Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

AIR FLUIDIZED AND LOW AIR LOSS BED CERTIFICATION OF MEDICAL NECESSITY

SECTION A: CLIENT / SUPPLIER INFORMATION (COMPLETED BY SUPPLIER)	
Client Name:	Supplier Name:
Client Medicaid Number:	Nurse Consultant:

SECTION B: INITIAL EVALUATION (COMPLETED BY NURSE CONSULTANT)					
Date Placed on Bed Unit:			Location Home Nursing Facility		
Brand / Model:			Date Skin Breakdown First Noticed:		
Name of Nursing Facility					
Previous Treatment Tried, But Ineffective					
Pressure Reduction Device(s) Used – Bed:					
Pressure Reduction Device(s) Used – Chair:					
Has Client Used Air Fluidized / Low Air Loss Bed Prior to Placement				Yes	No
If Yes, Date / Location / Outcome:					
Dietary Consult Date:			Recommended Caloric Intake:		
Initial Serum Albumin Testing	Level:		Date of Test:		
Special Dietary Measures (IV, NG, Supplements, etc.)					
Contractures	None	1 Extremity	2 Extremities	3+ Extremities	
Mobility	Ambulates Independently	Ambulates w/Assistance	Able to Reposition	Chair Confined	Bed Confined
Incontinence	Never	Occasionally	Urine Only	Urine / Fecal	
Hydration	Good Turgor	Poor Turgor	Skin Supple	Skin Dry	

RN Consultant Signature	Date	Telephone Number

SECTION C: INITIAL PHYSICIAN ORDER (SIGNED BY PHYSICIAN)						
Type of Bed Ordered:		Air Fluidized		Low Air Loss		
ICD-10 Diagnosis:		Date of Surgery:				
I Last Examined This Client for This Condition On:						
Prognosis for Wound Healing	Excellent	Good	Fair	Poor		
Expected Total Length of Need of Bed (Months)	<1	2	3	4	5	
Coexisting Condition(s)	Absent	Controlled	Moderate	Advanced		
Specify Condition(s)						
I Certify the Medical Necessity of This Item						
	Physician Signature			Date		

SECTION D: CLIENT STATUS AND WEEKLY WOUND DESCRIPTIONS (COMPLETED BY NURSE CONSULTANT)

		Location #1:				**Location #2:**			
Week	Date	Stage	LxWxD	Undermining	% Slough and / or Escar	Stage	LxWxD	Undermining	% Slough and / or Escar
1									
2									
3									
4									

Treatment/Diet Changes	
Comments	

Is Prevention or "Step-Down" Established	Yes	No

Physician Signature	Date	Nurse Consultant Signature	Date

		Location #1:				**Location #2:**			
Week	Date	Stage	LxWxD	Undermining	% Slough and / or Escar	Stage	LxWxD	Undermining	% Slough and / or Escar
5									
6									
7									
8									

Treatment/Diet Changes	
Comments	

Is Prevention or "Step-Down" Established	Yes	No

Physician Signature	Date	Nurse Consultant Signature	Date

		Location #1:				**Location #2:**			
Week	Date	Stage	LxWxD	Undermining	% Slough and / or Escar	Stage	LxWxD	Undermining	% Slough and / or Escar
9									
10									
11									
12									

Treatment/Diet Changes	
Comments	

Is Prevention or "Step-Down" Established	Yes	No

Physician Signature	Date	Nurse Consultant Signature	Date

		Location #1:				**Location #2:**			
Week	Date	Stage	LxWxD	Undermining	% Slough and / or Escar	Stage	LxWxD	Undermining	% Slough and / or Escar
13									
14									
15									
16									

Treatment/Diet Changes	
Comments	

Is Prevention or "Step-Down" Established	Yes	No

Physician Signature	Date	Nurse Consultant Signature	Date

		Location #1:				**Location #2:**			
Week	Date	Stage	LxWxD	Undermining	% Slough and / or Escar	Stage	LxWxD	Undermining	% Slough and / or Escar
17									
18									
19									
20									

Treatment/Diet Changes	
Comments	

Is Prevention or "Step-Down" Established	Yes	No

Physician Signature	Date	Nurse Consultant Signature	Date

COMPLETION INSTRUCTIONS FOR FORM MS-80

SECTION A: CLIENT / SUPPLIER INFORMATION (COMPLETED BY SUPPLIER)

