HOME OXYGEN THERAPY (AT REST)
HOME OXYGEN THERAPY (DURING EXERCISE)
HOME OXYGEN THERAPY (DURING SLEEP)
VENTILATOR AND SUPPLIES
VENT WITH NONINVASIVE INTERFACES (VENT VS BI-LEVEL PAP)
TRACHEOSTOMY CARE SUPPLIES
SUCTION PUMP & SUPPLIES
CPAP/BIPAP AND SUPPLIES
RESPIRATORY ASSIST DEVICE
COUGH STIMULATING DEVICE
HIGH FREQUENCY CHEST WALL OSCILLATION DEVICE
NEBULIZER AND ACCESSORIES
INHALATION NEBULIZATION SOLUTION

ENTERAL VIA PUMP
ENTERAL VIA GRAVITY
ENTERAL VIA BOLUS
HOSPITAL BED
HOSPITAL BED HEAVY-DUTY / EXTRA HEAVY-DUTY
LOW AIR LOSS MATTRESS
ALTERNATIVE PRESSURE PAD (APP) / GEL MATTRESS
PATIENT LIFT
COMMODE
WHEELCHAIR
WALKER
Documentation Required:
• Detail written order prior to delivery
• Medical records must support medical need for product ordered

Coverage Criteria:
Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:
1. The treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The patient’s blood gas study meets the following criteria: an arterial PO₂ at or below 55 mm Hg or an arterial oxygen saturation at or below 88% taken at rest (awake), and
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
   • If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
   • If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state—i.e., not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

* Our clinician will follow up and evaluate patient on use of a conserving device to see if they are able to tolerate pulse dose oxygen

Copy of chart notes for this order must be provided
Home Oxygen with Portability

X LPM During Exercise
Pulse Ox XX% on Room Air @ Rest
Pulse Ox XX% on Exercise
Pulse Ox XX% on Exercise with O₂ applied
Evaluate for conserving device*

Dx: __________________
Ht: _________ Wt:________
Length of need
(# of month):_________________
i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations
Refill [0] [1] [2] [3] [4] [5]

Documentation Required:
• Detail written order prior to delivery
• Medical records must support medical need for product ordered

Coverage Criteria:
Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:
1. The treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The patient’s blood gas study meets the following criteria: an arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 % taken during exercise, and
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
   • If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
   • If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

* Our clinician will follow up and evaluate patient on use of a conserving device to see if they are able to tolerate pulse dose oxygen

Required Copy of chart notes for this order must be provided

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Documentation Required:
• Detail written order prior to delivery
• Medical records must support medical need for product ordered

Coverage Criteria:
Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:
1. The treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The patient’s blood gas study meets the following criteria: an arterial oxygen saturation at or below 88% for at least 5 minutes (5 min does not have to be continuous) taken during sleep, and
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
   • If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
   • If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

Phone: 215-464-7304      Fax: 215-464-7308
Mode: ____________
Pressure/Tidal Volume: _______
Rate: ______________
FIO2 _________ Usage: _______

Dx: ______________
Ht: _________ Wt:________

Length of need
(# of month): ___________
  i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations

Refill [ ] [1] [2] [3] [4] [5]

In order for a brand name product to be dispensed, the prescriber must handwrite "brand necessary" or "brand medically necessary" in the space below.

Today's Date: ___________
Patient's Name: ___________
Address: _______________
City, State, Zip Code: _______
Birth Date: ___________
Signature: ___________
Title: _______________
Print Name: ___________
PA Lic. #: _______________
NPI #: _______________
DEA #: _______________

Coverage Criteria:
Cover for treatment of neuromuscular disease, thoracic restrictive disease, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. Includes both positive/negative pressure types.

Copy of chart notes for this order must be provided
VENT WITH NONINVASIVE INTERFACES (VENT VS BI-LEVEL PAP)

**Ventilator and Supplies**

**Mode:**

**Pressure/Tidal Volume:**

**Rate:**

**FIO2**

**Usage:**

**Dx:**

**Ht:**

**Wt:**

**Length of need (# of month):**

i.e. 1-99 (99=lifetime)

**Write legible, no unacceptable abbreviations**

**Refill** [ ] [ ] [ ] [ ] [ ]

**IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.**

**Copy of chart notes for this order must be provided**

**Documentation Required:**
- Detail written order **prior to delivery**
- Medical records **must** support medical need for product ordered

**Coverage Criteria:**
Cover for treatment of neuromuscular disease, thoracic restrictive disease, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.

