PRESSURE REDUCING SUPPORT SURFACES

Guideline Number: MPG259.03
Approval Date: May 10, 2017

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Related Medicare Advantage Policy Guidelines
- Air Fluidized Bed (NCD 280.8)
- Hospital Beds (NCD 280.7)
- KX Modifier

Related Medicare Advantage Reimbursement Policy
- Durable Medical Equipment Charges in a Skilled Nursing Facility

Related Medicare Advantage Coverage Summary
- Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid

INSTRUCTIONS FOR USE

This Policy Guideline is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates for health care services submitted on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450), or their electronic comparative. The information presented in this Policy Guideline is believed to be accurate and current as of the date of publication.

This Policy Guideline provides assistance in administering health benefits. All reviewers must first identify member eligibility, any federal or state regulatory requirements, Centers for Medicare and Medicaid Services (CMS) policy, the member specific benefit plan coverage, and individual provider contracts prior to use of this Policy Guideline. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document may differ greatly from the standard benefit plan upon which this Policy Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Policy Guideline. Other Policies and Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

UnitedHealthcare follows Medicare coverage guidelines and regularly updates its Medicare Advantage Policy Guidelines to comply with changes in CMS policy. UnitedHealthcare encourages physicians and other healthcare professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other healthcare professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. This Policy Guideline is provided for informational purposes. It does not constitute medical advice.

POLICY SUMMARY

Overview
Pressure reducing support surfaces are a type of durable medical equipment (DME) used for the care of pressure sores, also known as pressure ulcers. Pressure ulcers are lesions caused by unrelieved pressure resulting in damage of underlying tissue. A major distinction between support surfaces is that some are powered by electricity and others are not. They may be categorized into the following three groups:

- Group 1 support surfaces are generally designed to either replace a standard hospital or home mattress or as an overlay placed on top of a standard hospital or home mattress. Products in this category include mattresses, pressure pads and mattress overlays (foam, air, water, or gel).
- Group 2 support surfaces are generally designed to either replace a standard hospital or home mattress or as an overlay placed on top of a standard hospital or home mattress. Products in this category include powered air flotation beds, powered pressure reducing air mattresses, and non-powered advanced pressure reducing mattresses.
- Group 3 support surfaces are complete bed systems, known as air-fluidized beds, which use the circulation of filtered air through silicone beads. For additional information, please reference Air Fluidized Bed (NCD 280.8).
For any item to be covered by UnitedHealthcare, it must:

- Be eligible for a defined UnitedHealthcare benefit category
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable UnitedHealthcare statutory and regulatory requirements.

Guidelines – Group 1
A group 1 mattress overlay or mattress (E0181-E0189, E0196-E0199, and A4640) is covered if one of the following three criteria is met:

- The beneficiary is completely immobile - i.e., beneficiary cannot make changes in body position without assistance, OR
- 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 below, OR
- The beneficiary has any stage pressure ulcer on the trunk or pelvis AND at least one of conditions 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):

- Impaired nutritional status
- Fecal or urinary incontinence
- Altered sensory perception
- 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.

Guidelines – Group 2
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 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:
   - Use of an appropriate group 1 support surface, and
   - Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and
   - Appropriate turning and positioning, and
   - Appropriate wound care, and
   - Appropriate management of moisture/incontinence, and
   - 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

3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, 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".

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.

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:

- Other aspects of the care plan are being modified to promote healing, or
- The use of the group 2 support surface is reasonable and necessary for wound management.

Appropriate use of the KX modifier 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.

Guidelines – Group 3
Group 3 support surfaces are complete bed systems, known as air-fluidized beds, which use the circulation of filtered
air through silicone beads.

Coverage of a group 3 support surface is limited to bed-ridden or chair-bound patients with stage III or stage IV
pressure ulcers that without the use of an air-fluidized bed would be institutionalized. For additional information,
please reference Air Fluidized Bed (NCD 280.8).

Policy Specific Documentation Requirements
Affordable Care Act (ACA) 6407 Requirements

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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</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.

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 UnitedHealthcare 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:

- Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers
- Regular assessment by a nurse, physician, or other licensed healthcare practitioner
- Appropriate turning and positioning
- Appropriate wound care (for a stage II, III, or IV ulcer)
- Appropriate management of moisture/incontinence
- Nutritional assessment and intervention consistent with the overall plan of care

Prescription (Order) Requirements
All items billed to UnitedHealthcare 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
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
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.

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. 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**

**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 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
- 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 UnitedHealthcare 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**

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 UnitedHealthcare 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 UnitedHealthcare reimbursement and that the item(s) are intended for, and received by, a specific UnitedHealthcare 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 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:

- Delivery directly to the beneficiary or authorized representative
- 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. 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 document, the beneficiary or beneficiary’s designee-entered date is the date of service. 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.

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.

