

Medical Policy



Pressure Reducing Support Surfaces – Group 1

Description

A pressure reducing support surface is a foam overlay or mattress that provides support to prevent pressure ulcers.

Policy

Pressure reducing support surfaces are considered reasonable and necessary for Members requiring support to prevent pressure ulcers.

Policy Guidelines

The Group 1 mattress overlay or mattress (E0181-E0189, E0196-E0199, and A4640) is covered if one of the following three criteria are met:

1. The member is completely immobile – i.e., member cannot independently make changes in body position without assistance, or
2. The member has limited mobility – i.e., member cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
3. The member has any stage pressure ulcer on the trunk or pelvis and at least one of conditions A-D below.

Conditions for criteria 2 and 3 (in each case the medical record must document the severity of the condition sufficiently to demonstrate the medical necessity for a pressure reducing support surface):

- A. Impaired nutritional status
- B. Fecal or urinary incontinence
- C. Altered sensory perception
- D. Compromised circulatory status

When the coverage criteria for a group 1 overlay or mattress are not met, a claim will be denied as not medically necessary.

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 mattress 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

Medical Policy



Pressure Reducing Support Surfaces – Group 1

head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side lying position.

A support surface which does not meet the characteristics specified in the Coding Guidelines section of Policy Article will be denied as not medically necessary.

HCPCS Level II Codes and Description

A4640	Replacement pad for use with medically necessary alternating pressure pad owned by member
A9270	Non-covered item or service
E0181	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty
E0182	Pump for alternating pressure pad, for replacement only
E0184	Dry pressure mattress
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width
E0186	Air pressure mattress
E0187	Water pressure mattress
E0188	Synthetic sheepskin mattress
E0189	Lambs wool sheepskin pad, any size
E0196	Gel pressure mattress
E0197	Air pressure pad for mattress, standard mattress length and width
E0198	Water pressure pad for mattress, standard mattress length and width
E0199	Dry pressure pad for mattress, standard mattress length and width
E1399	Durable medical equipment, miscellaneous

Coding Guidelines

Codes E0185 and E0197 – E0199 termed “pressure pad for mattress” describe non-powered 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 inches or greater.

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

Medical Policy



Pressure Reducing Support Surfaces – Group 1

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

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

1. Base thickness of 2” or greater and peak height of 3” or greater if it is a convoluted overlay (e.g., egg crate) or an overall height of at least 3 inches if it is a non-convoluted 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 non-powered pressure reducing mattresses.

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

1. Foam height of 5 inches or greater, and
2. Foam with a density and other qualities that provide 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, E0196) are characterized by all of the following:

1. Height of 5 inches 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, 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 inches or greater, and

Medical Policy



Pressure Reducing Support Surfaces – Group 1

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.

Code A4640 or E0182 should only be billed when they are provided as replacement components for a member-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

Column I	Column II
E0181	A4640, E0182

Related Clinical Information:

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

1. Education of the member and caregiver on the prevention and/or management of pressure ulcers.
2. Regular assessment by a nurse, physician, or other licensed healthcare practitioner.
3. Appropriate turning and positioning.
4. Appropriate wound care (for 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 (National Pressure Ulcer Advisory Panel, 2016 Revision):

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin

Medical Policy



Pressure Reducing Support Surfaces – Group 1

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 (MARSI), 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

Medical Policy



Pressure Reducing Support Surfaces – Group 1

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.

Medical Policy



Pressure Reducing Support Surfaces – Group 1

Statement of Ordering Physician
Group 1 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.

Indicate which of the following conditions describe the patient. Circle all that apply:

1. Completely immobile – i.e. patient cannot make changes in body position without assistance.
2. Limited mobility – i.e. patient cannot independently make changes in body position significant enough to alleviate pressure.
3. Any pressure ulcer on the trunk or pelvis.
4. Impaired nutritional status.
5. Fecal or urinary incontinence.
6. Altered sensory perception.
7. Compromised circulatory status.

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: _____

Medical Policy



Pressure Reducing Support Surfaces – Group 1

Documentation Requirements

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

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.

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.

Medical Policy



Pressure Reducing Support Surfaces – Group 1

References

Centers for Medicare and Medicaid Services, Medicare Coverage Database, National Coverage Documents; October 1, 2015.

CGS Administrators, LLC. Jurisdiction B DME MAC, Pressure Reducing Support Surfaces – Group 1. Local Coverage Determination No. L33830; revised date October 1, 2015. Accessed December 18, 2017. Reviewed December 12, 2018, December 13, 2019.

Noridian Healthcare Solutions, LLC. Pressure Reducing Support Surfaces – Group 1. Local Coverage Determination No. L33830. 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:	Effective Date:
A	11-20-06	Initial Release	Rosanne Brugnoni	Ken Fasse	n/a	
01		Annual Review – no changes	Rosanne Brugnoni	Ken Fasse	01-2007	
02		Annual Review – no changes	Susan Glomb	Ken Fasse	Dec.2008	
03	12-01-09	Revised criteria for coverage of Group I mattress. Revised definitions of pressure ulcer staging. Instructions for the use of GA and GZ modifiers. Revised KX modifier.	Susan Glomb	Ken Fasse		

Medical Policy



Pressure Reducing Support Surfaces – Group 1

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	04-04-12	Added reference to NH Medicaid	Susan Glomb	Dr. B. Almasri		
09	12-3-12	Annual Review. No changes	Susan Glomb	Dr. B. Almasri	Dec 12	
10	12-18-13	Annual Review. No changes	Susan Glomb	Dr. B. Almasri		
11	12-4-14	Annual Review. Added: Items in this policy may be subject to the Affordable Care Act (ACA) 6407 requirements.	Susan Glomb	Dr. B. Almasri		
12	12-7-15	Annual Review. References updated.	Susan Glomb	Dr. B. Almasri	12-7-15	
13	12-08-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	December 2016	
14	12-18-17	Annual review. Revised: Pressure ulcer staging criteria per NPUAP 2016 Staging Consensus Conference	Carol Dimech	Dr. C. Lerchin	December 2017	
15	12-12-18	Annual review. Updated Medicare references.	Carol Dimech	Dr. C. Lerchin	December 2018	
16	12-13-19	Annual Review. No Changes.	Carol Dimech	Dr. C. Lerchin	December 2019	December 2019