Local Coverage Determination (LCD): Pressure Reducing Support Surfaces - Group 3 (L33692)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

### Contractor Information

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**LCD Information**

**Document Information**

**LCD ID**
L33692

**LCD Title**
Pressure Reducing Support Surfaces - Group 3

**Original Effective Date**
For services performed on or after 10/01/2015

**Revision Effective Date**
For services performed on or after 01/01/2020

**Proposed LCD in Comment Period**
N/A

**Revision Ending Date**
N/A

**Source Proposed LCD**
N/A

**Retirement Date**
N/A

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**Notice Period Start Date**
N/A

**Notice Period End Date**
N/A
CMS National Coverage Policy

CMS Pub. 100-03, (Medicare National Coverage Determinations Manual), Chapter 1, Section 280.8

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.
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.

An air-fluidized bed is covered only if all of the following criteria are met:

1. The beneficiary has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcer (Refer to the ICD-10 codes in the LCD-related Policy Article for applicable diagnoses).

2. The beneficiary is bedridden or chair bound as a result of severely limited mobility.

3. In the absence of an air-fluidized bed, the beneficiary would require institutionalization.

4. The air-fluidized bed is ordered in writing by the beneficiary’s treating practitioner based upon a comprehensive assessment and evaluation of the beneficiary after completion of a course of conservative treatment designed to optimize conditions that promote wound healing. The evaluation generally must be performed within one month prior to initiation of therapy with the air-fluidized bed.

5. The course of conservative treatment must have been at least one month in duration without progression toward wound healing. This month of prerequisite conservative treatment may include some period in an institution as long as there is documentation available to verify that the necessary conservative treatment was rendered. Conservative treatment must include:

   a. Frequent repositioning of the beneficiary with particular attention to relief of pressure over bony prominences (usually every 2 hours); and

   b. Use of a Group 2 support surface to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation; and

   c. Necessary treatment to resolve any wound infection; and

   d. Optimization of nutrition status to promote wound healing; and

   e. Debridement by any means, including wet-to-dry gauze dressings, to remove devitalized tissue from the wound bed; and

   f. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals.

In addition, conservative treatment should generally include:

   g. Education of the beneficiary and caregiver on the prevention and management of pressure ulcers; and

   h. Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly, and

   i. Appropriate management of moisture/incontinence.

An occlusive barrier is required, when necessary, to maintain a moist wound-healing environment that may
otherwise be compromised by the drying action of airflow generated by air-fluidized therapy. If moist dressings are NOT required because of the wound characteristics (e.g. heavily exudative wound, etc.), the occlusive barrier is not required as a condition for reimbursement.

Wet-to-dry dressings when used for debridement do not require an occlusive dressing. Use of wet-to-dry dressings for wound debridement, begun during the period of conservative treatment and which continue beyond 30 days will not preclude coverage of an air-fluidized bed. Should additional debridement again become necessary while a beneficiary is using an air-fluidized bed (after the first 30-day course of conservative treatment) that will not cause the air-fluidized bed to be denied.

6. A trained adult caregiver is available to assist the beneficiary with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage.

7. A treating practitioner directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis.

8. All other alternative equipment has been considered and ruled out.

An air-fluidized bed will be denied as not reasonable and necessary under any of the following circumstances:

1. The beneficiary has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions);

2. The beneficiary requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material;

3. The caregiver is unwilling or unable to provide the type of care required by the beneficiary on an air-fluidized bed;

4. Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1600 pounds or more);

5. Electrical system is insufficient for the anticipated increase in energy consumption; or

6. Other known contraindications exist.

Payment is not included for the caregiver or for architectural adjustments such as electrical or structural improvement.

The continued coverage of an air-fluidized bed as reasonable and necessary must be documented by the treating practitioner every month. Continued use of an air-fluidized bed is covered until the ulcer is healed or, if healing does not continue, there is documentation to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the bed is reasonable and necessary for wound management.

If the stated coverage criteria for an air-fluidized bed are not met, the claim will be denied as not reasonable and necessary.

GENERAL

A Standard Written Order (SWO) must be communicated to the supplier before a claim is submitted. If the supplier
bills for an item addressed in this policy without first receiving a completed SWO, 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 have received a signed SWO before the DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a WOPD, the claim shall be denied as not reasonable and necessary. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

For DMEPOS base items that require a WOPD, and also require separately billed associated options, accessories, and/or supplies, the supplier must have received a WOPD which lists the base item and which may list all the associated options, accessories, and/or supplies that are separately billed prior to the delivery of the items. In this scenario, if the supplier separately bills for associated options, accessories, and/or supplies without first receiving a completed and signed WOPD of the base item prior to delivery, the claim(s) shall be denied as not reasonable and necessary.

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.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:
The appearance of a code in this section does not necessarily indicate coverage.
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:

- SWO
- 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.
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 (MARSI), 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

N/A

Bibliography

N/A

Revision History Information

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| 01/01/2020            | R6                      | Revision Effective Date: 01/01/2020  
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:  
Removed: Statement to refer to ICD-10 Codes that are Covered section in the LCD-related PA  
Added: Statement to refer to ICD-10 code list in the LCD-related Policy Article  
Revised: “attending physician” to “treating practitioner”  
Revised: “physician” to “treating practitioner”  
Revised: Order information as a result of Final Rule 1713  
CODING INFORMATION:  
Removed: Field titled “Bill Type”  
Removed: Field titled “Revenue Codes”  
Removed: Field titled “ICD-10 Codes that Support Medical Necessity”  
Removed: Field titled “ICD-10 Codes that DO NOT Support Medical Necessity”  
Removed: Field titled “Additional ICD-10 Information”  
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• Other |
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<td>Added: Instructions for Equipment Retained from a Prior Payer</td>
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<td>Revised: Repair to beneficiary-owned DMEPOS</td>
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**Associated Documents**

