# 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 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.

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
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:

**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.

**Stage I -** 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.

**Stage II -** 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.

**Stage III -** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

**Stage IV -** 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.

## 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.

## References

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

National Government Services, Inc. Jurisdiction B DME MAC, Pressure Reducing Support Surfaces – Group 1. Local Coverage Determination No. L33830; revised date October 1, 2015.

National Heritage Insurance Company (NHIC), Pressure Reducing Support Surfaces – Group 1. Local Coverage Determination No. L5067. Durable Medical Equipment Medicare Administrative Carrier Jurisdiction A. Chico, CA: NHIC; revised January 1, 2011.

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: _____

## Applicable URAC Standard

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|---|---|
| Core 8 | Staff operational tools and support |

**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 | 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 | |
| 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 |

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|---|---|---|---|---|---|
| 13 | 12-08-16 | Annual Review. No Changes. | Lisa Wojno | Dr. B. Almasri | December 2016 |