Each of these disease categories are comprised of conditions that can vary from severe and life-threatening to less serious forms. Choice of an appropriate device i.e., a ventilator versus a bi-level PAP device is made based upon the severity of the condition. CMS distinguished the use of respiratory product types in a National Coverage Analysis Decision Memo (CAG-00052N) in June 2001 saying that RAD is “distinguished from ventilation in a patient for whom interruption or failure of respiratory support leads to death.” This must be very well documented in patient’s chart notes along with the reason why the Bi-level PAP device cannot be part of the patient treatment plan.

**Phone:** 215-464-7304  **Fax:** 215-464-7308

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Documentation Required:
• Detail written order prior to delivery
• Medical records must support medical need for product ordered

Coverage Criteria:
• The patient must have an open surgical tracheostomy which has been open, or is expected to remain open, for at least 3 months
• J95.00 Unspecified tracheostomy complication
J95.01 Hemorrhage from tracheostomy stoma
J95.02 Infection of tracheostomy stoma
J95.03 Malfunction of tracheostomy stoma
J95.04 Tracheo-esophageal fistula following tracheostomy
J95.09 Other tracheostomy complication
Z43.0 Encounter for attention to tracheostomy
Z93.0 Tracheostomy status

Copy of chart notes for this order must be provided
Documentation Required:
• Detail written order prior to delivery
• Medical records must support medical need for product ordered

Coverage Criteria:
Use of a respiratory suction pump (E0600) is covered for patients who have difficulty raising and clearing secretions secondary to:
• Cancer or surgery of the throat or mouth
• Dysfunction of the swallowing muscles
• Unconsciousness or obtunded states
• Tracheostomy

Usual Maximum Quantity Of Supplies With Initial Order if not used for tracheostomy suctioning:
• Suction Tubing #4
• Suction Filter #4
• Canister Disposable #4
• Yankauer #4
• Suction catheter not sterile. No more than 3 per week

Copy of chart notes for this order must be provided
Documentation Required:

- Detail written order **prior to delivery**
- Medical records **must** support medical need for product ordered. The patient has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea.

Coverage Criteria:

Criteria A or B must be met:

A. AHI or RDI is greater than or equal to 15 events per hour, with a minimum of 30 events; or
B. AHI or RDI is 5-14 events per hour (minimum of 10 events) with documentation of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease, or history of stroke
C. The patient and/or their caregiver has received instruction from the supplier of the device in the proper use and care of the equipment.

BIPAP device is covered for those patients with OSA who meet criteria A-C above, in addition to criterion D:

D. CPAP has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in a home setting.

Phone: 215-464-7304       Fax: 215-464-7308

Copy of chart notes for this order must be provided

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**CPAP/BIPAP AND SUPPLIES**

Refill [0] [1] [2] [3] [4] [5]

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.
Documentation Required:

- Detail written order prior to delivery
- Medical records must support medical need for product ordered, along with documented symptoms characteristics of sleep-associated hypoventilation such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc

Coverage Criteria:

- Restrictive thoracic disorder (i.e., neuromuscular diseases or severe thoracic cage abnormalities)
- PaCO2 > 45mmHg or Pulse Ox < 88% for ≥5mins, MIN 2 hrs recording time or FVC ≤ 50% of predicted or MIP, 60cm H2O
- Severe chronic obstructive pulmonary disease (COPD)
- PaCO2 > 52mm Hg (patient’s prescribed FiO2) and Pulse Ox < 88% for ≥5mins, MIN 2 hrs recording time
- Central sleep apnea (CSA) or complex sleep apnea (Comp SA), or
- PSG and, Settings that will be prescribed for initial use at home and Patient’s prescribed FiO2
- Hypoventilation syndrome
- PaCO2 > 45 mm Hg (patient’s prescribed FiO2) and, FEV1/FVC > 70 % and an FEV1 > 50% of predicted and ABGs (done during sleep or immediately upon awakening) PaCO2 worsened > 7 mm Hg compared to original ABG (patient’s prescribed FiO2) or PSG demonstrates oxygen saturation < 88% for > 5 minutes, minimum 2 hours recording time not caused by obstructive upper airway events (i.e., AHI < 5)

Copy of chart notes for this order must be provided
Cough Stimulating Device and Accessories

Dx: ________________
Ht: _________ Wt: __________
Length of need (# of month): i.e. 1-99 (99 = lifetime)

Write legible, no unacceptable abbreviations

Refill [0] [1] [2] [3] [4] [5]

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.

