

# Pressure Reducing Support Surfaces – Group II

For any item to be covered by The Health Plan, it must:

1. Be eligible for a defined Medicare or The Health Plan benefit category
2. Be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
3. Meet all other applicable Medicare and/or The Health Plan statutory and regulatory requirements

For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity. *Please refer to individual product lines certificates of coverage for possible exclusions of benefit.*

For an item to be covered by The Health Plan, the supplier must receive a written, signed, and dated order before a claim is submitted to The Health Plan. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

Suppliers are to follow The Health Plan requirements for precertification as applicable.

Group II support surfaces, specialty mattresses require precertification.

E0371 and E0373 require Pricing, Data Analysis and Coding Contractor (PDAC) review

<b>National Coverage Determination Policy</b>	CMS Publication 100-3 Medicare National Coverage Determinations Manual, Chapter 1, Section 280.1
<b>Local Coverage Determination Policy</b>	Jurisdiction B-C
<b>Effective Date</b>	For service performed on or after 10/31/13
<b>Revision/Review Date</b>	01/19, 11/18, 06/06/18, 07/01/17, 09/01/16, 09/16/14
<b>The Health Plan</b>	Plans will follow Coverage Determination posted on the CGS website unless otherwise indicated in sections of this policy, contractual agreements, or benefit plan documents.

## DESCRIPTION

As defined by the National Pressure Ulcer Advisory panel, "A support surface is a specialized device for pressure redistribution, designed for the management of tissue loads, micro-climate, and/or other therapeutic functions, (i.e., any mattresses, integrated bed systems, mattress replacement, overlay or seat cushion, or seat cushion overlay).(1)

## COVERAGE GUIDELINES

A Group II support surface is covered if the member meets clear documentation which justifies the medical necessity for the item in the individual case.

- A. Criterion 1 and 2 and 3, or
- B. Criterion 4, or
- C. Criterion 5 and 6.
  - 1. Multiple Stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02 - 707.05).
  - 2. Member has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate Group I support surface.
  - 3. The ulcers have worsened or remained the same over the past month.
  - 4. Large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis.
  - 5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) The patient has been on a Group II or III support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

The comprehensive ulcer treatment described in # 2 above should generally include:

- i. Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
- ii. Regular assessment by a nurse, physician, or other licensed health care practitioner (usually at least weekly for a patient with a Stage III or IV ulcer).
- iii. Appropriate turning and positioning.
- iv. Appropriate wound care (for a Stage II, III, or IV ulcer).
- v. Appropriate management of moisture/incontinence.
- vi. Nutritional assessment and intervention consistent with the overall plan of care.

If the member is on a Group II surface, there should be a care plan established by the physician or home care nurse which includes the above elements. The support surface provided for the member should be one in which the member does not "bottom out."

When a Group II surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

Continued use of a Group II 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 II support surface is medically necessary for wound management.

**Appropriate documentation should be submitted at time of precertification. If required documentation is not submitted, the referral may be pended or denied.**

In cases where a Group II product is inappropriate, a Group I or III support surface could be covered if coverage criteria for that group are met.

## **REPAIR, REPLACEMENT AND REASONABLE USEFUL LIFETIME**

Replacements and repairs require precertification. See **Replacement and Repair** policy.

Repairs are not separately payable during rental period.

Replacements are not covered due to neglect or misuse.

Please refer to The Health Plan DME POS Authorization and Compensation Guide for RUL expectations of items listed in this policy.

## CODING INFORMATION

**CPT/HCPCS codes: The appearance of a code in this section does not necessarily indicate coverage.**

### HCPCS MODIFIERS

<b>EY</b>	NO PHYSICIAN OR OTHER LICENSED HEALTH CARE PROVIDER ORDER FOR THIS ITEM OR SERVICE
<b>GA</b>	WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYOR POLICY, INDIVIDUAL CASE.
<b>GZ</b>	ITEM OR SERVICE EXPECTED TO BE DENIED AS NOT REASONABLE AND NECESSARY
<b>KX</b>	REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET

### HCPCS CODES

<b>E0193</b>	POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)
<b>E0277</b>	POWERED PRESSURE-REDUCING AIR MATTRESS
<b>E0371</b>	NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH, AND WIDTH
<b>E0372</b>	POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH, AND WIDTH
<b>E0373</b>	NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS
<b>E1399</b>	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

**For a listing of ICD-10 Codes that Support Medical Necessity Go To:**

<https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33642&ContrID=140>

**The presence of an ICD-10 code listed in the previous link is not sufficient by itself to assure coverage. Refer to coverage and billing guidelines for other coverage criteria and payment information.**

## DOCUMENTATION REQUIREMENTS

For the purposes of this policy, it is expected that the medical record will support the need for the care provided. It is generally understood that the medical record includes the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports.

