

## DOCUMENTATION CHECKLIST



## GROUP 2 PRESSURE REDUCING SUPPORT SURFACE (PRSS)

## REQUIRED DOCUMENTATION

Written Documentation of a Dispensing Order (written, fax, or verbal order) that includes:

- Description of the item
- Name of the beneficiary
- Prescribing physician/practitioner's name
- Date of the order
- Prescribing physician/practitioner's signature (if a written order) or supplier signature (if verbal order)

**NOTE:** A dispensing order for related supplies is only required if the items are dispensed prior to obtaining the detailed written order.

**Detailed Written Order**

- Beneficiary's name
- Prescribing physician/practitioner's signature (and date if applicable\*)
  - \* *Someone other than the physician/practitioner may complete the DWO of the item unless statute, manual instructions, the contractor's LCD or policy articles specify otherwise. However, the prescribing physician/practitioner must review the content and sign and date the document.*
- The date of the order
- All items, options or additional features that are separately billed or require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, a HCPCS code narrative, or a brand name/model number
- Any changes or corrections have been initialed/signed and dated by the ordering physician
- Physician's signature meets **CMS Signature Requirements** <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf>

**Delivery Documentation**

- Beneficiary's name
- Delivery address
- Quantity delivered
- A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number.
- Delivery date
- Signature of person accepting delivery
- Relationship to beneficiary

**Medical Records**

The medical records support that the beneficiary meets all of the criteria in one of the situations listed below.



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#### Situation A

Multiple (more than one) stage II pressure ulcers located on the trunk or pelvis AND Beneficiary has been on a comprehensive ulcer treatment program for at least the past month (minimum of 30 days) which has included all of the following:

- 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; and
- Use of an appropriate group 1 support surface. AND

The ulcers have failed to improve over the past month (minimum of 30 days).

OR

#### Situation B

Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis.

OR

#### Situation C

Recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis; and

The beneficiary was discharged from a hospital or nursing facility within the past 30 days; and  
The beneficiary was on a group 2 or 3 support surface immediately prior to the above discharge.

**NOTE:** Coverage following a myocutaneous flap or skin graft is generally limited to 60 days from the date of surgery.

Medical records concurrent with the date of service under review support continued use of a group 2 support surface (see Related Clinical Information and Documentation Supporting Continued Use – Continued Medical Need)

Signature(s) meets **CMS Signature Requirements** <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf>

#### Related Clinical Information

If the beneficiary is on a group 2 surface, there should be a care plan established by the physician or home care nurse which includes the elements of a comprehensive ulcer treatment program listed under Situation A.

#### Documentation Supporting Continued Medical Need

- Continued use of a group 2 support surface is covered until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is medically necessary for wound management.
- Appropriate use of the KX modifier is the responsibility of the supplier. The supplier should maintain adequate communication on an ongoing basis with the clinician providing the wound care in order to accurately determine that use of the KX modifier still reflects the clinical conditions which meet the criteria for coverage of a group 2 support surface, and that adequate documentation exists in the medical record reflecting these conditions.

### REMINDERS

- Suppliers must only add a KX modifier if the criteria in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the policy have been met. If the requirements



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for the KX modifier are not met, the KX modifier **must not** be used. This information must be available upon request.

- If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier **must** be added to the code. When there is an expectation of a medical necessity denial, suppliers **must** enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.
- Claim lines billed without a KX, GA, or GZ modifier will be **rejected** as missing information.
- Items with no physician or other licensed health care provider order must be submitted with an "EY" modifier added to each affected HCPCS code.

### ONLINE RESOURCES

- **Support Surface Resources**
  - **JB:** <https://www.cgsmedicare.com/jb/mr/ssr.html>
  - **JC:** <https://www.cgsmedicare.com/jc/mr/ssr.html>
- **DME MAC Supplier Manual**
  - **JB:** <https://www.cgsmedicare.com/jb/pubs/supman/index.html>
  - **JC:** <https://www.cgsmedicare.com/jc/pubs/supman/index.html>

**NOTE:** It is expected that the beneficiary's medical records will reflect the need for the care provided. These records are not routinely submitted to the DME MAC but must be available upon request. Therefore, while it is not a requirement, it is a recommendation that suppliers obtain and review the appropriate medical records and maintain a copy in the beneficiary's file.

### DISCLAIMER

This document was prepared as an educational tool and is not intended to grant rights or impose obligations. This checklist may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either written law or regulations. Suppliers are encouraged to consult the *DME MAC Supplier Manual* and the Local Coverage Determination/Policy Article for full and accurate details concerning policies and regulations.