Required Copy of chart notes for this order must be provided
### High Frequency Chest Wall Oscillation Device and Accessories

| **Dx:** |  |
| **Ht:** |  |
| **Wt:** |  |
| **Length of need (# of month):** | 1-99 (99=lifetime) |

**Write legible, no unacceptable abbreviations**

**Refill**

| 0 | 1 | 2 | 3 | 4 | 5 |

**IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.**

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**Copy of chart notes for this order must be provided**

**Documentation Required:**
- Detail written order **prior to delivery**
- Medical records **must** support medical need for product ordered

**Coverage Criteria:**

A. Criterion 1, 2, or 3, and

B. Criterion 4

1. There is a diagnosis of cystic fibrosis (see diagnosis codes that support medical necessity section below).
2. There is a diagnosis of bronchiectasis (see diagnosis codes that support medical necessity section below) which has been confirmed by a high resolution, spiral, or standard CT scan and which is characterized by:
   - Daily productive cough for at least 6 continuous months; or
   - Frequent (i.e., more than 2/year) exacerbations requiring antibiotic therapy. Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion.
3. The beneficiary has one of the following neuromuscular disease diagnoses (see diagnosis codes that support medical necessity section below): Post-polio Acid maltase deficiency Anterior horn cell diseases Multiple sclerosis Quadriplegia Hereditary muscular dystrophy Myotonic disorders Other myopathies Paralysis of the diaphragm
4. There must be well-documented failure of standard treatments to adequately mobilize retained secretions.
**NEBULIZER AND ACCESSORIES**

000 Main Street
Philadelphia, PA 19000
(900) 090-3000

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**Nebulizer and Accessories**

**Dx:** __________________

**Ht:** ________ **Wt:** ________

**Length of need (# of month):** i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations

Refill [ ] [1] [2] [3] [4] [5]

**IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.**

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**NEBULIZER AND ACCESSORIES**

**Phone:** 215 - 464 - 7304      **Fax:** 215 - 464 - 7308

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**Documentation Required:**
- Detail written order **prior to delivery**
- Medical records **must** support medical need for product ordered, along with prescribed medication frequency

**Coverage Criteria:**

- **A15.0** Tuberculosis of lung
- **A37.01-91** Whooping cough due to Bordetella pertussis, parapertussis, species or unspecified species with pneumonia
- **B20** Human immunodeficiency virus [HIV] disease
- **B25.0** Cytomegaloviral pneumonitis
- **B59** Pneumocystosis
- **E84.0** Cystic fibrosis with pulmonary manifestations
- **J41.0** Simple chronic bronchitis
- **J43.0-2** Unilateral, Panlobular, Centrilobular pulmonary emphysema
- **J43.8-9** Other or unspecified emphysema
- **J44.0** Chronic obstructive pulmonary disease with acute lower respiratory infection
- **J44.1** Chronic obstructive pulmonary disease with (acute) exacerbation
- **J44.9** Chronic obstructive pulmonary disease, unspecified
- **J45.20-22** Mild intermittent asthma
- **J45.30-32** Mild persistent asthma
- **J45.40-42** Moderate persistent asthma
- **J45.50-52** Severe persistent asthma
- **J47.0** Bronchiectasis with acute lower respiratory infection
- **J47.1** Bronchiectasis with (acute) exacerbation
- **J47.9** Bronchiectasis, uncomplicated

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**Copy of chart notes for this order must be provided**

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**Phone:** 215-464-7304  **Fax:** 215-464-7308

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**PERSONAL SUPPORT Medical Suppliers**
We Care for Your Health
INHALATION NEBULIZATION SOLUTION

