Pressure Reducing Support Surfaces - Group 1

Noridian Healthcare Solutions, LLC

Contractor Information
Contractor Name Noridian Healthcare Solutions, LLC
Contract Type DME MAC

LCD Information
LCD ID L33830
Original ICD-9 LCD ID L11578 - Pressure Reducing Support Surfaces - Group 1
LCD Title Pressure Reducing Support Surfaces - Group 1

AMA CPT ADA CDT AHA NUBC Copyright Statements
The Code on Dental Procedures and Nomenclature (Code) is published in Current Dental Terminology (CDT). Copyright (c) American Dental Association. All rights reserved. CDT and CDT-2010 are trademarks of the American Dental Association.

UB-04 Manual. OFFICIAL UB-04 DATA SPECIFICATIONS MANUAL, 2014, is copyrighted by American Hospital Association ("AHA"), Chicago, Illinois. No portion of OFFICIAL UB-04 MANUAL may be reproduced, sorted in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior express, written consent of AHA. Health Forum reserves the right to change the copyright notice from time to time upon written notice to Company.

CMS National Coverage Policy
CMS Pub. 100-03, (Medicare National Coverage Determinations Manual), Chapter 1, Section 280.1

Jurisdiction
Alaska
American Samoa
Arizona
California - Entire State
Guam
Hawaii
Idaho
Iowa
Kansas
Missouri - Entire State
Montana
Nebraska
Nevada
North Dakota
Northern Mariana Islands
Oregon
South Dakota
Utah
Washington
Wyoming

**DME Region**
Jurisdiction D

**LCD Covers**

**Date Information**

- **Original Effective Date**
  For services performed on or after 10/01/2015
- **Revision Effective Date**
  For services performed on or after 10/01/2015
- **Revision Ending Date**
- **Retirement Date**
- **Notice Period Start Date**
- **Notice Period End Date**

**Coverage Guidance**

**Coverage Indications, Limitations 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 local coverage determination, the criteria for "reasonable and necessary", based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Medicare does not automatically assume payment for a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) item that was covered prior to a beneficiary becoming eligible for the Medicare Fee For Service (FFS) program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary, may be required upon request of the DME MAC.
For an item to be covered by Medicare, a detailed written order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed DWO, the item will be denied as not reasonable and necessary.

For some items in this policy to be covered by Medicare, a written order prior to delivery (WOPD) is required. Refer to the DOCUMENTATION REQUIREMENTS section of this LCD and to the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article for information about WOPD prescription requirements.

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 beneficiary is completely immobile - i.e., beneficiary cannot make changes in body position without assistance, or

2. The beneficiary has limited mobility - i.e., beneficiary cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or

3. The beneficiary 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 mattress overlay or mattress are not met, the claim will be denied as not reasonable and necessary.

The support surface provided for the beneficiary should be one in which the beneficiary 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 beneficiary’s bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the beneficiary 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 the Policy Article will be denied as not reasonable and necessary.
Coding Information
Bill Type Codes
Revenue Codes

CPT/HCPCS Codes
Group 1: Paragraph
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 issued as required by payer policy, individual case
- 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:

<table>
<thead>
<tr>
<th>Group 1: Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPCS</td>
</tr>
<tr>
<td>A4640</td>
</tr>
<tr>
<td>A9270</td>
</tr>
<tr>
<td>E0181</td>
</tr>
<tr>
<td>E0182</td>
</tr>
<tr>
<td>E0184</td>
</tr>
<tr>
<td>E0185</td>
</tr>
<tr>
<td>E0186</td>
</tr>
<tr>
<td>E0187</td>
</tr>
<tr>
<td>E0188</td>
</tr>
<tr>
<td>E0189</td>
</tr>
<tr>
<td>E0196</td>
</tr>
<tr>
<td>E0197</td>
</tr>
<tr>
<td>E0198</td>
</tr>
<tr>
<td>HCPCS</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>E0199</td>
</tr>
<tr>
<td>E1399</td>
</tr>
</tbody>
</table>

**Does the CPT 30% Coding Rule Apply?** No

**ICD-10 Codes that Support Medical Necessity**

Note: Performance is optimized by using code ranges.

**Group 1: Paragraph**

Not specified

**Group 1: Codes**

**ICD-10 Codes that DO NOT Support Medical Necessity**

Note: Performance is optimized by using code ranges.

**Group 1: Paragraph**

Not specified

**Group 1: Codes**

**Additional ICD-10 Information**

**General Information**

**Associated 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 beneficiary’s medical records will reflect the need for the care provided. The beneficiary’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.

