

# Local Coverage Determination (LCD): Pressure Reducing Support Surfaces - Group 1 (L33830)

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## Contractor Information

| Contractor Name                                    | Contract Type | Contract Number | Jurisdiction | State(s)  |
|--|---------------|-----------------|--------------|---|
| <a href="#">CGS Administrators, LLC</a>            | DME MAC       | 17013 -         | DME MAC J-B  | Illinois<br>Indiana<br>Kentucky<br>Michigan<br>Minnesota<br>Ohio<br>Wisconsin<br>Alabama<br>Arkansas<br>Colorado<br>Florida<br>Georgia<br>Louisiana<br>Mississippi<br>North Carolina<br>New Mexico<br>Oklahoma<br>Puerto Rico<br>South Carolina<br>Tennessee<br>Texas<br>Virginia<br>Virgin Islands<br>West Virginia<br>Connecticut<br>District of Columbia<br>Delaware<br>Massachusetts<br>Maryland<br>Maine<br>New Hampshire<br>New Jersey<br>New York - Entire State<br>Pennsylvania<br>Rhode Island<br>Vermont<br>Alaska<br>American Samoa<br>Arizona<br>California - Entire State<br>Guam<br>Hawaii<br>Iowa<br>Idaho<br>Kansas<br>Missouri - Entire State<br>Montana<br>North Dakota<br>Nebraska<br>Nevada<br>Oregon<br>South Dakota |
| <a href="#">CGS Administrators, LLC</a>            | DME MAC       | 18003 -         | DME MAC J-C  |   |
| <a href="#">Noridian Healthcare Solutions, LLC</a> | DME MAC       | 16013 -         | DME MAC J-A  |   |
| <a href="#">Noridian Healthcare Solutions, LLC</a> | DME MAC       | 19003 -         | DME MAC J-D  |   |

## LCD Information

### Document Information

LCD ID  
L33830Original Effective Date  
For services performed on or after 10/01/2015

Original ICD-9 LCD ID

[L11578](#)  
[L11563](#)  
[L27008](#)  
[L5067](#)Revision Effective Date  
For services performed on or after 01/01/2017Revision Ending Date  
N/ALCD Title  
Pressure Reducing Support Surfaces - Group 1Retirement Date  
N/A

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Notice Period Start Date  
N/ANotice Period End Date  
N/A

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CMS National Coverage Policy CMS Pub. 100-03, (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.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding "reasonable and necessary" criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

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.

GENERAL

A Detailed Written Order (DWO) (if applicable) 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 a completed DWO, the claim shall be denied as not reasonable and necessary.

For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must also obtain a DWO before submitting a claim for any associated options, accessories, and/or supplies that are separately billed. In this scenario, if the supplier bills for associated options, accessories, and/or supplies without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

A WOPD (if applicable) must be received by the supplier before a DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a completed WOPD, the claim shall be statutorily denied. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

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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 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:

**Group 1 Codes:**

A4640 REPLACEMENT PAD FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY PATIENT  
A9270 NON-COVERED ITEM OR SERVICE  
E0181 POWERED PRESSURE REDUCING MATTRESS OVERLAY/PAD, ALTERNATING, WITH PUMP, INCLUDES HEAVY DUTY  
E0182 PUMP FOR ALTERNATING PRESSURE PAD, FOR REPLACEMENT ONLY  
E0184 DRY PRESSURE MATTRESS  
E0185 GEL OR GEL-LIKE PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH  
E0186 AIR PRESSURE MATTRESS  
E0187 WATER PRESSURE MATTRESS  
E0188 SYNTHETIC SHEEPSKIN PAD  
E0189 LAMBSWOOL SHEEPSKIN PAD, ANY SIZE  
E0196 GEL PRESSURE MATTRESS  
E0197 AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH  
E0198 WATER PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH  
E0199 DRY PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH  
E1399 DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

ICD-10 Codes that Support Medical Necessity

**Group 1 Paragraph:** Not specified

**Group 1 Codes:** N/A

ICD-10 Codes that DO NOT Support Medical Necessity

**Group 1 Paragraph:** Not specified

**Group 1 Codes:** N/A

ICD-10 Additional Information

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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 treating practitioner'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.