**Dx:** ____________________________
**Ht:** _________  **Wt:**________

### Albuterol Sulfate 0.083% (2.5mg/3ml)
1 vial via nebulizer _____  (qid, every 6 hrs)
**Quantity:**

### Ipratropium Bromide 0.02% (0.5mg/2.5ml)
1 vial via nebulizer _____  (qid, every 6 hrs)
**Quantity:**

### Duoneb 0.5mg/5mg
1 vial via nebulizer _____  (qid, every 6 hrs)
**Quantity:**

**Coverage Criteria:**

**PA Medicaid:**
- Albuterol - Maximum milligrams/months (300mg/120 vials)
- Ipratropium - Maximum milligrams/months (60mg/120 vials)
- Duoneb – Not covered by PA Medicaid and PA Medicaid HMOs (Health Partners, Keystone Mercy, Aetna Better Heath)
  - If Duoneb is required, it can be prescribe by separate prescriptions for Albuterol and Ipratropium

**Medicare**
- Albuterol - Maximum milligrams/months (460mg/186 vials)
- Ipratropium - Maximum milligrams/months (93mg/186 vials)
- Duoneb – Maximum 186 vials

**Documentation Required:**
- Detail written order prior to delivery
- Medical records must support medical need for product ordered, along with prescribed medication frequency

**Copy of chart notes for this order must be provided**
1. **IV Pole, Feeding Pump, 4 Irrigation Kits/month, Feeding Bags (1 per day)**

Dx: _______________
Ht: ___________ Wt: ___________

Length of need (# of month): ___________, i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations

Refill [ ] [ ] [ ] [ ] [ ]

**Documentation Required:**
- Detail written order **prior to delivery**
- Medical records must support medical need for product ordered, include diagnostic testing (e.g. swallowing evaluation). If a pump is ordered, there **must be documentations in the patient's medical record to justify its use** (e.g. gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding.

**Coverage Criteria:**
The patient must have a permanent impermanent (3 or more consecutive months)
- Permanent non-function or disease of the structure that normally permit food to reach the small bowel, or
- Disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feeding to provide sufficient nutrients to maintain weight and strength commensurate with the patient's health status.

1. **IV Pole, Feeding Pump, 4 Irrigation Kits/month, Feeding Bags (1 per day)**

Dx: _______________
Ht: ___________ Wt: ___________

Length of need (# of month): ___________, i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations

Refill [ ] [ ] [ ] [ ] [ ]

**coverage Criteria:**
The patient must have a permanent impermanent (3 or more consecutive months)
- Permanent non-function or disease of the structure that normally permit food to reach the small bowel, or
- Disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feeding to provide sufficient nutrients to maintain weight and strength commensurate with the patient's health status.

**Documention Required:**
- Detail written order **prior to delivery**
- Medical records must support medical need for product ordered, include diagnostic testing (e.g. swallowing evaluation). If a pump is ordered, there **must be documentations in the patient's medical record to justify its use** (e.g. gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding.

**Coverage Criteria:**
The patient must have a permanent impermanent (3 or more consecutive months)
- Permanent non-function or disease of the structure that normally permit food to reach the small bowel, or
- Disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feeding to provide sufficient nutrients to maintain weight and strength commensurate with the patient's health status.

1. **IV Pole, Feeding Pump, 4 Irrigation Kits/month, Feeding Bags (1 per day)**

Dx: _______________
Ht: ___________ Wt: ___________

Length of need (# of month): ___________, i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations

Refill [ ] [ ] [ ] [ ] [ ]

**coverage Criteria:**
The patient must have a permanent impermanent (3 or more consecutive months)
- Permanent non-function or disease of the structure that normally permit food to reach the small bowel, or
- Disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feeding to provide sufficient nutrients to maintain weight and strength commensurate with the patient's health status.

**Documention Required:**
- Detail written order **prior to delivery**
- Medical records must support medical need for product ordered, include diagnostic testing (e.g. swallowing evaluation). If a pump is ordered, there **must be documentations in the patient's medical record to justify its use** (e.g. gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding.

**Coverage Criteria:**
The patient must have a permanent impermanent (3 or more consecutive months)
- Permanent non-function or disease of the structure that normally permit food to reach the small bowel, or
- Disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feeding to provide sufficient nutrients to maintain weight and strength commensurate with the patient's health status.
Documentation Required:
• Detail written order **prior to delivery**
• Medical records **must** support medical need for product ordered, include diagnostic testing (e.g. swallowing evaluation)

Coverage Criteria:
The patient must have a permanent impermanent (3 or more consecutive months)
• Permanent non-function or disease of the structure that normally permit food to reach the small bowel, or
• Disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feeding to provide sufficient nutrients to maintain weight and strength commensurate with the patient’s health status.

