Medical Policy

Northwood

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 beneficiary 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 member 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 member should be one in which the member 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.

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 are coded based on the characteristics specified in the above definitions. Products which do not meet these definitional characteristics but meet the characteristics for another support surface grouping i.e., Group 1

support surfaces will be coded based on the characteristics specified in the Group 1 Support Surfaces policy. Products which do not meet the characteristics specified in either the Group1 or Group2 Support Surfaces policies must be coded using 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" powered air cells on top of a 3" foam base would be coded as a powered overlay (code E0181) not as a powered mattress.

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.

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 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.

ICD-10 Code	Description
L89.100	Pressure ulcer of unspecified part of back, unstageable
L89.102	Pressure ulcer of unspecified part of back, stage 2
L89.103	Pressure ulcer of unspecified part of back, stage 3
L89.104	Pressure ulcer of unspecified part of back, stage 4
L89.110	Pressure ulcer of right upper back, unstageable
L89.112	Pressure ulcer of right upper back, stage 2
L89.113	Pressure ulcer of right upper back, stage 3
L89.114	Pressure ulcer of right upper back, stage 4
L89.120	Pressure ulcer of left upper back, unstageable
L89.122	Pressure ulcer of left upper back, stage 2
L89.123	Pressure ulcer of left upper back, stage 3
L89.124	Pressure ulcer of left upper back, stage 4
L89.130	Pressure ulcer of right lower back, unstageable
L89.132	Pressure ulcer of right lower back, stage 2
L89.133	Pressure ulcer of right lower back, stage 3
L89.134	Pressure ulcer of right lower back, stage 4
L89.140	Pressure ulcer of left lower back, unstageable
L89.142	Pressure ulcer of left lower back, stage 2
L89.143	Pressure ulcer of left lower back, stage 3
L89.144	Pressure ulcer of left lower back, stage 4
L89.150	Pressure ulcer of sacral region, unstageable
L89.152	Pressure ulcer of sacral region, stage 2
L89.153	Pressure ulcer of sacral region, stage 3
L89.154	Pressure ulcer of sacral region, stage 4
L89.200	Pressure ulcer of unspecified hip, unstageable
L89.202	Pressure ulcer of unspecified hip, stage 2
L89.203	Pressure ulcer of unspecified hip, stage 3
L89.204	Pressure ulcer of unspecified hip, stage 4

ICD-10 Code	Description
L89.210	Pressure ulcer of right hip, unstageable
L89.212	Pressure ulcer of right hip, stage 2
L89.213	Pressure ulcer of right hip, stage 3
L89.214	Pressure ulcer of right hip, stage 4
L89.220	Pressure ulcer of left hip, unstageable
L89.222	Pressure ulcer of left hip, stage 2
L89.223	Pressure ulcer of left hip, stage 3
L89.224	Pressure ulcer of left hip, stage 4
L89.300	Pressure ulcer of unspecified buttock, unstageable
L89.302	Pressure ulcer of unspecified buttock, stage 2
L89.303	Pressure ulcer of unspecified buttock, stage 3
L89.304	Pressure ulcer of unspecified buttock, stage 4
L89.310	Pressure ulcer of right buttock, unstageable
L89.312	Pressure ulcer of right buttock, stage 2
L89.313	Pressure ulcer of right buttock, stage 3
L89.314	Pressure ulcer of right buttock, stage 4
L89.320	Pressure ulcer of left buttock, unstageable
L89.322	Pressure ulcer of left buttock, stage 2
L89.323	Pressure ulcer of left buttock, stage 3
L89.324	Pressure ulcer of left buttock, stage 4
L89.42	Pressure ulcer of contiguous site of back, buttock and hip, stage 2
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.45	Pressure ulcer of contiguous site of back, buttock and hip, unstageable

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:

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 sheer. 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; it's 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.

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 1, 2015

National Government Services, Inc. Jurisdiction B DME MAC, Pressure Reducing Support Surfaces – Group 2. Local Coverage Determination No. L33642; revised date October 1, 2015.

National Heritage Insurance Company (NHIC), Pressure Reducing Support Surfaces – Group 2. Local Coverage Determination No. L5068. Durable Medical Equipment Medicare Administrative Carrier Jurisdiction A. Chico, CA: NHIC; revised January 1, 2011.

Applicable URAC Standard

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	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	12-3-12	Annual Review	Susan Glomb	Dr. B. Almasri	Dec 12
09	12-18-13	Annual Review	Susan Glomb	Dr. B. Almasri	12-18-13
10	12-4-14	Annual Review. Added: Items in this policy may be subject to the Affordable Care Act (ACA) requirements. Also added information re: E1399	Susan Glomb	Dr. B. Almasri	12-4-14
11	12-3-15	Annual Review. Changed criteria requirement section. Removed reference to ICD-9 codes and added ICD-10 code table. Updated references.	Susan Glomb	Dr. B. Almasri	12-3-15