Lake Region HOME MEDICAL SUPPLY

Physician's Order for Group 1 or 2 Support Surface

Account: _____

Date of Order: _____

Patient Name: _____ DOB: _____

Group 1 (overlays) **Must meet criteria 1, 2 or 3**

Yes	No	
☐	☐	**1. Completely Immobile –** Cannot make changes in body position without assistance
☐	☐	**2. Limited Mobility –** Cannot independently make changes in body position significant enough to alleviate pressure
☐	☐	**3. Any stage pressure ulcer on the trunk or pelvis**

***If meets criteria 2 or 3 above, must also have at least one of the following conditions (check all that apply):

☐ Impaired nutritional status ☐ Altered sensory perception

☐ Fecal or urinary incontinence ☐ Compromised circulatory status

Group 2 (powered pressure-reducing mattresses) **Patient must meet criteria 1 and 2 *OR* criteria 3 *OR* criteria 4**

Yes	No	
☐	☐	1. Multiple Stage II pressure ulcers on the trunk or pelvis that have failed to improve over the last month. Number/Location: _____ ***AND***
☐	☐	2. Patient has been on a comprehensive ulcer treatment program for at least the past month, which has included: ▪ Use of an appropriate Group 1 support surface ▪ Regular assessment ▪ Appropriate turning, positioning and wound care ▪ Moisture/incontinence management ▪ Nutritional assessment and intervention. ***OR***
☐	☐	3. Large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis Stage: _____ Measurements: _____ _____ ***OR***
☐	☐	4. Recent myocutaneous flap or skin graft (within past 60 days) for a pressure ulcer on trunk or pelvis and patient has been on Group 2 or 3 support surface immediately prior to discharge (within past 30 days) from the hospital/nursing facility. Surgery date: _____

Physician Order:

Start Date: _____ (if different than Date of Order)

Diagnoses: _____ Length of Need: _____

Equipment:

☐ E0181 Alternating pressure pad system, pump & pad kit (Group 1)

☐ E0277 Powered pressure-reducing air mattress (Group 2)

☐ Other _____

Physician Signature: _____ **Date:** _____

Physician Name: (please print) _____ **NPI:** _____

******Must attach documentation supporting medical necessity of ordered supplies******

******A Care Plan established by doctor or home care must be on file in patient medical record******

Fax back to: 320-231-4941

Support Surfaces Order and Documentation Requirements

Medicare, and other insurance providers who follow Medicare guidelines, requires that a physician, NP, CNS or PA has had a Face-to-Face (F2F) examination with the patient that documents that the patient was evaluated and/or treated for a condition that supports the need for the prescribed equipment. The date of the F2F exam may be no older than 6 months prior to the prescription date.

A Written Order Prior to Delivery (WOPD) is also required; the WOPD cannot be completed until after the F2F exam, and must be received by the supplier prior to dispensing the equipment. This order must contain:

- Patient's name
- Physician's name
- Date of the order and the start date, if start date is different from date of order
- Detailed description of the item(s)
- Ordering Practitioner's National Provider Identifier (NPI)
- Signature of ordering practitioner and signature date. Signature and date stamps are not allowed. Signatures must be legible and/or physician's name must also be printed.

A Group 1 mattress overlay is covered if one of the following three criteria are met:

1. The patient is completely immobile - i.e., cannot make changes in body position without assistance, or
2. The patient has limited mobility - i.e., 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 medical necessity for a pressure reducing support surface):

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

A Group 2 support surface mattress is covered if the patient meets at least one of the following three Criteria (1, 2 or 3):

1. The patient has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the patient has been on a comprehensive ulcer treatment program including each of the following:
    - Use of an appropriate Group 1 support surface, and
    - Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and
    - Appropriate turning and positioning, and
    - Appropriate wound care, and
    - Appropriate management of moisture/incontinence, and
    - Nutritional assessment and intervention consistent with the overall plan of care
2. The patient has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis
3. The patient had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a Group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days

RELATED CLINICAL INFORMATION: A patient needing a pressure reducing support surface **should have a care plan which has been established by the physician or home care nurse, which is documented in the patient's medical records**, and which generally should include the following:

1. Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers
2. Regular assessment by a nurse, physician, or other licensed healthcare practitioner
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

Thank you for making Lake Region Home Medical Supply part of your healthcare team. Please call 218-332-5920 with questions.