**Attachments**
Related Local Coverage Documents

Article(s)
- A52468 - Pressure Reducing Support Surfaces - Group 3 - Policy Article
- A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

Related National Coverage Documents

N/A

Public Version(s)

Updated on 02/21/2020 with effective dates 01/01/2020 - N/A
Updated on 02/21/2019 with effective dates 01/01/2019 - 12/31/2019
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

N/A
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.
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## Article Information

### General Information

**Article ID**
A52468

**Original Effective Date**
10/01/2015

**Original ICD-9 Article ID**

- A37055
- A47128
- A37217
- A37080

**Revision Effective Date**
01/01/2020

**Revision Ending Date**
N/A

**Article Title**
Pressure Reducing Support Surfaces - Group 3- Policy Article

**Retirement Date**
N/A

**Article Type**
Article
Article Guidance

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 §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 §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.

**REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217)**

Final Rule 1713 (84 Fed. Reg Vol 217) requires a face-to-face encounter and a Written Order Prior to Delivery (WOPD) for specified HCPCS codes. CMS and the DME MACs provides a list of the specified codes, which is periodically updated. The link will be located here once it is available.

Claims for the specified items subject to Final Rule 1713 (84 Fed. Reg Vol 217) that do not meet the face-to-face encounter and WOPD requirements specified in the LCD-related Standard Documentation Requirements Article (A55426) will be denied as not reasonable and necessary.

If a supplier delivers an item prior to receipt of a WOPD, it will be denied as not reasonable and necessary. If the WOPD is not obtained prior to delivery, payment will not be made for that item even if a WOPD is subsequently obtained by the supplier. If a similar item is subsequently provided by an unrelated supplier who has obtained a WOPD 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.

**MODIFIERS**

**KX, GA, AND GZ MODIFIERS**

Suppliers must add a KX modifier to E0194 on the initial claim 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 retained in the supplier’s files and available to the DME MAC upon request.

For each subsequent month’s claim use a KX modifier only if the treating practitioner’s monthly certification indicates that continued use is necessary. Discontinue use of the KX modifier if the coverage criteria are not met or use is discontinued.

In all of the situations above describing use of the KX modifier, if all of the specific coverage criteria 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.

Claims lines billed with codes without a KX, GA or GZ modifier will be rejected as missing information.
MISCELLANEOUS

On a monthly basis, the treating practitioner must document the need for the equipment with a written statement specifying:

1. The size of the ulcer;
2. If the ulcer is not healing, what other aspects of the care plan are being modified to promote healing;
3. Continued use of the bed is reasonable and necessary for wound management.

This monthly treating practitioner statement must be kept on file by the supplier and be available for inspection upon request.

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

CODING GUIDELINES

An air-fluidized bed (E0194) is a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid.

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

Coding Information

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<td><strong>Group 1 Paragraph:</strong> The presence of an ICD-10 code listed in this section is not sufficient by itself to assure coverage. Refer to the LCD section on “Coverage Indications, Limitations, and/or Medical Necessity” for other coverage criteria and payment information.</td>
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**ICD-10 Codes that DO NOT Support Medical Necessity**

**Group 1 Paragraph:**

All ICD-10 codes that are not specified in the preceding section.

**Group 1 Codes:**

N/A

**Additional ICD-10 Information**

N/A

**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

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| 01/01/2020            | R6                      | Revision Effective Date: 01/01/2020  
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:  
Removed: REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g) section  
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):  
Added: Section and related information based on Final Rule 1713  
MODIFIERS:  
Revised: “physician’s” to “treating practitioner’s”  
MISCELLANEOUS:  
Revised: “physician” to “practitioner”  
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:  
Revised: Section header “ICD-10 Codes that are Covered” updated to “ICD-10 Codes that Support Medical Necessity”  
ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:  
Revised: Section header “ICD-10 Codes that are Not Covered” updated to “ICD-10 Codes that DO NOT Support Medical Necessity”  

02/27/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination. |
| 01/01/2019            | R5                      | Revision Effective Date: 01/01/2019  
ICD-10 CODES THAT ARE COVERED:  
Added: All diagnosis codes formerly listed in the LCD  
ICD-10 CODES THAT ARE NOT COVERED:  
Added: Notation excluding all unlisted diagnosis codes from coverage  

02/28/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination. |
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| 01/01/2017            | R4                     | Revision Effective Date: 01/01/2017  
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:  
Added: 42 CFR 410.38(g)  
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:  
Added: Modifier instructions and Physician statement requirement  
RELATED LOCAL COVERAGE DOCUMENTS:  
Added: LCD-related Standard Documentation Requirements Language Article |
| 07/01/2016            | R3                     | Revision Effective Date: 7/01/2016  
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:  
Revised Standard Language to add Statutory Prescription (Order) Requirements, revised Face to Face and ACA requirements (Effective 04/28/2016) |
| 07/01/2016            | R2                     | 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. |
| 10/01/2015            | R1                     | Revision Effective Date: 10/31/2014  
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:  
Removed: “When required by state law” from ACA new prescription requirements  
Revised: Face-to-Face Requirements for treating practitioner |

**Associated Documents**

**Related Local Coverage Document(s)**

- Article(s)
  - A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs
- LCD(s)
  - L33692 - Pressure Reducing Support Surfaces - Group 3

**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

**Public Version(s)**

N/A
Keywords

N/A