Client: Enter Client's Full Name
Supplier: Enter Supplier's Name
Client's Medicaid Number: Enter Client's 11-Digit Medicaid Number
Nurse Consultant: Enter Name of Supplier's RN Consultant Responsible for Weekly On-Site Visits and Evaluation

SECTION B: INITIAL EVALUATION (COMPLETED BY NURSE CONSULTANT)

Date Placed on Bed Unit: Enter the date the client was placed on the bed
Location: Check the box which indicates the location of the bed
Brand/Model: Enter the brand and model of the bed placed
Name of Nursing Facility: If the bed unit is located in a nursing facility, enter the name of the facility
Date Skin Breakdown First Noticed: Enter the date the skin breakdown was first noticed by the client and/or caregiver
Previous Treatment Tried, But Ineffective: Describe all treatment used and measures taken to treat the skin breakdown prior to placement of the bed
Pressure Reduction Device(s) Used – Bed: List the products used for pressure reduction prior to placement of the bed
Pressure Reduction Device(s) Used – Chair: List the products used for pressure reduction prior to placement of the bed
Has Client Used Air Fluidized / Low Air Loss Bed Prior This Placement: Check "Yes" or "No"
If "Yes", Date / Location / Outcome: List the dates, locations and outcomes of air fluidized / low air loss bed use prior to this placement
Dietary Consult Date: Enter the date of the initial dietary consult
Recommended Caloric Intake: Enter the recommended caloric intake determined during the initial dietary consult
Initial Serum Albumin Testing: Enter the level and date of the initial serum albumin testing
Special Dietary Measures (IV, NG, Supplements, etc.): Enter dietary measures recommended during the initial dietary consult
Contractures: Check the box which describes the existence and type of contractures present
Mobility: Check the box(s) which describes the client's ability to ambulate and / or reposition
Incontinence: Check the box which describes the client's incontinence status
Hydration: Check the box which describes the client's hydration status
RN Consultant Signature and Date: Form MS-80 must be signed and dated by the supplier's RN Consultant responsible for weekly on-site visits and evaluation
Telephone Number: Enter the telephone number at which the RN Consultant can be reached

SECTION C: INITIAL PHYSICIAN ORDER (SIGNED BY PHYSICIAN)

Type of Bed Ordered: Check the box which indicates the type of product ordered
ICD-10 Diagnosis: Enter the current ICD-10 Diagnosis
Date of Surgery: Enter the date of myocutaneous flap or skin graft surgery, if applicable
I last examined this Client for this Condition On: Enter the date the client was last seen by the physician

Prognosis for Wound Healing: Check the box which indicates the expectation for this client's wound healing
Expected Total Length of Need: Check the box which indicates the expected total length of need for air fluidized / low air loss bed
Coexisting Condition(s): Check the box which describes coexisting conditions which may affect wound healing
Specify Condition(s): If coexisting conditions are present, list the condition(s)
Physician Signature and Date: Form MS-80 must be signed and dated by the physician prescribing the equipment

SECTION D: CLIENT STATUS AND WEEKLY WOUND DESCRIPTIONS (COMPLETED BY NURSE CONSULTANT)

Location: Describe the location of the primary wound site under "Location #1" and the secondary site under "Location #2". Use separate forms to report additional sites. For each site, complete the following on a weekly basis:

- **Date:** Enter the date of RN Consultant on-site visit and wound measurements
- **Stage:** Enter the stage of the wound
- **L x W x D:** Enter the measurements (length, width and depth) of the wound
- **Undermining:** Enter the location and depth of undermining
- **% Slough and / or Escar:** Enter the percent of slough and / or Escar

Treatment / Diet Conditions: Describe any changes to the information provided on the initial evaluation or physician order (Section B or C) including changes in treatment, dietary intake / recommendations, patient status, etc.
Comments: List any information pertinent to the client's condition, wound healing, etc.
Is Prevention or "Step-Down" Plan Established: Check "Yes" or "No" to indicate if a plan has been developed to address prevention and / or continued wound healing once the client is no longer on the bed unit. Plan of care must be established by the end of the first four weeks of bed use
Physician Signature and Date: Form MS-80 must be signed and dated by the physician prescribing the equipment
RN Consultant Signature and Date: Form MS-80 must be signed and dated by the Supplier's RN Consultant responsible for weekly on-site visits and evaluation

DISTRIBUTION: The Supplier must maintain a copy of Form MS-80 in their records