Repair/Replacement

A new 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:

- The treating physician must document that the DMEPOS item being repaired continues to be reasonable and necessary; and,
- Either the treating physician or the supplier must document that the repair itself is reasonable and necessary.

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Group 1 Codes</td>
<td></td>
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<tr>
<td>A4640</td>
<td>Replacement pad for use with medically necessary alternating pressure pad owned by patient. Characterized as:</td>
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<tr>
<td></td>
<td>• An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and</td>
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<tr>
<td></td>
<td>• Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and</td>
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<tr>
<td></td>
<td>• 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.</td>
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<tr>
<td></td>
<td>Code A4640 should only be billed when provided as a replacement component for a beneficiary-owned (E0181) mattress overlay system.</td>
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<tr>
<td>HCPCS Code</td>
<td>Description</td>
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<tr>
<td><strong>Group 1 Codes</strong></td>
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</tr>
<tr>
<td>A9270</td>
<td>Code A9270 describes a foam overlay or mattress which does not have a waterproof cover. (Status Indicator of “N”, Not Covered by Medicare)</td>
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</tbody>
</table>
| E0181 | Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy-duty Characterized as:  
- An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and  
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and  
- 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 |
| E0182 | Pump for alternating pressure pad, for replacement only Characterized as:  
- An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and  
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and  
- 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  
Code E0182 should only be billed when provided as a replacement component for a beneficiary-owned (E0181) mattress overlay system. |
| E0184 | Dry pressure mattress Characterized as:  
- Foam height of 5 inches or greater, and  
- Foam with a density and other qualities that provide adequate pressure reduction, and  
- Durable, waterproof cover, and  
- Can be placed directly on a hospital bed frame |
| E0185 | Gel or gel-like pressure pad for mattress, standard mattress length and width Characterized as a gel or gel-like layer with a height of 2 inches or greater. |
| E0186 | Air pressure mattress  
An air, water or gel pressure mattress’ (E0186, E0187, E0196) are characterized by all of the following:  
- Height of 5 inches or greater of the air, water, or gel layer (respectively), and  
- Durable, waterproof cover, and  
- Can be placed directly on a hospital bed frame |
| E0187 | Water pressure mattress  
An air, water or gel pressure mattress’ (E0186, E0187, E0196) are characterized by all of the following:  
- Height of 5 inches or greater of the air, water, or gel layer (respectively), and  
- Durable, waterproof cover, and  
- Can be placed directly on a hospital bed frame |
| E0188 | Synthetic sheepskin pad |
| E0189 | Lambswool sheepskin pad, any size |
| E0196 | Gel pressure mattress  
An air, water or gel pressure mattress’ (E0186, E0187, E0196) are characterized by all of the following:  
- Height of 5 inches or greater of the air, water, or gel layer (respectively), and  
- Durable, waterproof cover, and  
- Can be placed directly on a hospital bed frame |
<p>| E0197 | Air pressure pad for mattress, standard mattress length and width Characterized by interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump. |</p>
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Group 1 Codes</strong></td>
<td></td>
</tr>
<tr>
<td>E0198</td>
<td>Water pressure pad for mattress, standard mattress length and width Characterized by a filled height of 3 inches or greater.</td>
</tr>
</tbody>
</table>
| E0199 | Dry pressure pad for mattress, standard mattress length and width Characterized by all of the following:  
- 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  
- Foam with a density and other qualities that provide adequate pressure reduction, and  
- Durable, waterproof cover |
| **Group 2 Codes** | |
| E0277 | Powered pressure-reducing air mattress (alternating pressure, low air loss, or powered flotation without low air loss) Characterized by all of the following:  
- 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  
- Inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and  
- 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 patient lift, reduce pressure and prevent bottoming out, and  
- A surface designed to reduce friction and shear, and  
- Can be placed directly on a hospital bed frame. Either alternating pressure mattresses or low air loss mattresses are coded using code E0277 |
| E0371 | Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width Characterized by all of the following:  
- Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out, and  
- Total height of 3 inches or greater, and  
- A surface designed to reduce friction and shear, and  
- Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces. |
| E0372 | Powered air overlay for mattress, standard mattress length and width Characterized by all of the following:  
- 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  
- Inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and  
- 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 patient lift, reduce pressure and prevent bottoming out, and  
- A surface designed to reduce friction and shear |
| E0373 | Nonpowered advanced pressure reducing mattress Characterized by all of the following:  
- Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out, and  
- Total height of 5 inches or greater, and  
- A surface designed to reduce friction and shear, and  
- 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  
- Can be placed directly on a hospital bed frame |
### HCPCS Code | Description
--- | ---
**Both 1 and 2**
E1399 | Durable Medical Equipment, Miscellaneous
Group 2 support surfaces which do not meet the characteristics specified in the Definitions above, should be coded using code E1399
When code E1399 is billed, the claim must include the manufacturer and the product name/number