**PRESCRIPTION (ORDER) REQUIREMENTS**

**GENERAL (PIM 5.2.1)**

All items billed to Medicare require a prescription. 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 dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

**WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.3.1)**
ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS codes specified in the table contained in the Policy Specific Documentation Requirements Section below. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. Refer the related Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about the statutory requirements associated with a WOPD.

DETAILED WRITTEN ORDERS (PIM 5.2.3)

A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

For items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use, if applicable
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills or length of need

For the “Date of the order” described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state “PRN” or “as needed” utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)
The detailed description in the written order may be either a narrative description or a brand name/model number.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record. (PIM 5.2.3)

MEDICAL RECORD INFORMATION

GENERAL (PIM 5.7 - 5.9)

The Coverage Indications, Limitations and/or Medical Necessity section of this LCD contains numerous reasonable and necessary (R&N) requirements. The Non-Medical Necessity Coverage and Payment Rules section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.

- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

CONTINUED MEDICAL NEED

For all Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been
created prior to, or at the time of, the initial date of service (DOS) to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or DIF with an appropriate length of need specified
- Timely documentation in the beneficiary's medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

This information must be kept on file and be available upon request.

CONTINUED USE

Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories and supplies
- Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements (This is deemed to be sufficient to document continued use for the base item, as well)
- Supplier records documenting beneficiary confirmation of continued use of a rental item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.
PROOF OF DELIVERY (PIM 4.26, 5.8)

Proof of delivery (POD) is a Supplier Standard and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as any person who can sign and accept the delivery of DMEPOS on behalf of the beneficiary.

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. For items addressed in this policy, there are two methods of delivery:

1. Delivery directly to the beneficiary or authorized representative

2. Delivery via shipping or delivery service

Method 1—Direct Delivery to the Beneficiary by the Supplier

Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery document. The POD document must include:

- Beneficiary’s name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
Beneficiary (or designee) signature

The date delivered on the POD must be the date that the DMEPOS item was received by the beneficiary or designee. The date of delivery may be entered by the beneficiary, designee or the supplier. When the supplier's delivery documents have both a supplier-entered date and a beneficiary or beneficiary’s designee signature date on the POD document, the beneficiary or beneficiary’s designee-entered date is the date of service.

In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary

If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

Equipment Retained From a Prior Payer

When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage plan) becomes eligible for the Medicare FFS program, the first Medicare claim for that item or service
is considered a new initial Medicare claim for the item. Even if there is no change in the beneficiary’s medical condition, the beneficiary must meet all coverage, coding and documentation requirements for the DMEPOS item in effect on the date of service of the initial Medicare claim.

A POD is required for all items, even those in the beneficiary’s possession provided by another insurer prior to Medicare eligibility. To meet the POD requirements for a beneficiary transitioning to Medicare, the supplier:

1. Must obtain a new POD as described above under “Methods of Delivery” (whichever method is applicable); or,

2. Must obtain a statement, signed and dated by the beneficiary (or beneficiary’s designee), attesting that the supplier has examined the DMEPOS item, it is in good working order and that it meets Medicare requirements.

For the purposes of reasonable useful lifetime and calculation of continuous use, the first day of the first rental month in which Medicare payments are made for the item (i.e., date of service) serves as the start date of the reasonable useful lifetime and period of continuous use. In these cases, the proof of delivery documentation serves as evidence that the beneficiary is already in possession of the item.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS

ACA 6407 contains provisions that are applicable to certain specified items in this policy. In this policy the specified items are:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0185</td>
<td>GEL OR GEL-LIKE PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
<tr>
<td>E0188</td>
<td>SYNTHETIC SHEEPSKIN PAD</td>
</tr>
<tr>
<td>E0189</td>
<td>LAMBSWOOL SHEEPSKIN PAD, ANY SIZE</td>
</tr>
<tr>
<td>E0197</td>
<td>AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
<tr>
<td>E0198</td>
<td>WATER PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
<tr>
<td>E0199</td>
<td>DRY PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
</tbody>
</table>

These items require an in-person or face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing
order is not sufficient to provide these items. A Written Order Prior to Delivery (WOPD) is required. Refer to the related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about these statutory requirements.

The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

Suppliers are reminded that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

RELATED CLINICAL INFORMATION:

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

1. Education of the beneficiary 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

REPAIR/REPLACEMENT (100-02, Ch 15, §110.2)

A new Certificate of Medical Necessity (CMN) and/or physician’s order is not needed for repairs.

