Commonwealth Home Health Care

Home Medical Equipment, Products and Services

Face-to-Face Notes

Guidelines for the Most Frequently Referred Medical Equipment

Semi-Electric Hospital Beds

The prescription for an *Semi-Electric Hospital Bed* must include: patient's name, physician's name, physician's NPI, date of the order and start date (if different), detailed description of the item *(specify if you want rails—one side or both sides of the bed)*, physician's signature, signature date and length of need.

Face-to-Face Notes for *Semi-Electric Hospital Bed* must state why it is medically necessary, why the patient requires frequent or immediate positioning of the body that cannot be accomplished with an ordinary bed. For example "Patient requires semi-electric hospital bed because patient must be quickly elevated more than 30 degrees due to (CHF, COPD or problems with aspiration) so that patient does not aspirate, etc." or "Semi-electric hospital bed is needed so that patient's body position can be changed frequently for pain management due to _____" or "Semi-electric hospital bed is required because the patient is not able to position himself/herself for feeding/grooming, etc and to prevent bedsores."

If a *trapeze bar* is required this must be explained in the notes as well... "Trapeze bar is needed to assist patient with changes in position and with getting in and out of bed."

Pressure Pad Alternating with Pump (App Pump and Pad) or Gel Pressure Pad for Mattress

The prescription for an *Pressure Pad Alternating with Pump (App Pump & Pad) or Gel Pressure Pad for Mattress* must include: patient's name, physician's name, physician's NPI, date of the order and start date (if different), detailed description of the item, physician's signature, signature date and length of need.

Face-to-Face Notes for Pressure Pad Alternating with Pump *(App Pump & Pad) or Gel Pressure Pad for Mattress* must state why it is medically necessary, whether the patient is completely immobile or has limited mobility or a pressure ulcer and impaired nutritional status, fecal or urinary incontinence, altered sensory perception or compromised circulatory status. For example: *"Patient has limited ability to change positions and cannot independently judge when to make changes in his/her body position to relieve pressure due to altered sensory perception"* or *"Gel pressure pad for mattress is needed for the healing of stage 1 decubitus ulcer of the ____ , patient also has compromised circulatory status"* or *"Patient is completely immobile and requires Pressure Pad Alternating with Pump for prevention of bed sores"* or *"Patient needs a gel pressure pad for mattress because of inability to change position in bed and has impaired nutritional status."*

Cane, Walker or Rollator

The prescription for *Cane, Walker or Rollator* must include: patient's name, physician's name, physician's NPI, date of the order and start date (if different), detailed description of the item, physician's signature, signature date and length of need.

Face-to-Face Notes for *Cane, Walker or Rollator* must state why it is medically necessary, what mobility limitation significantly impairs their ability to complete one or more MRADL and if ordering walker, why a cane is not sufficient. For example: "Due to arthritis of the knees, patient can only walk ____ feet unassisted, making it difficult for patient to get to the bathroom, fix his/herself something to eat, etc., a cane would not provide enough support to hold patient up" or "Patient is at increased risk of falls due to dizziness from _____ and requires the use of a cane/walker/rollator for stability so he/she can complete MRADL's." When ordering a Rollator, specify walker with wheels, seat and brakes.

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Commonwealth Home Health Care is Joint Commission Accredited (JCAHO) for Equipment Management and Clinical Respiratory Services.

Commonwealth Home Health Care, Inc.

Making Patient Care Personal!

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Bedside Commode

The prescription for a *Bedside Commode* must include: patient's name, physician's name, physician's NPI, date of the order and start date (if different), detailed description of the item, physician's signature, signature date and length of need.

Notes for *Bedside Commode* must state why the beneficiary is physically incapable of utilizing regular toilet facilities, for example: "Patient is confined to bedroom, unable to walk to the bathroom due to (diagnosis)" or "Due to (diagnosis or condition) patient is confined to the bottom level of the home and cannot make it up the stairs, the bathroom is located on the top floor" or "The patient lives in an old home in which there is no inside bathroom, the patient is unable to walk to the outside bathroom due to (diagnosis or condition)."

Standard Manual Wheelchair

The prescription for a *Standard Manual Wheelchair* must include: patient's name, physician's name, physician's NPI, date of the order and start date (if different), detailed description of the item, physician's signature, signature date and length of need.

Notes for a Standard Manual *Wheelchair* must state why the wheelchair is medically necessary, what physical limitations does the patient have in his/her home without the wheelchair, have cane and/or walker been tried and why they do not sufficiently resolve the patient's mobility issues, for example "Patient requires a standard manual wheelchair in order to complete MRADLs due to (list diagnoses). Without wheelchair patient is only able to ambulate (__ feet). A cane does not provide enough support and stability. Patient was previously using a walker, however it has become increasingly difficult for the patient to hold himself/herself up with the walker due to her the weakness in his/her arms (or due to unstable legs, etc.)"

Oxygen

The prescription for *Oxygen* must include: patient's name, physician's name, physician's NPI, date of the order and start date (if different), detailed description of the item, physician's signature, signature date and length of need.

Face-to-Face Notes for *Oxygen* must state why it is medically necessary, whether the patient has a severe lung disease or hypoxia-related symptoms that are expected to improve with oxygen therapy, and alternative treatment measures that have been tried or considered and deemed clinically ineffective. Medicare policies require patients to be in a chronic stable state during F@F visit and testing.

Test results for oxygen during sleep only can be either an overnight oximetry showing 88 % or below for 5 minutes total or an ABG 55 mm or below. If portables are being ordered the test must be done during the day: an ABG 55 mm or below or pulse oximetry oxygen saturation at or below 88 percent taken at rest (awake), or oxygen saturation at or below 88 percent, taken during exercise. *If the patient is qualified during exercise, three oxygen saturations must be documented: oxygen saturation at rest on room air, then oxygen saturation during exercise on room air and then oxygen saturation on oxygen showing that oxygen therapy improves patient's oxygen saturation.*

Please contact us with any questions you may have about medical equipment referrals.

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Trained personnel are on-call and available for emergencies 24 hours a day, seven days a week, 365 days a year.

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