

Medical Policy



Pressure Reducing Support Surfaces – Group 2

▼ Description

A powered or non-powered advanced pressure reducing mattress, overlay for mattress or powered air flotation bed.

▼ Policy

Powered or non-powered advanced pressure reducing mattress, overlay for mattress or powered air flotation beds are considered **reasonable and necessary** for Members that meet coverage criteria in the Policy Guidelines below.

▼ Policy Guidelines

Coverage Criteria:

A group 2 support surface is covered if the member meets at least one of the following three Criteria (1, 2 or 3):

1. The member has multiple stage II pressure ulcers located on the trunk or pelvis (described by the diagnosis codes listed in the table below) which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program including each of the following:
 - Use of an appropriate group 1 support surface, and
 - 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
2. The member has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (described by the diagnosis codes listed in the table below),
3. The member had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days (described by the diagnosis

codes listed in the table below), and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days

If the member is on a group 2 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 beneficiary should be one in which the beneficiary does not "bottom out" (see Appendices section).

When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

When the stated coverage criteria for a group 2 mattress or bed are not met, a claim will be denied as not reasonable and necessary.

A support surface which does not meet the characteristics specified in the Coding Guidelines section of the Pressure Reducing Support Surfaces – Group 2 Policy Article will be denied as not reasonable and necessary. (See Coding Guidelines and Documentation sections concerning billing of E1399.)

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 reasonable and necessary for wound management.

▼ Coding Guidelines

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 inches 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 non-powered 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 1 overlay and prevent bottoming out, and
- 2) Total height of 3 inches 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 2 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 flower 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 inches 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 non-powered 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 1 mattress and prevent bottoming out, and
2. Total height of 5 inches 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 group2 support surfaces, and
5. Can be placed directly on a hospital bed frame.

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.

Group 2 support surfaces which do not meet the characteristics specified in the Definition section should be coded using code E1399.

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" powered air cells on top of a 3" foam base would be coded as a powered overlay (code E0180 or E0181) not as a powered mattress (E0277).

Limitations:

1. When the stated coverage criteria for a group 2 mattress or bed are not met, a claim will be denied as not medically necessary unless there is clear documentation which justifies the medical necessity for the item in the individual case.
2. 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 Member in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position.
3. The provider must obtain information concerning which, if any, of criteria 1-6 listed in the Coverage Criteria section of this policy the Member meets in a signed and dated statement from the Member's treating physician. A suggested form for collecting this information is attached. Questions pertaining to medical necessity on any form used to collect this information may not be completed by the provider or anyone in a financial relationship with the provider. This statement must be supported by information in the Member's medical record which would be available upon request. Do not submit this form unless specifically requested.
4. When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.
5. 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.
6. In cases where a group 2 product is inappropriate, a group 1 or 3 support surface could be covered if coverage criteria for that group are met.

Exclusions:

1. A support surface which does not meet the characteristics specified in the Coding Guidelines section of this policy will usually be denied as not medically necessary.

Documentation Requirements:

Items in this policy may be subject to the Affordable Care Act (ACA) 6407.

The Affordable Care Act (ACA) 6407 requires that the treating physician conduct a face-to-face examination during the six month period

preceding the written order. The documentation must be received by the provider prior to delivery for certain DME items. The documentation must describe a medical condition for which the DME is being prescribed.

▼ HCPCS Level II Codes and Description

E0193 POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)

E0277 POWERED PRESSURE-REDUCING AIR MATTRESS

E0371 NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH

E0372 POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH

E0373 NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS

▼ Related Clinical Information

The staging of pressure ulcers used in this policy is as follows (National Pressure Ulcer Advisory Panel, 2016 Revision):

Stage 1 Pressure Injury: 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 Pressure Injury: 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 (MARS), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: 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 Pressure Injury: 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.

Statement of Ordering Physician
Group 2 Support Surfaces

Patient name: _____

Policy number: _____

The information below may not be completed by the DME provider or anyone in a financial relationship with the provider.

Circle Y for Yes, N for No, D for Does not apply, unless otherwise noted.

- Y N D 1. Does the patient have multiple stage II pressure ulcers on the trunk or pelvis?
- Y N D 2. Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an alternating pressure or low air loss overlay which is less than 3.5 inches, or a non-powered pressure reducing overlay or mattress?
- Y N D 3. Over the past month, the patient's ulcer(s) has/have:
1) Improved 2) Remained the same 3) Worsened?
- Y N D 4. Does the patient have large or multiple stage III or IV Pressure ulcer(s) on the trunk or pelvis?
- Y N D 5. Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis?
If yes, give date of surgery: _____
- Y N D 6. Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility?

Estimated length of need (# of months): _____ (99=lifetime)

If none of the above apply, attach a separate sheet documenting medical necessity for the item ordered.

Physician name (printed or typed): _____

Physician signature: _____

Physician UPIN: _____

Date: _____

▼ Important Note:

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation and Northwood will use the applicable state requirements to determine required quantity limit guidelines.

Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

▼ References

Centers for Medicare and Medicaid Services, Medicare Coverage Database, National Coverage Documents; October 2015.

CGS Administrators, LLC. Jurisdiction B DME MAC, Pressure Reducing Support Surfaces – Group 2. Local Coverage Determination No. L33642; revised date October 1, 2015. Accessed December 18, 2017. Reviewed December 12, 2018.

Noridian Healthcare Solutions, LLC. Pressure Reducing Support Surfaces – Group 2. Local Coverage Determination No. L33642 Durable Medical Equipment Medicare Administrative Carrier Jurisdiction A; revised January 1, 2011. Reviewed December 12, 2018.

Applicable URAC Standard

Core 8	Staff operational tools and support
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Change/Authorization History

Revision Number	Date	Description of Change	Prepared / Reviewed by	Approved by	Review Date:
A	11-20-06	Initial Release	Rosanne Brugnoni	Ken Fasse	n/a
01		Annual Review – no changes	Rosanne Brugnoni	Ken Fasse	07-2007
02		Annual Review – no changes	Susan Glomb	Ken Fasse	12-2008
03	Jan.09	Revised: Definitions of pressure ulcer stages. Added: reference to NPUAP guidelines for pressure ulcer staging.	Susan Glomb	Ken Fasse	
04	12-22-09	Annual Review/ no changes	Susan Glomb	Ken Fasse	Dec.2009
05	12-03-10	Annual Review – No changes	Susan Glomb	Ken Fasse	Dec.2010
06	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri	
07	11-10-11	Annual Review. Added References to Policy	Susan Glomb	Dr. B. Almasri	Nov. 2011
08	12-03-12	Annual review. No changes.	Susan Glomb	Dr. B. Almasri	Dec. 2012
09	12-18-13	Annual review. No changes	Susan Glomb	Dr. B. Almasri	
10	12-3-14	Annual Review. Added: Items in this policy may be subject to the Affordable Care Act (ACA) 6407 requirements. Also added information re: E1399	Susan Glomb	Dr. B. Almasri	
11	12-3-15	Annual Review. Coverage criteria updated. References updated.	Susan Glomb	Dr. B. Almasri	
12	12-08-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	December 2016

13	12-18-17	Annual review. Revised: Pressure ulcer staging criteria per NPUAP 2016 Staging Consensus Conference	Carol Dimech	Dr. C. Lerchin	December 2017
14	12-12-18	Annual review. Updated Medicare references.	Carol Dimech	Dr. C. Lerchin	December 2018