This documentation must be available with precertification.

Medicare has made changes to its requirements for dispensing orders, detailed written orders, and proof of delivery. The Health Plan will require the following:

1. Physician detailed written order. Order must include the following:
  - a. Member's name
  - b. Date
  - c. Description of item. The medical record must contain the information that supports the request for each item, and must be submitted with the precertification, if the item requires precertification, or with the claim, if no precertification was required.
  - d. Order must include diagnosis code.
  - e. Physician signature with date. Date stamps are not appropriate.
  - f. Quantity of items required and duration: A new order is required if there is an increase in the quantity of the supply used per month and/or the type of supply used.

The supplier is to contact The Health Plan in this instance to update referral

2. There must be documentation in the supplier's records to support the medical necessity of that item. This information must be available upon request usually with precertification per The Health Plan policy.
3. Proof of delivery to be kept on file by the provider of the item.

**Note:** If templates or forms are submitted, (e.g. a Medicare Certificate of Medical Necessity, and/or a provider created form), and all of the required information is not included, The Health Plan reserves the right to request the medical record, that may include, but not limited to, the physician office notes, hospital and nursing facility records, home health records.

**Note:** Template provider forms, prescriptions, and attestation letters are not considered part of the medical record, even if signed by the ordering physician.

#### **PRESSURE SUPPORT SURFACE PROVIDED TO MEMBER WHILE IN PART A COVERED STAY**

Reimbursement for pressure support devices provided to a member while the member is covered in a Part A facility (hospital, inpatient acute rehabilitation, or long-term acute care facility,) will be included in the facility reimbursement, if the device is intended for use while the member is in the facility for inpatient treatment or rehabilitation. In order for it to be billed separately, it must be given two days or less before discharge from a Part A covered stay and it must meet the above guidelines and be medically necessary for home use.

Reimbursement for a pressure support surface provided while a member is in a SNF receiving a Part A service, will be reimbursed according to individual facility contracts. In order for it to be billed separately, it must be given two days or less before discharge from a Part A covered stay and it must meet the above guidelines and be medically necessary for home use.

**EQUIPMENT RETAINED FROM A PRIOR PAYOR:**

The Health Plan will not pay in excess of the contracted purchase price for any item in this policy. If the provider is seeking payment from The Health Plan, the item must be precerted and The Health Plan will pay the remaining rental months up to purchase price- if member meets guidelines above.

**BILLING GUIDELINES**

When mattresses are provided with hospital beds (codes E0250, E0255, E0260, E0265, E0290, E0292, E0294, E0296, E0303, E0304, E0328, and E0290) are provided to a member who already has a Group II Pressure Support (E0277, E0373) the hospital bed will be denied. Per Medicare, Group II support mattresses indicated in this policy are considered same/ similar item with a hospital bed and mattress.

Group II support surfaces which do not meet the characteristics specified in the definition section should be coded using code E1399.

Either alternating pressure mattresses or low air loss mattresses are coded using code E0277.

Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product).

For example, a product with 3 in. powered air cells on top of a 3 in. foam base would be coded as a powered overlay (E0181), not as a powered mattress (E0277).

Please refer to like or similar billing guidelines with E0277, E0373 and hospital beds. Hospital bed with a mattress will be denied if provided to member while the renting of E0277 or E0373. The Health Plan will not reimburse both items at the same time.

Provider may bill a hospital bed without a mattress E0251, E0256, E0261, E0266, etc.... and a support surface E0277 and E0373.

Codes E0193, E0277, E0371, E0372, and E0373 include bariatric devices.

**KX, GA, and GZ MODIFIERS**

Suppliers may submit a claim with a KX modifier only if all the criteria for that item are met.

If the coverage criteria are not met, the GA or GZ modifier must be used. When there is an expectation of a medical 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.

**ADVANCED BENEFICIARY NOTICE**

The Health Plan expects providers to follow the Medicare policy on ABN across all Medicare, Medicaid, and Commercial plans.

