

Pressure Reducing Support Surfaces - Group 3

Tricenturion

Contractor Information	
Contractor Name	Tricenturion
Contractor Number	77011
Contractor Type	DMERC
LCD Information	
LCD Database ID Number	L5069
LCD Version Number	12
LCD Title	Pressure Reducing Support Surfaces - Group 3
Contractor's Determination Number	SPSRC20060101
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CMS National Coverage Policy	CMS Pub. 100-3, (Medicare National Coverage Determinations Manual), Chapter 1, Section 280.8
Primary Geographic Jurisdiction	CT DE MA ME NH NJ NY PA RI VT
Oversight Region	Region III
CMS Consortium	Northeast
DMERC Region LCD Covers	Region A
Original Determination Effective Date	For services performed on or after 10/01/1993
Original Determination Ending Date	
Revision Effective Date	For services performed on or after 01/01/2006
Revision Ending Date	
Indications and Limitations of Coverage and/or Medical Necessity	For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the

criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

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

1) The patient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure sore.

2) The patient is bedridden or chair bound as a result of severely limited mobility.

3) In the absence of an air-fluidized bed, the patient would require institutionalization.

4) The air-fluidized bed is ordered in writing by the patient's attending physician based upon a comprehensive assessment and evaluation of the patient 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 patient 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 patient 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.

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 patient 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 patient 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 medically necessary under any of the following circumstances:

1) The patient has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions);

2) The patient 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 patient 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 medical necessity of an air-fluidized bed 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 medically necessary for wound management.

If the stated coverage criteria for an air-fluidized bed are not met, the 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

Coverage Topic

Durable Medical Equipment
Pressure Reducing Support Surfaces - Group 3

Coding Information

Bill Type Codes

Revenue Codes

CPT/HCPCS Codes	<p>The appearance of a code in this section does not necessarily indicate coverage.</p> <p>HCPCS MODIFIER:</p> <p>EY – No physician or other health care provider order for this item or service</p> <p>E0194 AIR FLUIDIZED BED</p>
Does the CPT 30% Coding Rule Apply?	No
ICD-9 Codes that Support Medical Necessity	Not specified.
Diagnoses that Support Medical Necessity	Not specified.
ICD-9 Codes that DO NOT Support Medical Necessity	Not specified.
Non-Medical Necessity ICD-9 Codes Asterisk Explanation	
Diagnoses that DO NOT Support Medical Necessity	Not specified.
General Information	
Documentation Requirements	<p>Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (42 U.S.C. section 1395l(e)). It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available to the DMERC upon request.</p> <p>An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DMERC upon request. Items delivered before a signed written order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.</p> <p>A Certificate of Medical Necessity (CMN), which has been completed, signed, and dated by the treating physician, must be kept on file by the supplier and made available to the DMERC on request. The CMN may act as a substitute for a written order if it contains all of the required elements of an order. The CMN for Pressure Reducing Support Surfaces – Group 3 is CMS Form 842. The initial claim must include a copy of the CMN.</p> <p>If the answer to Question 15 of the CMN is "yes," the physician must provide additional information about the prior conservative treatment which should include information about the duration of treatment, wound care (including products used and frequency of change), pressure reducing support surfaces used within the last month, and nutritional support. The documentation of the comprehensive assessment should include information on the location of the</p>

	<p>ulcers, nutritional status, moisture control and other pressure ulcer risk factors as well as the date of the assessment and identification of the person performing the assessment. If the ulcer is less than 8 sq. cm surface area and/or it is on an area other than the posterior trunk or pelvis, there would need to be detailed documentation of why alternative treatment/equipment would not be effective.</p> <p>On a monthly basis, the treating physician must document the continued need for the equipment with a written statement (not a CMN) specifying: (1) the size of the ulcer; (2) if the ulcer is not healing, what other aspects of the care plan are being modified to promote healing; (3) 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 at the request of the DMERC.</p> <p>In the sixth month, the medical necessity for the bed must be documented using a revised CMN that is to be submitted with the seventh month's claim. If the answer to Question 22 indicates worsening or no improvement, additional documentation should be obtained which describes any changes in the treatment regimen, which have been made or are planned. This information must be available to the DMERC upon request.</p> <p>Refer to the Supplier Manual for more information on documentation requirements.</p>
<p>Appendices</p>	<p>The staging of pressure ulcers used in this policy is as follows:</p> <p>Stage I - Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.</p> <p>Stage II - Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.</p> <p>Stage III - Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.</p> <p>Stage IV - Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.</p>
<p>Utilization Guidelines</p>	<p>Refer to Indications and Limitations of Coverage and/or Medical Necessity.</p>
<p>Sources of Information and Basis for Decision</p>	
<p>Advisory Committee Meeting Notes</p>	
<p>Start Date of Comment Period</p>	<p>04/30/1993</p>

