Clinical indications and intake qualifications for group 2 and group 3 support surfaces

Wound Stage	Clinical Indications and documentation requirements	Medicare Group 2	Medicare Group 3	Managed Care Group 2	Managed Care Group 3
Multiple Stage 2 Pressure Injury (PI) on the trunk or pelvis					
	Not progressing after 30 day conservative treatment plan and use of a Group 1 support surface.	●		●	
	Plan includes: regular assessment by HCP; turning and repositioning; management of moisture/incontinence; appropriate wound care; nutritional assessment and care plan.	●		●	
Large or Multiple Stage 3 or 4 PI on the trunk or pelvis		●			
Myocutaneous or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days		●			
	Been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.				
Stage III (full thickness tissue loss) or Stage IV (deep tissue destruction) PI					
	30 day conservative treatment; wounds worsened or remained the same.				
Conservative Treatment Plan	Frequent repositioning with particular attention to relief of pressure over bony prominences (Q2 hrs.)		●		●
	Use of a Group 2 support surface to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation.		●		●
	Necessary treatment to resolve any wound infection.		●		●
	Optimization of nutrition status to promote wound healing.		●		●
	Debridement by any means, including wet-to-dry gauze dressings, to remove devitalized tissue from the wound bed.		●		●
	Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals.		●		●
	Education of the beneficiary and caregiver on the prevention and management of pressure ulcers		●		●
	Assessment by a physician, nurse, or other licensed healthcare practitioner, at least weekly.		●		●
	Appropriate management of moisture/incontinence.		●		●
	Bedridden or chair bound due to severe limited mobility.	●	●		●
	A trained adult caregiver is available to assist the patient with Activities of Daily Living (ADLS).		●		●
	Plan of care outlined in the physician's note for initial placement and monthly recertification.		●		●
	In the absence of the air-fluidized bed institutionalization would be required.		●		●
	Signed Detailed Physician's Order (prescription).	●	●	●	●
	Wound Care Progress Note completed and signed by Physician.	●	●	●	●
	Letter of Medical Necessity (LMN).				●

Documentation: Progress/nursing notes must be sent to the supplier prior to delivery. Include notes from the prior 30 days and the most current progress notes. Notes should include an assessment of the patient and wound. Physician and nursing documentation should include the following:

- The current support surface in use.
- Nutritional plan – be specific about the type of diet, supplements or instructions provided to the patient.
- Management of incontinence, if present.
- Turning and repositioning schedule provided to the patient and assessment of compliance.
- Wound bed assessment and treatment goals.
- Education to patient and caregiver on prevention and treatment of pressure ulcers.
- Treatment objective for air fluidized therapy in the healing process and prevention of new wounds.

This criteria should be re-evaluated monthly by the clinician and documented in the patient's medical record. It must be sent to the supplier each month to continue support surface therapy.

OutcomesMatter™ Resource Team

Therapy Consultants

- Help assess patient needs to align support surface to clinical treatment goals.
- Set therapy expectations with patient and caregiver.
- Initiate monthly review with the clinical team to help advance wound healing.
- Serve as a resource for staff and patient education.

Client Navigators

- Coordinate delivery, follow-up and product discharge with the clinician, caregiver and patient.
- Help with payer documentation requirements.
- Track wound progress monthly and review progress to plan with our clinicians and medical director while the patient is on the support surface.

Technical Specialists

- Highly trained technicians to deliver and set-up therapy.
- Provide patient and caregiver education to ensure safe product use.
- Serve as a resource for product questions or service needs.

Contact **Ethos™ Therapy Solutions** to start the healing today at **888-861-8612**.

