BINSON'S Medical Equipment & Supplies Since 1953

Longwood, FL
Fax To: 1-407-691-3021

BECN 152790010620

Reset Form

Beds, Support Surfaces Detailed Written Order Prior to Delivery

Patient Name: _____

Account #: _____ DOB: _____ Height: _____ Weight: _____

☐ ***Face Sheet/Demographics/Chart Notes Faxed*** **Date of visit prior to order:** _____

☒ I, the Physician, have seen this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes.

MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY:
Reason for Medical Necessity (other than diagnosis): _____

DIAGNOSIS (check appropriate diagnosis from list below) Length of Need: _____ (99 = Lifetime)

☐	CHF	☐	Emphysema	☐	Pneumonia
☐	COPD	☐	Hemiplegia	☐	Quadriplegia
☐	CVA	☐	Paraplegia	☐	Rheumatoid Arthritis
☐	Decubitus Ulcer – Location: _____ Stage: _____				
☐	Other:	☐	Other:		

HOSPITAL BED (*check all **QUALIFICATIONS** that apply*)

☐	Semi-Electric ☐ Full Rails ☐ Half Rails	☐	Patient requires frequent changes in body position and/or has an immediate need for a change in body position, to alleviate pain ***or***
		☐	Patient 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***
☐	Heavy Duty Full Electric (351 lbs. +) (E0303)	☐	Patient requires the head of the bed to be elevated more than 30 degrees a majority of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration, ***or***
		☐	Patient requires traction equipment which can only be attached to a hospital bed.

ACCESORIES (***Please List Below***)

☐	
☐	

SUPPORT SURFACES (*Patient must meet at least one of the following criteria to qualify*). (***Check all that apply***)

☐	Group 1 Gel Overlay (E0185)	☐	Patient is completely immobile ***or***
		☐	Ulcer(s) on trunk or pelvis ***and/or***
☐	Group 1 Alternating Pressure Pad & Pump (E0181)	☐	Partially immobile **and at least one of the following**:
		☐	Fecal or urinary incontinence ☐ Altered sensory perception
☐	Group 1 Dry Pressure Mattress (E0184)	☐	Compromised circulatory status ☐ Impaired nutritional status
☐	Group 2 Low Air Loss (E0277) ***PRIOR AUTHORIZATION REQUIRED FOR MEDICARE BENEFICIARIES***	☐	Multiple Stage 2 pressure ulcers located on the trunk or pelvis ***and*** patient 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***
		☐	Large or multiple Stage 3 or 4 pressure ulcer(s) on the trunk or pelvis ***or***
		☐	Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) ***and***
		☐	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/Credentials: _____ NPI Number: _____

Telephone: _____ Fax Number: _____

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.