

LCD for Pressure Reducing Support Surfaces - Group 1 (L5067)

Contractor Information

Contractor Name

[NHIC, Corp.](#)

Contractor Number

16003

Contractor Type

DME MAC

LCD Information

LCD ID Number

L5067

LCD Title

Pressure Reducing Support Surfaces - Group 1

Contractor's Determination Number

PRSS1

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CMS National Coverage Policy

CMS Pub. 100-3, (Medicare National Coverage Determinations Manual), Chapter 1, Section 280.1

Primary Geographic Jurisdiction

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

LCD Information

Oversight Region

Region I

DME Region LCD Covers

Jurisdiction 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 12/01/2009

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.

These items require a written order prior to delivery. Refer to the Policy Article for additional information on orders.

A 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 patient is completely immobile - i.e., patient cannot make changes in body position without assistance, or
2. The patient has limited mobility - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
3. The patient 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):

LCD Information

- 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 mattress overlay or mattress are not met, the claim will be denied as not medically necessary.

The support surface provided for the patient should be one in which the patient 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 patient's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the patient 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.

Coding Information

CPT/HCPCS Codes

The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

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

GA – Waiver of liability statement on file

GZ – Item or service expected to be denied as not reasonable and necessary

KX - Requirements specified in the medical policy have been met

HCPCS CODES:

A4640 REPLACEMENT PAD FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY PATIENT

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

Coding Information

E0187 WATER PRESSURE MATTRESS

E0188 SYNTHETIC SHEEPSKIN PAD

E0189 LAMBSWOOL 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

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.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Not specified.

General Information

Documentation Requirements

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." 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 upon request.

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available 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.

The supplier must obtain information concerning which, if any, of the criteria listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy the patient meets in a signed and dated statement from the 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 supplier or anyone in a financial relationship with the supplier. This statement must be supported by information in the patient's medical record which would be available upon request. Do not submit this form unless specifically requested.

KX, GA, AND GZ MODIFIERS:

General Information

Suppliers must add a KX modifier to a code only if all of the criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy have been met and evidence of such is maintained in the supplier's files. This information must be available upon request.

If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

When code E1399 is billed, the claim must include a narrative description of the item, the manufacturer, the product name/number, and information justifying the medical necessity for the item.

Refer to the Supplier Manual for more information on documentation requirements.

Appendices

RELATED CLINICAL INFORMATION:

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

1. Education of the patient 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 a 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.

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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.

Utilization Guidelines

Refer to Indications and Limitations of Coverage and/or Medical Necessity.

Sources of Information and Basis for Decision

National Pressure Ulcer Advisory Panel (NPUAP) Revised Staging Definitions for Pressure Ulcers accessed at www.npuap.org on August 28, 2008.

Advisory Committee Meeting Notes

Start Date of Comment Period

End Date of Comment Period

Start Date of Notice Period

08/01/1993

Revision History Number

SPSRA007

Revision History Explanation

Revision Effective Date: 12/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Criteria for coverage of Group I Mattress.

HCPCS CODES AND MODIFIERS:

Added: GA and GZ modifiers.

Revised: KX modifier.

DOCUMENTATION REQUIREMENTS:

Added: Instructions for the use of GA and GZ modifiers.

APPENDICES:

Revised: Definitions of pressure ulcer stages.

SOURCES OF INFORMATION AND BASIS FOR DECISION:

Added: Reference to NPUAP guidelines for pressure ulcer staging.

General Information

03/01/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) LCD L5067 from DME PSC TriCenturion (77011) LCD L5067.

06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

Revision Effective Date: 01/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: Reference to E0180.

HCPCS CODES AND MODIFIERS:

Deleted: E0180

Revised: E0181, E0182

DOCUMENTATION REQUIREMENTS:

Removed: References to DMERC.

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective Date: 07/01/2005

LMRP converted to LCD and Policy Article.

Revision Effective Date: 04/01/2003

HCPCS CODES AND MODIFIERS:

Added: EY modifier.

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Standard language concerning coverage of items without a written order prior to delivery.

DOCUMENTATION REQUIREMENTS:

Added: Standard language concerning use of EY modifier for items without a written order prior to delivery.

The revision dates listed below are the dates the revisions were published and not necessarily the effective dates for the revisions.

07/01/2002 - Changed ZX modifier to KX.

10/01/2001 - This policy revision incorporates a recent coverage determination by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, that reclassified synthetic sheepskin pads and lambswool sheepskin pads (HCPCS codes E0188 and E0189, respectively) as durable medical equipment and placed them in the inexpensive or routinely purchased payment category. Effective for dates of service on or after January 1, 2001, codes E0188 and E0189 will be given coverage consideration by the DMERC.

03/01/1998 – Revised description for HCPCS code E0185 from “gel” to “gel and gel-like”; and added codes E0188 and E0189. Added non-coverage language for E0188 and E0189 in Coverage and Payment Rules section.

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 codes for Group 1 – A9270, E0182, E0184-E0187, E0196-E0199, and E1399. Revised entire policy for information specific to Group 1 support surfaces and added Statement of Ordering Physician-Group 1 Support Surfaces form.

This LCD was converted from an LMRP on 5/10/2005.

General Information

Reason for Change

Last Reviewed On Date

Related Documents

Article(s)

[A33769 - Pressure Reducing Support Surfaces - Group 1 - Policy Article - Effective December 2009](#)

LCD Attachments

[Statement of Ordering Physician](#) (10,508 bytes)

Article for Pressure Reducing Support Surfaces - Group 1 - Policy Article - Effective December 2009 (A33769)

Contractor Information

Contractor Name

[NHIC, Corp.](#)

Contractor Number

16003

Contractor Type

DME MAC

Article Information

Article ID Number

A33769

Article Type

Article

Key Article

Yes

Article Title

Pressure Reducing Support Surfaces - Group 1 - Policy Article - Effective December 2009

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[Primary Geographic Jurisdiction](#)

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

Article Information

DME Region Article Covers

Jurisdiction A

Original Article Effective Date

07/01/2005

Article Revision Effective Date

12/01/2009

Article Text

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES

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.

A foam overlay or mattress which does not have a waterproof cover is not considered durable and will be denied as noncovered.

CODING GUIDELINES

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., eggcrate) 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 nonpowered 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) is 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

Article Information

3. Can be placed directly on a hospital bed frame.

Codes E0181, E0182, and 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.

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

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

Coding Information

No Coding Information has been entered in this section of the article.

Other Information

Revision History Explanation

Revision Effective Date: 12/01/2009

CODING GUIDELINES:

Changed: SADMERC to PDAC.

03/01/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A33769 from DME PSC TriCenturion (77011) Article A33769.

06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

Revision Effective Date: 01/01/2007

CODING GUIDELINES:

Removed: E0180

Other Information

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this article was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective Date: 07/01/2005

LMRP converted to LCD and Policy Article.

Related Documents

LCD(s)

[L5067 - Pressure Reducing Support Surfaces - Group 1](#)