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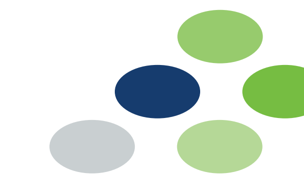
OutcomesMatter™ Clinical Resource Guide

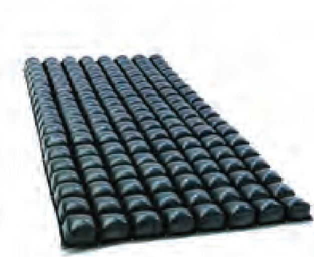


Learning tool

Quality products to help meet treatment goals

Group 2 Therapy Surfaces

Overlays and mattress replacements



E0371 ROHO® SOFFLEX® 2

E0277 Protekt® Aire 4000DX

E0277 Lumex® LS200

Group 3 Therapy Surfaces

E0194 Airus™ A210
Air Fluidized Therapy

E0194 Clinitron® Rite Hite®
Air Fluidized Therapy

E0194 Clinitron® At Home®
Air Fluidized Therapy

Emerg®
Auto-Emersiontherapy™

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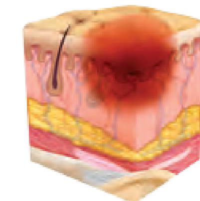
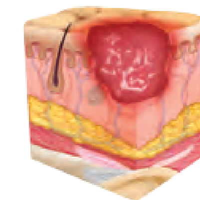
Pressure injury staging

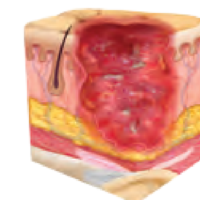
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.



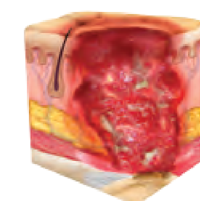
Stage 1: Non-blanchable erythema of intact skin
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.



Stage 2: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).



Stage 3: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.



Stage 4: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Definitions Adapted from NPUAP Pressure Injury Stages, 2016. Illustrations by permission, www.NPUAP.org

Wound assessment checklist

Pressure injury documentation should occur on admission, at least weekly and with any signs of deterioration.

Location
Document using correct anatomical terms; use an anatomical figure or diagram of the body to note wound location.

Wound Size
Length and Width: measure the greatest head to toe *length* and the greatest side to side *width* perpendicular (90-degree angle) to each other.
Depth: use a cotton tip applicator into the deepest part of the wound *depth*, mark it, then remove and measure upon removal. Calculate length x width x depth = wound volume.
Undermining/tunneling: Measure using a sterile, moistened cotton-tipped applicator; mark it; then measure the length upon removal. Using the hands of a clock (the head is 12 o'clock) document the location.

Wound Color
Include a description of the color of the wound bed (red, yellow, black, tan) and distinguish percent of viable from non-viable tissue and percent of granulation, epithelial, slough or eschar.

Peri-Wound
Assessment includes color, temperature, and integrity of surrounding skin. Descriptions of the peri-wound may include: intact, erythematous, edematous, induration, discolored, moist, dry, warm or cool.

Exudate
Assessment includes the amount, color, consistency and odor.
- *Color of exudate:* clear or yellow; pink or red; green or brown
- *Type of exudate:* may be of mixed consistency; Description includes – serous (clear fluid); sanguinous (pink or bloody); purulent (inflammatory cells and tissue debris); Amount – none, small (covers less than 33% of the dressing); moderate (covers less than 67% of the dressing); large (covers more than 67% of the dressing).
- *Odor:* present or not present.

Wound Bed Tissue
Indicator of the phase and progress of wound healing. Assessment and documentation include the color, type, amount and degree of moisture present in the wound.
Descriptions: *Color* - pink, red, yellow, black or brown
Type and percent of tissue - epithelialization, granulation or necrotic tissue.
Moisture - moist or dry.

Dressings
Identify the product name or category of the primary and secondary dressings and the treatment objective.

Support Surface Therapy
Identify the product category (Group 1, 2 or 3) of the surface. Include the name of the chair cushion and bed frame in use.

Baranoski, S. & Ayello, E. Wound Care Essentials: Practice Principles. 4th Ed., Wolters-Kluwer, 2016.