### **GENERAL DOCUMENTATION REQUIREMENTS**

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- Prescription (orders)

- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

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

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

## **POLICY SPECIFIC DOCUMENTATION REQUIREMENTS**

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

## **MISCELLANEOUS**

### **APPENDICES**

The staging of pressure ulcers used in this policy is as follows (National Pressure Ulcer Advisory Panel, 2016 Revision):

**Stage 1 Pressure Injury: Non-blanchable erythema of intact skin**

Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

**Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis**

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARS), or traumatic wounds (skin tears, burns, abrasions).

**Stage 3 Pressure Injury: Full-thickness skin loss**

Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

**Stage 4 Pressure Injury: Full-thickness skin and tissue loss**

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

**Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss**

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

**Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-**

intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

### Utilization Guidelines

Refer to Coverage Indications, Limitations and/or Medical Necessity

Sources of Information and Basis for Decision

N/A [Back to Top](#)

## Revision History Information

| Revision History Date | Revision History Number | Revision History Explanation  | Reason(s) for Change   |
|-----------------------|-------------------------|---|--|
| 01/01/2017            | R4                      | <p><b>Revision Effective Date: 01/01/2017</b><br/>           COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:<br/>           Removed: Standard Documentation Language<br/>           Added: New reference language and directions to Standard Documentation Requirements<br/>           Added: General Requirements<br/>           DOCUMENTATION REQUIREMENTS:<br/>           Removed: Standard Documentation Language<br/>           Added: General Documentation Requirements<br/>           Added: New reference language and directions to Standard Documentation Requirements<br/>           POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:<br/>           Removed: Standard Documentation Language<br/>           Added: Direction to Standard Documentation Requirements<br/>           Removed: Supplier Manual reference from Miscellaneous section<br/>           Removed: PIM reference under Appendices section<br/>           Revised: Pressure ulcer staging criteria per NPUAP 2016 Staging Consensus Conference<br/>           RELATED LOCAL COVERAGE DOCUMENTS:<br/>           Added: LCD-related Standard Documentation Requirements article</p> | <ul style="list-style-type: none"> <li>Provider Education/Guidance</li> </ul>                              |
| 07/01/2016            | R3                      | <p><b>Revision Effective Date: 07/01/2016</b><br/>           COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:<br/>           Revised: Standard Documentation language - ACA order requirements - Effective 04/28/16<br/>           DOCUMENTATION REQUIREMENTS:<br/>           Revised: Standard Documentation language to add ACA 6407 Prescriptions Requirements, New Order Requirements, and Correct Coding Instructions; revised Proof of Delivery instructions (Effective 04/28/16)</p>  | <ul style="list-style-type: none"> <li>Provider Education/Guidance</li> </ul>                              |
| 07/01/2016            | R2                      | <p>Effective July 1, 2016 oversight for DME MAC LCDs is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the LCDs.</p>  | <ul style="list-style-type: none"> <li>Change in Assigned States or Affiliated Contract Numbers</li> </ul> |
| 10/01/2015            | R1                      | <p><b>Revision Effective Date: 10/01/2015</b><br/>           COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p>  | <ul style="list-style-type: none"> <li>Provider Education/Guidance</li> </ul>                              |

| Revision History Date | Revision History Number | Revision History Explanation   | Reason(s) for Change |
|-----------------------|-------------------------|--|----------------------|
|                       |                         | Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility<br>DOCUMENTATION REQUIREMENTS:<br>Revised: Standard Documentation Language to add who can enter date of delivery date on the POD<br>Added: Instructions for Equipment Retained from a Prior Payer<br>Revised: ACA 6407 verbiage<br>Added: Repair and Replacement section |                      |

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## [Associated Documents](#)

Attachments N/A

Related Local Coverage Documents Article(s) [A52489 - Pressure Reducing Support Surfaces - Group 1 - Policy Article](#)

[A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#)

Related National Coverage Documents N/A

Public Version(s) Updated on 05/04/2017 with effective dates 01/01/2017 - N/A [Updated on 08/19/2016 with effective dates 07/01/2016 - 12/31/2016](#) [Updated on 06/07/2016 with effective dates 07/01/2016 - N/A](#) [Updated on 04/10/2015 with effective dates 10/01/2015 - 06/30/2016](#) [Updated on 04/04/2014 with effective dates 10/01/2015 - N/A](#) [Back to Top](#)

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## [Keywords](#)

N/A Read the [LCD Disclaimer](#) [Back to Top](#)