### Modifier | Description
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EY | No physician or other health care provider order for this item or service
KX | Requirements specified in the medical policy have been met
RR | Rental (use the RR modifier when DME is to be rented)
TW | Back Up Equipment

### Place of Service Code | Description
--- | ---
01 | Pharmacy
04 | Homeless shelter
09 | Prison/Correctional Facility
12 | Home
13 | Assisted living facility
14 | Group home
16 | Temporary lodging
33 | Custodial Care Facility
54 | Intermediate Care Facility/Mentally Retarded
55 | Residential Substance Abuse Treatment Facility
56 | Psychiatric Residential Treatment Center
65 | End Stage Renal Disease (ESRD) Treatment Facility

### ICD-10 Diagnosis Code | Description
--- | ---
**Codes for HCPCS codes E0277, E0371, E0372 and E0373**
L89.100 | Pressure ulcer of unspecified part of back, unstageable
L89.102 | Pressure ulcer of unspecified part of back, stage 2
L89.103 | Pressure ulcer of unspecified part of back, stage 3
L89.104 | Pressure ulcer of unspecified part of back, stage 4
L89.110 | Pressure ulcer of right upper back, unstageable
L89.112 | Pressure ulcer of right upper back, stage 2
L89.113 | Pressure ulcer of right upper back, stage 3
L89.114 | Pressure ulcer of right upper back, stage 4
L89.120 | Pressure ulcer of left upper back, unstageable
L89.122 | Pressure ulcer of left upper back, stage 2
L89.123 | Pressure ulcer of left upper back, stage 3
L89.124 | Pressure ulcer of left upper back, stage 4
L89.130 | Pressure ulcer of right lower back, unstageable
L89.132 | Pressure ulcer of right lower back, stage 2
L89.133 | Pressure ulcer of right lower back, stage 3
L89.134 | Pressure ulcer of right lower back, stage 4
L89.140 | Pressure ulcer of left lower back, unstageable
L89.142 | Pressure ulcer of left lower back, stage 2
L89.143 | Pressure ulcer of left lower back, stage 3
L89.144 | Pressure ulcer of left lower back, stage 4
<table>
<thead>
<tr>
<th>ICD-10 Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L89.150</td>
<td>Pressure ulcer of sacral region, unstageable</td>
</tr>
<tr>
<td>L89.152</td>
<td>Pressure ulcer of sacral region, stage 2</td>
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<tr>
<td>L89.153</td>
<td>Pressure ulcer of sacral region, stage 3</td>
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<tr>
<td>L89.154</td>
<td>Pressure ulcer of sacral region, stage 4</td>
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<tr>
<td>L89.200</td>
<td>Pressure ulcer of unspecified hip, unstageable</td>
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<td>Pressure ulcer of unspecified hip, stage 2</td>
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<tr>
<td>L89.210</td>
<td>Pressure ulcer of right hip, unstageable</td>
</tr>
<tr>
<td>L89.212</td>
<td>Pressure ulcer of right hip, stage 2</td>
</tr>
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<td>Pressure ulcer of contiguous site of back, buttock and hip, stage 2</td>
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<td>Pressure ulcer of contiguous site of back, buttock and hip, stage 4</td>
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<td>L89.45</td>
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**DEFINITIONS**

**Air Fluidized Bed:** Combines air fluidized therapy and low air loss therapy on an articulating frame providing patients with relief from bed pressure sores.

**Pressure Ulcer:** An area of skin that breaks down when constant pressure is placed against the skin.

**Stage I Ulcer:** 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 Ulcer:** 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 Ulcer:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
**Stage IV Ulcer:** 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.

**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.

**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.

**REFERENCES**

**CMS National Coverage Determinations (NCDs)**
- NCD 280.1 Durable Medical Equipment Reference List
- Reference NCDs: NCD 280.7 Hospital Beds, NCD 280.8 Air Fluidized Beds

**CMS Local Coverage Determinations (LCDs)**

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**CMS Articles**

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**CMS Claims Processing Manual**
- Chapter 5 Items and Services Having Special DME Review Considerations
- Chapter 23 Fee Schedule Administration and Coding Requirements

**MLN Matters**
- Article SE1014, Medicare Policy Regarding Pressure Reducing Surfaces

**Others**
- Decision Memo for Air-Fluidized Beds for Pressure Ulcers, CMS Website
- Department of Health and Human Services; Office Of Inspector General; Inappropriate Medicare Payments for Pressure Reducing Support Surfaces
- Medicare Program Integrity Manual: Chapter 3 Verifying Potential Errors and Taking Corrective Action; § 3.4.1.1 Linking LCD and NCD ID Numbers to Edits

**UnitedHealthcare Commercial Policies**
- Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies, and Repairs/Replacements
GUIDELINE HISTORY/REVISION INFORMATION

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