In the case of repairs to a beneficiary-owned DMEPOS item, if Medicare paid for the base equipment initially, medical necessity for the base equipment has been established. With respect to Medicare reimbursement for the repair, there are two documentation requirements:

1. The treating physician must document that that the DMEPOS item being repaired continues to be reasonable and necessary (see Continued Medical Need section above); and,
2. Either the treating physician or the supplier must document that the repair itself is reasonable and necessary.

The supplier must maintain detailed records describing the need for and nature of all repairs including
a detailed explanation of the justification for any component or part replaced as well as the labor time to restore the item to its functionality.

A physician’s order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

**KX, GA AND GZ MODIFIERS**

Suppliers must add a KX modifier to a code only if all of the criteria in the "Coverage Indications, Limitations 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 Coverage Indications, Limitations 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 denial as not reasonable and necessary, 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.

**Miscellaneous**

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

**Appendices**

PIM citations above denote references to CMS Program Integrity Manual, Internet Only Manual 100-08

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.

**Utilization Guidelines**
Refer to Coverage Indications, Limitations and/or Medical Necessity

**Sources of Information and Basis for Decision**

**Revision History Information**

**Revision History Table**

<table>
<thead>
<tr>
<th>Revision History Number</th>
<th>Revision History Date</th>
<th>Revision History Explanation</th>
<th>Reason for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10/01/2015</td>
<td><strong>Revision Effective Date:</strong> 10/01/2015</td>
<td><strong>Provider Education/Guidance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</strong></td>
<td><strong>Revised:</strong> Standard Documentation Language to add covered prior to a beneficiary’s Medicare eligibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>DOCUMENTATION REQUIREMENTS:</strong></td>
<td><strong>Revised:</strong> Standard Documentation Language to add who can enter date of delivery date on the POD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added: Instructions for Equipment Retained from a Prior Payer</td>
<td><strong>Added:</strong> Repair and Replacement section</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Revised:</strong> ACA 6407 verbiage</td>
<td><strong>Provider Education/Guidance</strong></td>
</tr>
</tbody>
</table>

**Associated Documents**

**Attachments**
There are no attachments for this LCD.

**Article(s)**

**Related Local Coverage Documents**

**A52489 - Pressure Reducing Support Surfaces - Group 1 - Policy Article - Effective October 2015**

**Related National Coverage Documents**
This LCD version has no Related National Coverage Documents.
END OF LOCAL COVERAGE DETERMINATION
Per the Code of Federal Regulations, 42 C.F.R § 426.325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.
Pressure Reducing Support Surfaces - Group 1 - Policy Article - Effective October 2015

Noridian Healthcare Solutions, LLC

Contractor Information
Contractor Name Noridian Healthcare Solutions, LLC
Contract Type DME MAC

Article Information
Article ID A52489
Original ICD-9 Article ID A33678 - Pressure Reducing Support Surfaces - Group 1 - Policy Article - Effective October 2014
Article Title Pressure Reducing Support Surfaces - Group 1 - Policy Article - Effective October 2015
Article Type Article

CPT only copyright 2002-2014 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

AMA CPT
ADA CDT
AHA NUBC
Copyright Statements

The Code on Dental Procedures and Nomenclature (Code) is published in Current Dental Terminology (CDT). Copyright (c) American Dental Association. All rights reserved. CDT and CDT-2010 are trademarks of the American Dental Association.

UB-04 Manual. OFFICIAL UB-04 DATA SPECIFICATIONS MANUAL, 2014, is copyrighted by American Hospital Association ("AHA"), Chicago, Illinois. No portion of OFFICIAL UB-04 MANUAL may be reproduced, sorted in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior express, written consent of AHA. Health Forum reserves the right to change the copyright notice from time to time upon written notice to Company.

Jurisdiction
Alaska
American Samoa
Arizona
California - Entire State
Guam
Hawaii

CPT codes, descriptors and other data are copyright 2015 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. This article applies to all Noridian administered states unless otherwise noted in the article.
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES

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. Information provided in this policy article relates to determinations other than those based on Social Security Act Section 1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

Pressure-reducing support surfaces are covered under the Durable Medical Equipment benefit (Social Security Act Section 1861(s)(6)). In order for a beneficiary’s DME to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

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 non-covered. 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 (WOPD), 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 non-covered.

**AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS**

ACA 6407 contains provisions that are applicable to specified items in this policy. In this policy the
specified items are:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0185</td>
<td>GEL OR GEL-LIKE PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
<tr>
<td>E0188</td>
<td>SYNTHETIC SHEEPSKIN PAD</td>
</tr>
<tr>
<td>E0189</td>
<td>LAMBSWOOL SHEEPSKIN PAD, ANY SIZE</td>
</tr>
<tr>
<td>E0197</td>
<td>AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
<tr>
<td>E0198</td>
<td>WATER PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
<tr>
<td>E0199</td>
<td>DRY PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH</td>
</tr>
</tbody>
</table>

**Face-to-Face Visit Requirements:**

As a condition for payment, Section 6407 of the Affordable Care Act (ACA) requires that a physician
(MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS)
has had a face-to-face examination with a beneficiary that meets all of the following requirements:

- The treating physician must have an in-person examination with the beneficiary within the six
  (6) months prior to the date of the WOPD.

- This examination must document that the beneficiary was evaluated and/or treated for a
  condition that supports the need for the item(s) of DME ordered.

A new face-to-face examination is required each time a new prescription for one of the specified
items is ordered. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals

- When there is a change in the prescription for the accessory, supply, drug, etc.
• If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)

• When an item is replaced

• When there is a change in the supplier

The first bullet, “For all claims for purchases or initial rentals”, includes all claims for payment of purchases and initial rentals for items not originally covered (reimbursed) by Medicare Part B. Claims for items obtained outside of Medicare Part B, e.g. from another payer prior to Medicare participation (including Medicare Advantage plans), are considered to be new initial claims for Medicare payment purposes.

Prescription Requirements:

A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician’s signature and signature date, and must be in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier’s possession BEFORE the item is delivered. The WOPD must include all of the items below:

• Beneficiary's name

• Physician’s name

• Date of the order and the start date, if start date is different from the date of the order

• Detailed description of the item(s)

• The prescribing practitioner's National Provider Identifier (NPI)

• The signature of the ordering practitioner

• Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include, in addition to the above:

• Item(s) to be dispensed

• Dosage or concentration, if applicable

• Route of Administration, if applicable

• Frequency of use

• Duration of infusion, if applicable
• Quantity to be dispensed

• Number of refills, if applicable

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DMEPOS items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, to assure that these ACA order requirements are met.

The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However the prescriber must:

• Verify that the in-person visit occurred within the 6-months prior to the date of their prescription, and

• Have documentation of the face-to-face examination that was conducted, and

• Provide the DMEPOS supplier with copies of the in-person visit records.

Date and Timing Requirements

There are specific date and timing requirements:

• The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than 6 months prior to the prescription date.

• The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.

• The date of the written order must be on or before the date of delivery.

• The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

A date stamp (or similar) is required which clearly indicates the supplier’s date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician’s signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

Claim Denial

Claims for the specified items subject to ACA 6407 that do not meet the requirements specified above will be denied as statutorily non-covered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily non-covered. 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.

CODING GUIDELINES

Codes E0185 and E0197-E0199 termed "pressure pad for mattress" describe nonpowered 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., 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
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.

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 beneficiary-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.

<table>
<thead>
<tr>
<th>Column I</th>
<th>Column II</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0181</td>
<td>A4640, E0182</td>
</tr>
</tbody>
</table>

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

Coding Information
Bill Type Codes
Revenue Codes

CPT/HCPCS Codes
Group 1: Paragraph

Group 1: Codes

Does the CPT 30% Coding Rule Apply? No

Covered ICD-10 Codes

Note: Performance is optimized by using code ranges.
Group 1: Paragraph

Group 1: Codes

Non-Covered ICD-10 Codes

Note: Performance is optimized by using code ranges.

Group 1: Paragraph

Group 1: Codes

Revision History Information
Revision History Table

<table>
<thead>
<tr>
<th>Revision History Number</th>
<th>Revision History Date</th>
<th>Revision History Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10/01/2015</td>
<td>Removed: &quot;When required by state law&quot; from ACA new prescription requirements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revised: Face-to-Face Requirements for treating practitioner</td>
</tr>
</tbody>
</table>

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

10/01/2015 Removed: "When required by state law" from ACA new prescription requirements
Revised: Face-to-Face Requirements for treating practitioner

Associated Documents

Related Local Coverage Documents

Related National Coverage Documents

Statutory Requirements URL(s)
Rules and Regulations URL(s)
CMS Manual Explanations URL(s)
Other URL(s)

This Article version has no Related National Coverage Documents.