**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.

# Local Coverage Article: Pressure Reducing Support Surfaces - Group 1 - Policy Article (A52489)

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## Contractor Information

| Contractor Name                                    | Contract Type | Contract Number | Jurisdiction | State(s)   |
|--|---------------|-----------------|--------------|--|
| <a href="#">CGS Administrators, LLC</a>            | DME MAC       | 17013 -         | DME MAC J-B  | Illinois<br>Indiana<br>Kentucky<br>Michigan<br>Minnesota<br>Ohio<br>Wisconsin<br>Alabama<br>Arkansas<br>Colorado<br>Florida<br>Georgia<br>Louisiana<br>Mississippi<br>North Carolina<br>New Mexico<br>Oklahoma<br>Puerto Rico<br>South Carolina<br>Tennessee<br>Texas<br>Virginia<br>Virgin Islands<br>West Virginia<br>Connecticut<br>District of Columbia<br>Delaware<br>Massachusetts<br>Maryland<br>Maine<br>New Hampshire<br>New Jersey<br>New York - Entire State<br>Pennsylvania<br>Rhode Island<br>Vermont<br>Alaska<br>American Samoa<br>Arizona<br>California - Entire State<br>Guam<br>Hawaii |
| <a href="#">CGS Administrators, LLC</a>            | DME MAC       | 18003 -         | DME MAC J-C  | Iowa<br>Idaho<br>Kansas<br>Missouri - Entire State<br>Montana<br>North Dakota<br>Nebraska<br>Nevada  |
| <a href="#">Noridian Healthcare Solutions, LLC</a> | DME MAC       | 16013 -         | DME MAC J-A  |  |
| <a href="#">Noridian Healthcare Solutions, LLC</a> | DME MAC       | 19003 -         | DME MAC J-D  |  |

## Article Information

### General Information

**Article ID**

A52489

**Original Article Effective Date**

10/01/2015

Original ICD-9 Article ID

[A33678](#)[A33747](#)[A47098](#)[A33769](#)**Revision Effective Date**

01/01/2017

**Revision Ending Date**

N/A

**Article Title**

Pressure Reducing Support Surfaces - Group 1 - Policy Article

**Retirement Date**

N/A

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### Article Guidance

**Article Text:****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.

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

**REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g)**

42 CFR 410.38(g) requires a face-to-face evaluation and a specific written order prior to delivery for specified HCPCS codes. CMS provides a list of the specified codes, which is periodically updated, located [here](#).

Claims for the specified items subject to 42 CFR 410.38(g) that do not meet the requirements specified in the LCD-related Standard Documentation Requirements Article will be denied as statutorily noncovered – failed to meet statutory requirements.

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

**POLICY SPECIFIC DOCUMENTATION REQUIREMENTS**

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

**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

## **MODIFIERS**

### **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 the related LCD 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.

## **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.

| Column I | Column II       |
|----------|-----------------|
| E0181    | A4640,<br>E0182 |

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items. [Back to Top](#)

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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 article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article 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 article, 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 article should be assumed to apply equally to all Revenue Codes.

N/A

**CPT/HCPCS Codes** N/A

**ICD-10 Codes that are Covered** N/A

## Revision History Information

| Revision History Date | Revision History Number | Revision History Explanation   |
|-----------------------|-------------------------|--|
| 01/01/2017            | R4                      | <b>Revision Effective Date: 01/01/2017</b><br>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:<br>Added: 42 CFR 410.38(g)<br>POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:<br>Added: Related Clinical Information and Modifier requirements<br>RELATED LOCAL COVERAGE DOCUMENTS:<br>Added: LCD-related Standard Documentation Requirements Language Article   |
| 07/01/2016            | R3                      | <b>Revision Effective Date: 07/01/2016</b><br>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:<br>Revised Standard Language to add Statutory Prescription (Order) Requirements, revised Face to Face and ACA requirements (Effective 04/28/2016)<br>Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles. |
| 07/01/2016            | R2                      | <b>Revision Effective Date: 10/31/2014</b><br>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:<br>Removed: "When required by state law" from ACA new prescription requirements<br>Revised: Face-to-Face Requirements for treating practitioner  |
| 10/01/2015            | R1                      |  |

[Back to Top](#) **Related Local Coverage Document(s)** Article(s) [A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#) LCD(s) [L33830 - Pressure Reducing Support Surfaces - Group 1](#)

**Related National Coverage Document(s)** N/A

**Statutory Requirements URL(s)** N/A

**Rules and Regulations URL(s)** N/A

**CMS Manual Explanations URL(s)** N/A

**Other URL(s)** N/A

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## Keywords

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