1. **IV Pole - 4 Irrigation Kits/month - Gravity Feeding Bags (1 per day)**
2. **Formula (name)**
3. **Administer XXX ml X times per day via (type of tube; i.e. J or G)**

Dx: __________________
Ht: __________ Wt: ______
Length of need (# of month): __________

Write legible, no unacceptable abbreviations

Refill: [0] [1] [2] [3] [4] [5]

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**Required**

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.

Phone: 215-464-7304      Fax: 215-464-7308

COPY OF CHART NOTES FOR THIS ORDER MUST BE PROVIDED
Documentation Required:
• Detail written order prior to delivery
• Medical records must support medical need for product ordered, include diagnostic testing (e.g. swallowing evaluation)

Coverage Criteria:
The patient must have a permanent impermanent (3 or more consecutive months)
• Permanent non-function or disease of the structure that normally permit food to reach the small bowel, or
• Disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feeding to provide sufficient nutrients to maintain weight and strength commensurate with the patient’s health status.

1. 4 Irrigation Kits/month
2. Formula (name)
3. Administer XXX ml X times per day via (type of tube; i.e. J or G)

Dx: __________________
Ht: ______ Wt: ______
Length of need (# of month): i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations

Refill [0] [1] [2] [3] [4] [5]

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.

Copy of chart notes for this order must be provided
Hospital Bed

Dx: ________________
Ht: _______  Wt:_______
Length of need (# of month): i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations
Refill [0] [1] [2] [3] [4] [5]

Documentation Required:
• Detail written order prior to delivery
• Medical records must support medical need for product ordered

Coverage Criteria:
• The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed or
• The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
• The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to CHF, chronic pulmonary disease or problems with aspiration, or
• The patient requires frequent changes in body position and/or an immediate need for a change in body position.

Copy of chart notes for this order must be provided
Documentation Required:

- Detail written order **prior to delivery**
- Medical records **must** support medical need for product ordered along with:
  - **Heavy-Duty**: Documentation that patient weight is more than **350 pounds** but does not exceed 600 pounds
  - **Extra Heavy-Duty**: Documentation that patient weight **exceeds 600 pounds**

Coverage Criteria:

- The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed or
- The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
- The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to CHF, chronic pulmonary disease or problems with aspiration, or
- The patient requires frequent changes in body position and/or an immediate need for a change in body position.

**Hospital Bed Heavy-Duty** or
**Hospital Bed - Extra Heavy-Duty**

Dx: ______________
Ht: _________ Wt:________
Length of need (# of month): i.e. 1-99 (99= lifetime)

Write legible, no unacceptable abbreviations

Refill [0] [1] [2] [3] [4] [5]

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.

**Copy of chart notes for this order must be provided**
Low Air Loss Mattress

Dx: ______________

Ht: __________ Wt:________

Length of need (# of month):_______ i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations

Refill [ ] [1] [2] [3] [4] [5]

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.

today's date
patient's name
address
city, state, zip code
birth date
signature title
print name
PA/Lc #
NPI# Required
DEA#

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Low Air Loss Mattress

Coverage Criteria:
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 (ICD-10 L89.100-L89.324) 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:
   a. Use of APP or Gel Mattress, and
   b. Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and
   c. Appropriate turning and positioning, and
   d. Appropriate wound care, and
   e. Appropriate management of moisture/incontinence, and
   f. 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 (ICD-10 L89.100-L89.324)

3. The patient had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days (ICD-10 L89.100-L89.324), and has been on low air loss mattress immediately prior to discharge from a hospital or nursing facility within the past 30 days.

Low Air Loss Mattress

Copy of chart notes for this order must be provided
Alternative Pressure Pad (App) or Gel Pressure Mattress

Dx: ________________

Ht: _______ Wt: _______

Length of need (# of month): i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations

Refill [0] [1] [2] [3] [4] [5]

Copy of chart notes for this order must be provided

Documentation Required:
- Detail written order prior to delivery
- Medical records must support medical need for product ordered.

Coverage Criteria:
Mattress is covered if the patients meet criterion 1, or criterion 2 or 3, and at least one of criteria 4-7

1. Completely immobile – i.e., patient cannot make changes in body position without assistance.
2. Limited Mobility –i.e., patient cannot independently make changes in body position significant enough to alleviate pressure
3. Any stage pressure ulcer on the trunk or pelvis.
4. Impaired nutritional status.
5. Fecal or urinary incontinence
6. Altered sensory perception.
7. Compromised circulatory status.