**NOTE:** Providers may be held financially responsible if they furnish the above items without notifying the member, verbally and in writing, that the specific service being provided is not covered. This must be done prior to the dispensing of the device. The provider must submit the waiver or ABN to The Health Plan with the claim showing the member agreed to pay for the device. Generalized statements on waivers or ABN are not acceptable.

## PRICING, DATA ANALYSIS, AND CODING (PDAC)

The Health Plan has implemented use of Medicare’s PDAC contractor for review of authorizations. Suppliers should contact the PDAC contractor for guidance on the correct coding of these items. [dmepdac.com/](http://dmepdac.com/)

The only products that may be coded and billed using code E0371 or E0373 are those products for which a written coding determination specifying the use of these codes has been made by the PDAC.

## MEDICARE DEFINITIONS AND DESCRIPTION

**Suspected Deep Tissue Injury** - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

The staging of pressure ulcers used in this policy is as follows:

<b>Stage I</b>	Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
<b>Stage II</b>	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
<b>Stage III</b>	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
<b>Stage IV</b>	Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

**Unstageable** - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.

Bottoming out is the finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. This bottoming out criterion should be tested with the patient in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30°), and in the side lying position.

Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following:

1. An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, and
2. Inflated cell height of the air cells through which air is being circulated is 5 in. or greater, and

3. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out, and
4. A surface designed to reduce friction and shear, and
5. Can be placed directly on a hospital bed frame.

Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above.

Code E0371 describes an advanced nonpowered pressure-reducing mattress overlay which is characterized by all of the following:

1. Height and design of individual cells which provide significantly more pressure reduction than a Group I overlay and prevent bottoming out, and
2. Total height of 3 in. or greater, and
3. A surface designed to reduce friction and shear, and
4. Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group II support surfaces.

Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by all of the following:

1. An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and
2. Inflated cell height of the air cells through which air is being circulated is 3.5 in. or greater, and
3. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out, and
4. A surface designed to reduce friction and shear.

Code E0373 describes an advanced nonpowered pressure reducing mattress which is characterized by all of the following:

1. Height and design of individual cells which provide significantly more pressure reduction than a Group I mattress and prevent bottoming out, and
2. Total height of 5 in. or greater, and
3. A surface designed to reduce friction and shear, and
4. Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group II support surfaces, and
5. Can be placed directly on a hospital bed frame.

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**INTERNET LINKS AND SOURCES**

NATIONAL ULCER ADVISORY PANAL SUPPORT SURFACES STANDARD INITIATIVES TERMS AND DEFINITIONS VERSION 1/29/07 <http://npuap.org>

National Government Services website. Medical Policy Center. Durable Medical Equipment. Local Coverage Determination Pressure Reducing Support Surfaces – Group II. LCD L27009 and Article A47114 Jurisdiction B. Last accessed 11/1/18. Retrieved from <http://ngsmedicare.com>

CGS Medicare: A Celerian Group Company. Local Coverage Determination Policy. Pressure Reducing Support Surfaces. LCD L11564 and Article A35357. Jurisdiction C. Last accessed 11/1/18. Retrieved from [cgsmedicare.com/jc/coverage/lcdinfo.html](http://cgsmedicare.com/jc/coverage/lcdinfo.html)

West Virginia Medicaid Internet Provider Manual. Chapter 506. Covered Services, Limitations, and Exclusions for DME Medical Supplies. Last accessed 11/1/18. Retrieved from [dhhr.wv.gov/bms/Pages/default.aspx](http://dhhr.wv.gov/bms/Pages/default.aspx)

Face-to-Face Examination and Prescription Requirements Prior to the Delivery of Certain DME Items Specified in the Affordable Care Act DME MAC Joint Publication. Posted February 20, 2014. Last accessed 11/1/18. Retrieved from [www.cms.gov](http://www.cms.gov) › ... › Medical Review and Education

Department Health and Human Services Med Learn Matters Medicare Policy Regarding Pressure Reducing Support Surfaces. SE1014. Updated 8/27/12. Last accessed 11/1/18. Retrieved from [cms.gov/MLNMattersArticles/downloads/SE1014.pdf](http://cms.gov/MLNMattersArticles/downloads/SE1014.pdf)

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<https://www.dmepdac.com/dmeapps/>

The Health Plan Provider Procedural Manual. Payment Voucher, Section 14, Page 11