETAILED WRITTEN ORDER PRIOR TO DELIVERY

Patient Name _____		Account Number _____	
Patient DOB _____		Order Date _____ Height _____ Weight _____	
<input type="checkbox"/> Face Sheet/Demographics/Chart Notes Attached (Chart notes must include the need for equipment being ordered). Date of visit prior to order: _____			
***MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY: Reason for Medical Necessity (other than diagnosis): _____			
DIAGNOSIS (Provide diagnosis below)		Length of Need: <input type="checkbox"/> 12 Months <input type="checkbox"/> Other _____ 99 = Lifetime	
<input type="checkbox"/> CHF	<input type="checkbox"/> COPD	<input type="checkbox"/> CVA	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Paraplegia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Quadriplegia	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Decubitus Ulcer – Location: _____		Stage: _____	
HOSPITAL BED (check all qualifications that apply)			
<input type="checkbox"/> Semi Electric Hospital Bed (E0260)		<input type="checkbox"/> Full Rails <input type="checkbox"/> Half Rails	
<input type="checkbox"/> Patient requires frequent changes in body position and/or has an immediate need for a change in body position to alleviate pain or		<input type="checkbox"/> Heavy Duty Hospital Bed (E0303) (351 lbs. +)	
<input type="checkbox"/> Patient has a medical condition which requires positioning of the body in ways not feasible with and ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or			
<input type="checkbox"/> Patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration, or			
<input type="checkbox"/> Patient requires traction equipment which can only be attached to a hospital bed.			
ACCESSORIES (Patient must meet at least one of the following criteria to qualify) CHECK ALL THAT APPLY			
<input type="checkbox"/> Bedside Commode		<input type="checkbox"/> Patient is confined to a single room, or	
<input type="checkbox"/> Drop Arm Commode		<input type="checkbox"/> Patient is confined to one level of the home environment and there is no toilet on that level, or	
<input type="checkbox"/> Heavy Duty Bedside Commode (301 lbs. +)		<input type="checkbox"/> Patient is confined to the home and there are no toilet facilities in the home.	
<input type="checkbox"/> Trapeze (250 lbs.)		<input type="checkbox"/> Bariatric Trapeze (650 lbs.) <input type="checkbox"/> Patient Lift (250 lbs.)	
SUPPORT SURFACES (Patient must meet at least one of the following criteria to qualify) CHECK ALL THAT APPLY			
<input type="checkbox"/> Group 1 Dry Pressure Mattress (E0184)		<input type="checkbox"/> Patient is completely immobile, or	
<input type="checkbox"/> Group 1 Gel Overlay (E0185)		<input type="checkbox"/> Ulcer(s) on the trunk or pelvis, and/or	
<input type="checkbox"/> Group 1 Alternating Pressure Pad & Pump (E0181)		<input type="checkbox"/> Patient is partially immobile and at least one of the following:	
		<input type="checkbox"/> Fecal or urinary incontinence <input type="checkbox"/> Altered sensory perception <input type="checkbox"/> Compromised circulatory status <input type="checkbox"/> Impaired Nutritional status	
<input type="checkbox"/> Group 2 Low Air Loss (E0277) <u>Prior authorization required for Medicare beneficiaries</u>		<input type="checkbox"/> Multiple stage 2 pressure ulcers located on the trunk or pelvis and has been on a comprehensive ulcer treatment program for at least the past month with group 1 support surface and the ulcers have worsened or remained the same over the past month or <input type="checkbox"/> Large or multiple stage 3 or 4 pressure ulcer(s) on the trunk or pelvis or <input type="checkbox"/> Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the last 60 days) and <input type="checkbox"/> The patient has been on a group 2 or 3 support surface immediately prior to recent discharge from a hospital or nursing facility (discharge within the past 30 days)	
PRESCRIBING PHYSICIAN'S INFORMATION			
Name and Credentials _____		NPI No. _____	
Telephone No. _____		Fax No. _____	
Signature _____		Signature Date _____	
(Stamped Signature Not Accepted)			

If filled out completely, this form serves as the Detailed Written Order (DWO) and proof that patient was seen by the physician within 6 months prior to the date of order. This must be received by supplier before equipment is dispensed.

1. The beneficiary has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or
2. The beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
3. The beneficiary requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration, or
4. The beneficiary requires traction equipment, which can only be attached to a hospital bed.

When ordering a bariatric hospital bed (E0303) the patient must exceed 350lbs as well as meet one of the criteria listed above. A group 1 mattress overlay or mattress is covered if one of the following criteria are met:

1. The beneficiary is completely immobile, or
2. The beneficiary has limited mobility and cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
3. The beneficiary has any stage pressure ulcer on the trunk or pelvis and at least one of conditions A-D below.

Conditions for criteria 2 and 3, in each case the medical record must document the severity of the condition sufficiently to demonstrate the reasonable and necessary need for a pressure reducing support surface:

A. Impaired nutritional status B. Fecal or urinary incontinence C. Altered sensory perception D. Compromised circulatory status

Additional Clinical Information:

A beneficiary needing a pressure reducing support surface should have a care plan established by the physician or home care nurse, which is generally documented with the following:

- Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers.
- Regular assessment by a nurse, physician, or other licensed health-care practitioner.
- Appropriate turning and positioning.
- Appropriate wound care (for a stage II, III, or IV ulcer).
- Appropriate management of moisture/incontinence.
- Nutritional assessment and intervention consistent with the overall plan of care.

A group 2 support surface is covered if the patient meets:

Criterion 1 and 2 and 3, or B. Criterion 4, or C. Criterion 5 and 6

1. The patient has multiple stage II pressure ulcers located on the trunk or pelvis, and
2. Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface, and
3. The ulcers have worsened or remained the same over the past month, or
4. The patient has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or
5. The patient had a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) and
6. The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

The comprehensive ulcer treatment described in #2 above should generally include:

1. Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
2. Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer).
3. Appropriate turning and positioning.
4. Appropriate wound care (for a stage II, III, or IV ulcer).
5. Appropriate management of moisture/incontinence.
6. Nutritional assessment and intervention consistent with the overall plan of care.

If the patient is on a group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements. The support surface provided for the patient should be one in which the patient does not "bottom out" (see Appendices section). When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

A commode is covered when the beneficiary is physically incapable of utilizing regular toilet facilities. This would occur in the following situations:

1. The beneficiary is confined to a single room, or
2. The beneficiary is confined to one level of the home environment and there is no toilet on that level, or
3. The beneficiary is confined to the home and there are no toilet facilities in the home.
4. An extra wide/heavy duty commode chair (E0168) is covered for a beneficiary who weighs 300 pounds or more.

Medicare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary. The chart note from the office visit exam must be signed and dated by the author of the note. If completed by a PA, NP, or CNS, the physician (MD, DO or DPM) must cosign and date the note.