Local Coverage Determination (LCD): Pressure Reducing Support Surfaces - Group 2 (L5068)

Contractor Information

Contractor Name	Contract Number	Contract Type
NHIC, Corp. opens in new window	16003	DME MAC

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LCD Information

Document Information

LCD ID
L5068

LCD Title
Pressure Reducing Support Surfaces - Group 2

Jurisdiction opens in new window
Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

Original Effective Date
For services performed on or after 10/01/1993

Revision Effective Date
For services performed on or after 01/01/2011

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date 08/01/1993

Notice Period End Date N/A

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

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 indications and limitations of coverage and/or medical necessity.

For these items 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 2 support surface is covered if the beneficiary meets at least one of the following three Criteria (1, 2 or 3):

1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02-707.05) which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program including each of the following:
    a. Use of an appropriate group 1 support surface, and
    b. Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and
    c. Appropriate turning and positioning, and
    d. Appropriate wound care, and
    e. Appropriate management of moisture/incontinence, and
    f. Nutritional assessment and intervention consistent with the overall plan of care

2. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02 -707.05),

3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days (ICD-9 707.02 -707.05), and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days

If the beneficiary is on a group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements. The support surface provided for the beneficiary should be one in which the beneficiary does not "bottom out" (see Appendices section).

When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

When the stated coverage criteria for a group 2 mattress or bed are not met, a claim will be denied as not reasonable and necessary.

A support surface which does not meet the characteristics specified in the Coding Guidelines section of the Pressure Reducing Support Surfaces – Group 2 Policy Article will be denied as not reasonable and necessary. (See Coding Guidelines and Documentation sections concerning billing of E1399.)

Continued use of a group 2 support surface is covered until the ulcer is healed, or if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is reasonable and necessary for wound management.

Appropriate use of the KX modifier (see Documentation section) is the responsibility of the supplier. The supplier should maintain adequate communication on an ongoing basis with the clinician providing the wound care in order to accurately determine that use of the KX modifier still reflects the clinical conditions which meet the criteria for coverage of a group 2 support surface, and that adequate documentation exists in the medical record reflecting these conditions. Such documentation should not be submitted with a claim but should be available upon request.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

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 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:

Group 1 Codes:

E0193	POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)
E0277	POWERED PRESSURE-REDUCING AIR MATTRESS
E0371	NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH
E0372	POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH
E0373	NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

ICD-9 Codes that Support Medical Necessity

Group 1 Paragraph: The presence of an ICD-9 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on Indications and Limitations of Coverage and/or Medical Necessity for other coverage criteria and payment information.

Group 1 Codes:
707.02 - 707.05 opens in new window PRESSURE ULCER, UPPER BACK - PRESSURE ULCER, BUTTOCK

ICD-9 Codes that DO NOT Support Medical Necessity
Paragraph: All ICD-9 codes that are not specified in the previous section.

N/A

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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 5.2.4)

A detailed written order prior to delivery (WOPD) is required for support surfaces. The supplier must have received a WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

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.

MEDICAL RECORD INFORMATION

GENERAL (PIM 5.7 - 5.9)

The **Indications and Limitations of Coverage and/or Medical Necessity** section of this LCD contains numerous reasonable and necessary (R&N) requirements. The **Nonmedical 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 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.

CONTINUED MEDICAL NEED

For all 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 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.

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. 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 slip. The POD record 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 and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the item is delivered directly by the supplier, the date the beneficiary received the DMEPOS item 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.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

KX, GA, AND GZ MODIFIERS

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 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 the manufacturer and the model name/number.

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

Appendices

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.

Bottoming out is the finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under 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

Utilization Guidelines

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

Sources of Information and Basis for Decision
N/A

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Revision History Information

Please note: The Revision History information included in this LCD prior to 1/24/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 1/24/2013 will display as a row in the Revision History section of the LCD and numbering will begin with "R2".

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
01/01/2011	R2	**Revision Effective Date: 01/01/2011 (March 2013 Publication)** INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Language explaining coverage criteria Revised: Order requirements language to specify a "detailed written order" Changed: Word "patient" to "beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard language (Note: The effective date above is not applicable to these items. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Removed: Requirement for the Statement of Certifying Physician (effective April 1, 2013)	• Provider Education/Guidance
01/01/2011	R1	**Revision Effective Date: 01/01/2011** INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Preamble language HCPCS CODES AND MODIFIERS: Revised: GA modifier **Revision Effective Date: 04/01/2010** HCPCS CODES AND MODIFIERS: Added: GA and GZ modifiers Revised: KX modifier. DOCUMENTATION REQUIREMENTS: Added: Instructions for the use of GA and GZ modifiers. **Revision Effective Date: 01/01/2009** APPENDICES: Revised: Definitions of pressure ulcer stages. SOURCES OF INFORMATION AND BASIS FOR DECISION: Added: Reference to NPUAP guidelines for pressure ulcer staging. **03/01/2008** - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) LCD L5068 from DME PSC TriCenturion (77011) LCD L5068. **Revision Effective Date: 07/01/2007** INDICATIONS AND LIMITATIONS OF COVERAGE: Removed: DMERC references. DOCUMENTATION REQUIREMENTS: Removed: DMERC references. **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). **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).	• Maintenance (annual review with new changes • formatting • etc.)

