Pressure Reducing Support Surfaces – Group I

*Adopted from National Government Services website*

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 meeting coverage guidelines.

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

Group I support surfaces, specialty mattresses require precertification and codes E0185, E0188, E0189, E0194, E0197 - E0199 require physician face-to-face.

<table>
<thead>
<tr>
<th>CMS National Coverage Policy</th>
<th>CMS Publication 100-3 Medicare National Coverage Determinations Manual, Chapter 1, Section 280.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME Region LCD Covers</td>
<td>Jurisdiction B</td>
</tr>
</tbody>
</table>
| Revision/Review Effective Date | For service performed on or after 10/31/13  
Reviewed/revised: 09/01/16 |
| The Health Plan             | Will follow Oversight Region V Coverage Determination posted on the National Government Services website unless otherwise indicated in sections of this policy or contractual agreements |

**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).

**COVERAGE GUIDELINES**

These items require a written order prior to delivery.
A Group I mattress overlay or mattress (E0181 - E0189, E0196 - E0199, and A4640) is covered if the patient meets:

A. Criterion 1, or
B. Criteria 2 or 3 and at least one of criteria 4-7.
   1. Completely immobile, i.e., member cannot make changes in body position without assistance.
   2. Limited mobility, i.e., member cannot independently make changes in body position significant enough to alleviate pressure.
   3. Any stage pressure ulcer on the trunk or pelvis.
   4. Impaired nutritional status.
   5. Fecal or urinary incontinence.
   6. Altered sensory perception.
   7. Compromised circulatory status.

The support surface provided for the member should be one in which the member does not "bottom out." Bottoming out is the finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the member’s bony prominence (coccyx or lateral trochanter), can readily palpate 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.

NONCOVERAGE STATEMENT

A foam overlay or mattress, which does not have a waterproof cover, is not considered durable and will be denied as noncovered.
CODING INFORMATION

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

HCPCS MODIFIERS

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

HCPCS CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4640</td>
<td>REPLACEMENT PAD FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY PATIENT</td>
</tr>
<tr>
<td>A9270</td>
<td>NON-COVERED ITEM OR SERVICE</td>
</tr>
<tr>
<td>E0181</td>
<td>POWERED PRESSURE REDUCING MATTRESS OVERLAY/PAD, ALTERNATING, WITH PUMP, INCLUDES HEAVY DUTY</td>
</tr>
<tr>
<td>E0182</td>
<td>PUMP FOR ALTERNATING PRESSURE PAD, FOR REPLACEMENT ONLY</td>
</tr>
<tr>
<td>E0184</td>
<td>DRY PRESSURE MATTRESS</td>
</tr>
<tr>
<td>E0185</td>
<td>GEL OR GEL-LIKE PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
<tr>
<td>E0186</td>
<td>AIR PRESSURE MATTRESS</td>
</tr>
<tr>
<td>E0187</td>
<td>WATER PRESSURE MATTRESS</td>
</tr>
<tr>
<td>E0188</td>
<td>SYNTHETIC SHEEPSKIN PAD</td>
</tr>
<tr>
<td>E0189</td>
<td>LAMBSWOOL SHEEPSKIN PAD, ANY SIZE</td>
</tr>
<tr>
<td>E0196</td>
<td>GEL PRESSURE MATTRESS</td>
</tr>
<tr>
<td>E0197</td>
<td>AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
<tr>
<td>E0198</td>
<td>WATER PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
<tr>
<td>E0199</td>
<td>DRY PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
<tr>
<td>E1399</td>
<td>DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS</td>
</tr>
</tbody>
</table>

There are no specific diagnoses or ICD-10 codes that indicate medical necessity.
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. Information from the member’s medical record and the supplier must be available upon request.

PRESSURE SUPPORT SURFACE PROVIDED TO A 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. A separate claim from a DME supplier must not be submitted in
this situation. 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 code E1399 is billed, the claim must include a narrative description of the item, the manufacturer, the product name/number, and information justifying the medical necessity for the item.

Code A4640 or E0182 should only be billed when they are provided as replacement components for a patient-owned E0181 mattress overlay system.

