



GROUP 2 PRESSURE REDUCING SUPPORT SURFACE (PRSS)

REQUIRED DOCUMENTATION

Standard Written Order

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
Order date
General description of the item
The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (List each separately).
Quantity to be dispensed, if applicable
Any changes or corrections have been initialed/signed and dated by the ordering practitioner
Treating Practitioner Name or NPI
Treating practitioner's signature
Treating practitioner's signature meets CMS Signature Requirements https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf

Delivery Documentation

Table with 3 columns: Direct Delivery, Shipped/Mail Order Tracking Slip, and Shipped/Mail Order Return Post-Paid Delivery Invoice. Each column lists required documentation items such as beneficiary name, address, quantity, and shipping details.

NOTE: If a supplier utilizes a shipping service or mail order, suppliers have two options for the DOS to use on the claim:

- 1. Suppliers may use the shipping date as the DOS. The shipping date is defined as the date the delivery/shipping service label is created or the date the item is retrieved by the shipping service for delivery. However, such dates should not demonstrate significant variation.
2. Suppliers may use the date of delivery as the DOS on the claim.

Medical Records

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



DOCUMENTATION CHECKLIST

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Situation A

Multiple (more than one) stage 2 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 3 or 4 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 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 treating practitioner 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 "Coverage Indications, Limitations and/or Medical Necessity" section of the policy have been met. If the requirements 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 "Coverage Indications, Limitations and/or Medical Necessity" section have not been met, the GA or GZ modifier **must** be added to the code. When there



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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>
- **Condition of Payment Required Prior Authorization Program**
 - **JB:** <https://www.cgsmedicare.com/jb/mr/prsspa.html>
 - **JC:** <https://www.cgsmedicare.com/jc/mr/prsspa.html>
- **Pressure Reducing Support Surfaces - Group 2 LCD and Policy Article**
 - **JB:** <https://www.cgsmedicare.com/jb/coverage/lcdinfo.html>
 - **JC:** <https://www.cgsmedicare.com/jc/coverage/lcdinfo.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.