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change

Revision Effective Date: 10/01/2005
LMRP converted to LCD and Policy Article.
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: ICD-9 codes 707.02-707.05
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 codes 707.02-707.05

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 awritten 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 - Staging of pressure ulcers revised under Definition section. Changed ZX modifier to KX, including all references in policy.

03/01/1998 – HCPCS codes K0413, K0414, and K0454 crosswalked to E0371, E0372 and E0373.

06/01/1997 - In the Pressure Reducing Support Surfaces - Group 2 policy, the narrative for code K0413 has been revised and a new code has been added.

K0413 - Non-powered, advanced pressure- reducing overlay for mattress, standard mattress length and width

K0454 - Non-powered, advanced pressure- reducing mattress

The revision and addition are valid for dates of service on or after 9/1/97. Both codes are in the capped rental payment category.

The ZX modifier should be used for billing these codes only when the criteria for its use (as specified in the Documentation section of the Group 2 Support Surfaces policy) are met.

04/01/1996 – Two new codes have been established for Group 2 support surfaces:

K0413 – Non-powered adjustable zone pressure-reducing air mattress overlay

K0414 – Powered air overlay for mattress

Both codes are valid for dates of service on or after April 1, 1996. Both codes are in the capped rental category.

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		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 2 – E0193 and E1399. Revised entire policy for information specific to Group 2 support surfaces and added Statement of Ordering Physician-Group 2 Support Surfaces form. 12/01/1993 – Clerical corrections as follows: CMN for Group 2 corrected to 01 from 01.00; and HAO corrected to HA0 in Documentation section. This LCD was converted from an LMRP on 8/8/2005	

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Associated Documents

Attachments
N/A

Related Local Coverage Documents
Article(s)
A35350 - Pressure Reducing Support Surfaces - Group 2 - Policy Article - Effective April 2013 opens in new window

Related National Coverage Documents
N/A

All Versions
Updated on 03/08/2013 with effective dates 01/01/2011 - N/A
Updated on 03/07/2012 with effective dates 01/01/2011 - N/A
Updated on 02/25/2011 with effective dates 01/01/2011 - N/A
Some older versions have been archived. Please visit the MCD Archive Site opens in new window to retrieve them.

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Keywords

N/A

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Local Coverage Article for Pressure Reducing Support Surfaces - Group 2 - Policy Article - Effective April 2013 (A35350)

Contractor Information

Contractor Name	Contractor Number	Contractor Type
NHIC, Corp. opens in new window	16003	DME MAC

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Article Information

General Information

AMA CPT / ADA CDT Copyright Statement

Article ID Number
A35350

Article Type
Article

Key Article
Yes

Article Title
Pressure Reducing Support Surfaces - Group 2 - Policy Article - Effective April 2013

Primary Geographic Jurisdiction opens in new window
Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

DME Region Article Covers
Jurisdiction A

Original Article Effective Date
10/01/2005

Article Revision Effective Date
04/01/2013

Article Text

NON-MEDICAL 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 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.

CODING GUIDELINES

Heavy duty and bariatric devices are included in the codes for pressure reducing support surfaces: E0193, E0277, E0371, E0372 and E0373.

Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following:

1. An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, and
2. Inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and
3. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate beneficiary lift, reduce pressure and prevent bottoming out, and
4. A surface designed to reduce friction and shear, and
5. Can be placed directly on a hospital bed frame

Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above.

Code E0371 describes an advanced nonpowered pressure-reducing mattress overlay which is characterized by all of the following:

1. Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out, and
2. Total height of 3 inches or greater, and
3. A surface designed to reduce friction and shear, and
4. Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces

Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by all of the following:

1. An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and
2. Inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and
3. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate beneficiary lift, reduce pressure and prevent bottoming out, and
4. A surface designed to reduce friction and shear

Code E0373 describes an advanced nonpowered pressure reducing mattress which is characterized by all of the following:

1. Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out, and
2. Total height of 5 inches or greater, and
3. A surface designed to reduce friction and shear, and
4. Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces,and
5. Can be placed directly on a hospital bed frame

The only products that may be coded and billed using code E0371 or E0373 are those products for which a written coding determination specifying the use of these codes has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor.

Group 2 support surfaces which do not meet the characteristics specified in the Definition section should be coded using code E1399.

Either alternating pressure mattresses or low air loss mattresses are coded using code E0277.

Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with 3" powered air cells on top of a 3" foam base would be coded as a powered overlay (code E0181) not as a powered mattress (E0277).

Suppliers should contact the PDAC contractor for guidance on the correct coding of these items.
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Coding Information

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

Other Comments
3/1/2008- In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A35350 from DME PSC TriCenturion (77011) Article A35350.

Revision History Explanation
Revision Effective Date: 04/01/2013
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Changed: “patient” to “beneficiary”
CODING GUIDELINES:
Added: Statement for heavy duty and bariatric devices

Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY AND COVERAGE AND PAYMENT RULES:
Added: Preamble language
CODING GUIDELINES (Effective 01/01/2007)
Removed: Reference to E0180 as a possible code for a powered overlay

Revision Effective Date: 01/01/2009
CODING GUIDELINES:
Revised: Changed SADMERC to PDAC

3/1/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A35350 from DME PSC TriCenturion (77011) Article A35350.

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).

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: 10/01/2005
LMRP converted to LCD and Policy Article

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