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

<table>
<thead>
<tr>
<th>Column I</th>
<th>Column II</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0181</td>
<td>A4640, E0182</td>
</tr>
</tbody>
</table>

When the beneficiary owns or is renting a medically necessary Group I (E0184, E0186, E0187, E0196) or Group II support mattress (E0277, E0373) and a hospital bed becomes medically necessary, the hospital bed will be denied, if the item provided to the beneficiary includes a mattress (Healthcare Common Procedure Coding System (HCPCS) Codes E0250, E0255, E0260, E0265, E0290, E0292, E0294, E0296, E0303, E0304, E0328, and E0290). Previously indicated Group I and II support mattresses will be considered same/ similar item with a hospital bed and mattress.

Consideration will be made if the member’s condition changes and a different item is required (i.e., a hospital bed and a Group II support surface). However, at no time will a hospital bed with a mattress and a support surface, classified as a mattress (i.e., Group I support mattress (E0184, E0186) or Group II support mattress (E0277, E0373)) will be reimbursed at the same time.

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

**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.

Claim reimbursement is based on contract and timely filling policies of The Health Plan.

**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/)

**MEDICARE DEFINITIONS AND DESCRIPTION**

Patients needing pressure reducing support surfaces should have a care plan which has been established by the patient’s physician or home care nurse, which is documented in the patient’s medical records, and which generally should include the following:

1. Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
2. Regular assessment by a nurse, physician, or other licensed health care practitioner.
3. Appropriate turning and positioning.
4. Appropriate wound care (for a Stage II, III, or IV ulcer).
5. Appropriate management of moisture/incontinence.
6. Nutritional assessment and intervention consistent with the overall plan of care.

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

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.</td>
</tr>
<tr>
<td>Stage II</td>
<td>Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.</td>
</tr>
<tr>
<td>Stage III</td>
<td>Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.</td>
</tr>
</tbody>
</table>

Codes E0185 and E0197 - E0199 termed "pressure pad for mattress" describe nonpowered pressure reducing mattress overlays. These devices are designed to be placed on top of a standard hospital or home mattress.

A gel/gel-like mattress overlay (E0185) is characterized by a gel or gel-like layer with a height of 2 in. or greater.

An air mattress overlay (E0197) is characterized by interconnected air cells having a cell height of 3 in. or greater that are inflated with an air pump.

A water mattress overlay (E0198) is characterized by a filled height of 3 in. or greater.

A foam mattress overlay (E0199) is characterized by all of the following:

1. Base thickness of 2 in. or greater and peak height of 3 in. or greater, if it is a convoluted overlay (e.g., egg crate) or an overall height of at least 3 in., if it is a nonconvoluted overlay, and
2. Foam with a density and other qualities that provide adequate pressure reduction, and
3. Durable, waterproof cover.

Codes E0184, E0186, E0187, and E0196 describe nonpowered pressure reducing mattresses.

A foam mattress (E0184) is characterized by all of the following:

1. Foam height of 5 in. or greater, and
2. Foam with a density and other qualities that provide a adequate pressure reduction, and
3. Durable, waterproof cover, and
4. Can be placed directly on a hospital bed frame.

An air, water, or gel mattress (E0186, E0187, and E0196) is characterized by all of the following:

1. Height of 5 in. or greater of the air, water, or gel layer (respectively), and
2. Durable, waterproof cover, and
3. Can be placed directly on a hospital bed frame.

Codes E0181, E0182, and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss). They are characterized by all of the following:

1. An air pump or blower which provides either sequential inflation and deflation of 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 2.5 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 provide adequate patient lift, reduce pressure and prevent bottoming out.

A foam overlay or mattress which does not have a waterproof cover should be coded using A9270. Other Group 1 support surfaces which do not meet the characteristics specified in this section should be billed using code E1399.

Alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0181, E0182, and A4640.

AMA CPT/ADA CDT COPYRIGHT STATEMENT

CPT codes, descriptions, and other data only are copyrighted by the American Medical Association (AMA) 2009 (or such other date of publication of CPT). All rights reserved. Applicable FARS/DFARS clauses apply. Current Dental Terminology (CDT), including procedure codes, nomenclature, descriptors and other data contained therein is copyrighted by the American Dental Association (ADA) 2002, 2004. All rights reserved. Applicable FARS/DFARS apply.

INTERNET LINKS AND SOURCES


NATIONAL ULCER ADVISORY PANEL SUPPORT SURFACES STANDARD INITIATIVES TERMS AND DEFINITIONS VESION 1/29/07 npuap.org/wp-content/uploads/2012/03/NPUAP_S3I_TD.pdf

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