End Date of Comment Period	06/14/1993
Start Date of Notice Period	08/01/1993
Revision History Number	SPSRC006
Revision History Explanation	<p>Revision Effective Date: 01/01/2006 LMRP converted to LCD and Policy Article DOCUMENTATION REQUIREMENTS: Removed requirement to submit additional documentation with the sixth month revised CMN.</p> <p>Revision effective date: 04/01/2003 HCPCS CODES AND MODIFIERS: Added: EY modifier INDICATIONS AND LIMITATIONS OF COVERAGE: Adds standard language concerning coverage of items without a written order prior to delivery DOCUMENTATION REQUIREMENTS: Adds standard language concerning use of EY modifier for items without a written order prior to delivery</p> <p>The revision dates listed below are the dates the revisions were published and not necessarily the effective dates for the revisions.</p> <p>12/01/2000 - Incorporated recent revisions made to the national policy in Coverage Issues Manual, section 60-19.</p> <p>07/01/1998 - Effective August 1, 1998, the documentation requirements for this policy have been revised. A revised Certificate of Medical Necessity (CMN) will be required in the 6th month instead of on a monthly basis. The revised policy now specifies the contents of the monthly documentation from the treating physician, which must be kept on file by the supplier.</p> <p>10/01/1995 - Alternating Pressure Pads and Mattresses policy was separated into three policies – Pressure Reducing Support Surfaces, Group 1, Group 2, and Group 3. Added HCPCS code for Group 3 – E0194. Revised entire policy for information specific to Group 3 support surfaces.</p> <p>12/01/1993 – Clerical corrections as follows: CMN for Group 2 corrected to 01 from 01.00; and HAO corrected to HAO in Documentation section.</p> <p>This LCD was converted from an LMRP on 11/4/2005</p>
Last Reviewed on Date	
Notes	
Does this LCD contain a "Least Costly Alternative" provision?	No
Related Documents	Article(s) A37217 - Pressure Reducing Support Surfaces - Group 3 - Policy Article - Effective January 2006

Pressure Reducing Support Surfaces - Group 3 - Policy Article - Effective January 2006

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Contractor Information	
Contractor Name	Tricenturion
Contractor Number	77011
Contractor Type	DMERC
Article Information	
Article Database ID Number	A37217
Article Type	Article
Key Article	Yes
Article Version Number	2
Article Title	Pressure Reducing Support Surfaces - Group 3 - Policy Article - Effective January 2006
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Primary Geographic Jurisdiction	CT DE MA ME NH NJ NY PA RI VT
DMERC Region Article Covers	Region A
Original Article Effective Date	01/01/2006
Article Revision Effective Date	
Article Ending Effective Date	

Article Text	<p>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES</p> <p>For an item addressed in this policy to be covered by Medicare, a written signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to receipt of a written order, it will be denied as noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.</p> <p>CODING GUIDELINES</p> <p>An air-fluidized bed (E0194) is a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid.</p> <p>Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.</p>
Coverage Topic	Durable Medical Equipment Pressure Reducing Support Surfaces - Group 3
ICD-9 Codes that are Covered	
ICD-9 Codes that are Not Covered	
Other Information	
Other Comments	
Does this Article contain a "Least Costly Alternative" provision?	No
Approval Notes	Revision Effective Date: 01/01/2006 LMRP converted to LCD and Policy Article
Revision History Explanation	
Related Documents	LCD(s) L5069 - Pressure Reducing Support Surfaces - Group 3
Article Attachments	There are no attachments for this Article