

**Certificate of Medical Necessity (CMN) for Support Surfaces**

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Requesting Provider:** \_\_\_\_\_

**Pt. Name:** \_\_\_\_\_ **I.D. Number:** \_\_\_\_\_

|                  |  |
|------------------|--|
| <b>Group II</b>  | <b>Alternating Pressure Mattress E0277</b> |
| <b>Group III</b> | <b>Air Fluidized Beds E0194</b>            |

- |   |   |   |   |
|---|---|---|---|
| 1. Is the patient's physician going to supervise use of this device (for treatment and prevention of decubiti), and reevaluate progress monthly?  | Y | N | D |
| 2. Is the patient bedridden or chair bound as a result of severely limited mobility?  | Y | N | D |
| 3. Does the patient have significant co-existing pulmonary or cardiac disease? If yes – diagnosis. _____  | Y | N | D |
| 4. Has a conservative treatment program been tried without success? (Including freq. repositioning, optimal wound care, nutrition, etc.)  | Y | N | D |
| 5. Was a comprehensive assessment performed after failure of conservative treatment?  | Y | N | D |
| 6. Are <u>open</u> , moist or wet dressings used in the treatment of the patient?   | Y | N | D |
| 7. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of this device?  | Y | N | D |
| 8. Over the past months, the patient's ulcer(s) have in general: (please circle)<br>1) Improved      2) Remained the same      3) Worsened  |   |   |   |
| 9. Provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress or bed.<br><i>If the patient is highly susceptible to decubitus ulcers, but currently has no ulcer present, place a "9" under ulcer #1.</i><br>What condition puts patient at risk? _____ |   |   |   |

|                  | Ulcer #1 | Ulcer #2 | Ulcer #3 |
|------------------|----------|----------|----------|
| Stage:           |          |          |          |
| Max. Length (cm) |          |          |          |
| Max. Width (cm)  |          |          |          |

- |   |   |   |
|---|---|---|
| For Air Fluidized bed, has home been assessed for adequate structural support (bed weighs 1600 pounds) and for electrical system capacity to handle safely?   | Y | N |
| For Alternating Pressure mattress, has appropriate Group I (pressure reducing foam or gel) support surface been tried and failed before request for Group II? | Y | N |
| Has patient had recent (60 days) myocutaneous flap or skin graft?<br>If yes – what anatomic area? _____   | Y | N |

Estimated Length of Need (in months): \_\_\_\_\_ (99 = Permanent)

**Contact Name:** \_\_\_\_\_ **Phone :** \_\_\_\_\_

**Physician Signature** (Stamps are not acceptable) \_\_\_\_\_ **Date** \_\_\_\_\_

Key - (Y)es, (N)o, (D)oes not apply

**Requested Information:**  
1. Typed office note with pertinent information.