

# Medical Policy



## Pressure Reducing Support Surfaces – Group 3

### ▼Description

An air fluidized bed is a device employing the circulation of filtered air through ceramic spherules (small, round ceramic objects) that is marketed to treat and prevent pressure sores or treat extensive burns.

Air fluidized beds are beds filled with up to two thousand pounds of ceramic beads, covered by a polyester sheet. The flow of warm pressurized air circulates through the beads causing them to simulate fluid movement and distributing the member's weight over a large surface area. This creates a sensation of floating. In addition, the polyester sheet allows for moisture and air to pass through, which helps keep the skin dry and limits the skin breakdown caused by moisture and incontinence.

### ▼Policy

An air-fluidized bed is covered only if all of the following criteria are met:

1. The member has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcer.
2. The member is bedridden or chair bound as a result of severely limited mobility.
3. In the absence of an air-fluidized bed, the member would require institutionalization.
4. The air-fluidized bed is ordered in writing by the member's attending physician based upon a comprehensive assessment and evaluation of the member after completion of a course of conservative treatment designed to optimize conditions that promote wound healing. The evaluation generally must be performed within one month prior to initiation of therapy with the air-fluidized bed.
5. The course of conservative treatment must have been at least one month in duration without progression toward wound healing. This month of prerequisite conservative treatment may include some period in an institution as long as there is documentation available to verify that the necessary conservative treatment was rendered. Conservative treatment must include:
  - a. Frequent repositioning of the member with particular attention to relief of pressure over bony prominences (usually every 2 hours); and

- b. Use of a Group 2 support surface to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation; and
- c. Necessary treatment to resolve any wound infection; and
- d. Optimization of nutrition status to promote wound healing; and
- e. Debridement by any means, including wet-to-dry gauze dressings, to remove devitalized tissue from the wound bed; and
- f. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals.

In addition, conservative treatment should generally include:

- g. Education of the member and caregiver on the prevention and management of pressure ulcers; and
- h. Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly, and
- i. Appropriate management of moisture/incontinence.

An occlusive barrier is required, when necessary, to maintain a moist wound-healing environment that may otherwise be compromised by the drying action of airflow generated by air-fluidized therapy. If moist dressings are NOT required because of the wound characteristics (e.g. heavily exudative wound, etc.), the occlusive barrier is not required as a condition for reimbursement.

Wet-to-dry dressings when used for debridement do not require an occlusive dressing. Use of wet-to-dry dressings for wound debridement, begun during the period of conservative treatment and which continue beyond 30 days will not preclude coverage of an air-fluidized bed. Should additional debridement again become necessary while a beneficiary is using an air-fluidized bed (after the first 30-day course of conservative treatment) that will not cause the air-fluidized bed to be denied.

- 6. A trained adult caregiver is available to assist the beneficiary with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage.
- 7. A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis.
- 8. All other alternative equipment has been considered and ruled out.

An air-fluidized bed will be denied as not reasonable and necessary under any of the following circumstances:

1. The member has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions);
2. The member requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material;
3. The caregiver is unwilling or unable to provide the type of care required by the beneficiary on an air-fluidized bed;
4. Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1600 pounds or more);
5. Electrical system is insufficient for the anticipated increase in energy consumption; or
6. Other known contraindications exist.

Payment is not included for the caregiver or for architectural adjustments such as electrical or structural improvement.

The continued coverage of an air-fluidized bed as reasonable and necessary must be documented by the treating physician every month. Continued use of an air fluidized bed is covered until the ulcer is healed or, if healing does not continue, there is documentation to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the bed is reasonable d necessary for wound management.

If the stated coverage criteria for an air-fluidized bed are not met, the claim will be denied as not reasonable and necessary.

## ▼ HCPCS Level II Codes and Description

E0194	AIR FLUIDIZED BED
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## ▼ 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.

KX Modifier – specific required documentation on file

EY Modifier – No physician or other health care provider order for this item or service.

1. On a monthly basis, the Member's treating physician must document the need for the equipment with a written statement specifying:
  - a. the size of the ulcer;
  - b. if the ulcer is not healing, what other aspects of the care plan are being modified to promote healing; and
  - c. continued use of the bed is medically necessary for wound management.

This monthly physician statement must be kept on file by the supplier and be available for inspection upon request.

For the initial claim, suppliers must add a KX modifier to a code only if all of the criteria in this policy have been met. If the requirements for the KX modifier are not met, the KX modifier must not be used. For each subsequent month's claim use a KX modifier only if the physician's monthly certification indicates that continued use is necessary. Discontinue use of the KX modifier if the coverage criteria are not met or use is discontinued.

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.

#### **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

Statement of Ordering Physician  
Group 3 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: \_\_\_\_\_

## ▼ References

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

National Government Services, Inc. Jurisdiction B DME MAC, Pressure Reducing Support Surfaces – Group 3. Local Coverage Determination No. L33692; revised date October 1, 2015.

National Heritage Insurance Company (NHIC), Pressure Reducing Support Surfaces – Group 3. Local Coverage Determination No. L5069. 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
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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 Brugnani	Ken Fasse	n/a
01		Annual Review – no changes	Rosanne Brugnani	Ken Fasse	01-2007
02	12-2008	Added ICD-9 codes 707.23 and 707.24. Coverage Criteria #8 -Changed the requirements accepted from treating physician	Susan Glomb	Ken Fasse	n/a
03		Annual Review / no further changes	Susan Glomb	Ken Fasse	Dec.2008
04	01-01-09	Added: ICD-9 codes 707.23 and 707.24- Pressure ulcers, stages III and IV Added: Reference to NPUAP guidelines for pressure ulcer staging. Changed SADMERC to PDAC	Susan Glomb	Ken Fasse	
05	July 09	Updated policy according to LCD	Susan Glomb	Ken Fasse	

06	12-22-09	Annual Review/ no changes	Susan Glomb	Ken Fasse	Dec. 2009
07	12-03-10	Annual Review – No changes	Susan Glomb	Ken Fasse	Dec.2010
08	02-18-11	Policy updated to reflect current changes	Susan Glomb	Ken Fasse	
09	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri	
10	11-10-11	Annual Review. Added References to Policy	Susan Glomb	Dr. B. Almasri	Nov. 2011
11	04-04-12	Added reference to NH Medicaid	Susan Glomb	Dr. B. Almasri	
12	12-3-12	Annual Review – No changes	Susan Glomb	Dr. B. Almasri	Dec 12
13	12-18-13	Annual review. No changes	Susan Glomb	Dr. B. Almasri	
14	11-25-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri	
15	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	
16	12-3-15	Annual Review. Coverage criteria updated. References updated.	Susan Glomb	Dr. B. Almasri	