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.
Patient Lift

Dx: ______________
Ht: _________ Wt:_______

Length of need (# of month): ______ i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations
Refill [ ] [1] [2] [3] [4] [5]

today’s date
patient’s name
address
city, state, zip code
birth date
signature title
print name
PA Lic. #
NPI /
 DEA #

Required

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.

Copy of chart notes for this order must be provided

Documentation Required:
• Detail written order **prior to delivery**
• Medical records **must** support medical need for product ordered.

Coverage Criteria:
A patient lift (hydraulic or mechanical, include any seat, sling, trap(s) or pad(s)) is covered if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the patient would be bed confined.
Commode or Commode Extra Wide/Heavy Duty or Commode with detachable arms

Dx: ____________
Ht: _________ Wt:________

Length of need (# of month): i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations

Refill [0] [1] [2] [3] [4] [5]

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.

Commode
Commode Extra Wide/Heavy Duty
Commode with detachable arms

today’s date

patient’s name

address

city, state, zip code

birth date

signature title

print name

PA Lic. #: ________

NPI #: Required

DEA #: ________

Copy of chart notes for this order must be provided

Documentation Required:

• Detail written order prior to delivery
• Medical records must support medical need for product ordered along with:
  • Extra Wide/Heavy-Duty: Documentation that patient weight is 300 pounds or more
  • With detachable arms: Documentation that detachable arm feature is necessary to facilitate transferring the patient or if the patient has a body configuration that requires extra width.

Coverage Criteria:

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

• The patient is confined to a single room, or
• The patient is confined to one level of the home environment, and there is no toilet on that level, or
• The patient is confined to the home, and there are no toilet facilities in the home.

Phone: 215-464-7304      Fax: 215-464-7308

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Required Wheelchair lightweight or Wheelchair Heavy Duty (more than 250lb) or Wheelchair Extra Heavy Duty (more than 300lb) and Supplies

Dx: ___________________________
Ht: _________ Wt:_________
Length of need (# of month):_________________
i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations
Refill [0] [1] [2] [3] [4] [5]

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE “BRAND NECESSARY” OR “BRAND MEDICALLY NECESSARY” IN THE SPACE BELOW.

Documentation Required:
- Detail written order prior to delivery
- Medical records must support medical need for product ordered.

Coverage Criteria:
1. Criteria A, B, C, D and E are met; and
   A. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs), such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.
   B. The patient’s mobility limitation cannot be sufficiently resolved by use of an appropriately fitted cane or walker.
   C. The patient’s home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
   D. Use of a manual wheelchair will significantly improve the patient’s ability in MRADLs, and the patient will use it on a regular basis in the home.
   E. The patient has not expressed an unwillingness to use the manual wheelchair in the home.

2. Criteria F or G is met
   F. The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day.
   G. The patient has a caregiver who is available, willing and able to provide assistance with the wheelchair.

Copy of chart notes for this order must be provided

Phone: 215-464-7304 Fax: 215-464-7308
000 Main Street Philadelphia, PA 19100 (800) 980-3000
**Walker or Heavy Duty Walker**

Dx: ______________

Ht: _______ Wt: _______

Length of need (# of month): i.e. 1-99 (99=lifetime)

Write legible, no unacceptable abbreviations

Refill [0] [1] [2] [3] [4] [5]

In order for a brand name product to be dispensed, the prescriber must handwrite “BRAND NECESSARY” or “BRAND MEDICALLY NECESSARY” in the space below.

**Documentation Required:**
- Detail written order
- Medical records must support medical need for product ordered, along with:
  - **Heavy Duty Walker:** Documentation that patient weight is more than 300 pounds.

**Coverage Criteria:**
- The patient has mobility limitations that significantly impair his/her ability to participate in one or more mobility-related activities of daily living in (MRADL) the home
  1. Prevents the patient from accomplishing the MRADL entirely, or
  2. Places the patient at reasonably determined heightened risk or morbidity or mortality secondary to the attempts to perform the MRADL, or
  3. Presents the patient from completing the MRADL within a reasonable time frame; and
- The patient is able to safely use the walker; and
- The functional mobility deficit can be sufficiently resolved with the use of a walker.

**Copy of chart notes for this order must be provided**
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