IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy. This information is intended to serve only as a general resource regarding UnitedHealthcare’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee’s benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. CPT codes and descriptions are copyright 2010 American Medical Association (or such other date of publication of CPT). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to Government use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Current Dental Terminology (CDT), including procedure codes, nomenclature, descriptors, and other data contained therein, is copyright by the American Dental Association, 2002, 2004. All rights reserved. CDT is a registered trademark of the American Dental Association. Applicable FARS/DFARS apply.

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 Beds (NCD 280.8) reimbursement policy.

For any item to be covered by Medicare, it must:

- Be eligible for a defined Medicare 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 Medicare statutory and regulatory requirements.

Reimbursement 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 are met:

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

**Reimbursement Guidelines – Group 2**

A group 2 support surface is covered if:

1. The patient has multiple stage II pressure ulcers located on the trunk or pelvis **AND**
2. The patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface

Comprehensive ulcer treatment program includes:

- Education of the patient and caregiver on the prevention and/or management of pressure ulcers
- Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer)
- 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

**AND**

- The ulcers have worsened or remained the same over the past month.

**OR**

- The patient has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis.

**OR**

- The patient had a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days).

**AND**

- The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

**Indications, Limitations and Documentation Requirements – 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 (ICD-9 707.02-707.05) which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program including each of the following:
   
   a. Use of an appropriate group 1 support surface, and
Pressure Reducing Support Surfaces

b. Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and
c. Appropriate turning and positioning, and
d. Appropriate wound care, and
e. Appropriate management of moisture/incontinence, and
f. Nutritional assessment and intervention consistent with the overall plan of care

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

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

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:

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

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

Reimbursement 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 Beds (NCD 280.8) reimbursement policy.

Policy Specific Documentation Requirements

Affordable Care Act (ACA) 6407 Requirements

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<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 Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

**Related Clinical Information**

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

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

**Prescription (Order) Requirements**

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

**Written Orders Prior To Delivery**

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
- A properly completed CMN or DIF with an appropriate length of need specified
- Timely documentation in the beneficiary's medical record showing usage of the item

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

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

#### Continued Use

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

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

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

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

#### Proof of Delivery

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

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from determining the correctness of the information contained in the delivery documentation.

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

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Pressure Reducing Support Surfaces

from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

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

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

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

1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service

Method 1—Direct Delivery to the Beneficiary by the Supplier
Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

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

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

Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary
If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

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

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

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

<table>
<thead>
<tr>
<th>CPT/HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Group 1 Codes</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Code</strong></td>
<td><strong>Description</strong></td>
</tr>
</tbody>
</table>
| A4640 | Replacement pad for use with medically necessary alternating pressure pad owned by patient. Characterized as:  
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.  
Code A4640 should only be billed when provided as a replacement component for a beneficiary-owned (E0181) mattress overlay system. |
| A9270 | Code A9270 describes a foam overlay or mattress which does not have a waterproof cover.  
(Status Indicator of "N", Not Covered by Medicare) |
| E0181 | Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy-duty  
Characterized as:  
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.  
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 should only be billed when provided as a replacement component for a beneficiary-owned (E0181) mattress overlay system. |
| E0182 | Pump for alternating pressure pad, for replacement only  
Characterized as:  
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  
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:  
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  
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. |
Pressure Reducing Support Surfaces

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
</table>
| E0186 | Air pressure mattress  
An air, water or gel pressure mattress’ (E0186, E0187, E0196) are 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 |
| E0187 | Water pressure mattress  
An air, water or gel pressure mattress’ (E0186, E0187, E0196) are 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 |
| 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:  
  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 |
| 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. |
| E0198 | Water pressure pad for mattress, standard mattress length and width  
Characterized by a filled height of 3 inches or greater. |
| E0199 | Dry pressure pad for mattress, standard mattress length and width  
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 |

Group 2 Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
</table>
| E0277 | Powered pressure-reducing air mattress (alternating pressure, low air loss, or powered flotation without low air loss)  
Characterized by all of the following:  
  1. An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, and  
  2. Inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and  
  3. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out, and  
  4. A surface designed to reduce friction and shear, and  
  5. Can be placed directly on a hospital bed frame.  
Either alternating pressure mattresses or low air loss mattresses are coded using code E0277 |
## Pressure Reducing Support Surfaces

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0371</td>
<td>Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width</td>
</tr>
<tr>
<td></td>
<td>Characterized by all of the following:</td>
</tr>
<tr>
<td></td>
<td>1. Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out, and</td>
</tr>
<tr>
<td></td>
<td>2. Total height of 3 inches or greater, and</td>
</tr>
<tr>
<td></td>
<td>3. A surface designed to reduce friction and shear, and</td>
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<tr>
<td></td>
<td>4. Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces.</td>
</tr>
<tr>
<td>E0372</td>
<td>Powered air overlay for mattress, standard mattress length and width</td>
</tr>
<tr>
<td></td>
<td>Characterized by all of the following:</td>
</tr>
<tr>
<td></td>
<td>1. An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and</td>
</tr>
<tr>
<td></td>
<td>2. Inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and</td>
</tr>
<tr>
<td></td>
<td>3. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out, and</td>
</tr>
<tr>
<td></td>
<td>4. A surface designed to reduce friction and shear.</td>
</tr>
<tr>
<td>E0373</td>
<td>Nonpowered advanced pressure reducing mattress</td>
</tr>
<tr>
<td></td>
<td>Characterized by all of the following:</td>
</tr>
<tr>
<td></td>
<td>1. Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out, and</td>
</tr>
<tr>
<td></td>
<td>2. Total height of 5 inches or greater, and</td>
</tr>
<tr>
<td></td>
<td>3. A surface designed to reduce friction and shear, and</td>
</tr>
<tr>
<td></td>
<td>4. Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces, and</td>
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<tr>
<td></td>
<td>5. Can be placed directly on a hospital bed frame</td>
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### Both Group 1 and 2

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>E1399</td>
<td>Durable Medical Equipment, Miscellaneous</td>
</tr>
<tr>
<td></td>
<td>Group 2 support surfaces which do not meet the characteristics specified in the Definitions above, should be coded using code E1399</td>
</tr>
<tr>
<td></td>
<td>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. (L5067)</td>
</tr>
</tbody>
</table>

### Modifiers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>EY</td>
<td>No physician or other health care provider order for this item or service</td>
</tr>
<tr>
<td>KX</td>
<td>Requirements specified in the medical policy have been met</td>
</tr>
<tr>
<td>TW</td>
<td>Back Up Equipment</td>
</tr>
<tr>
<td>RR</td>
<td>Rental (use the RR modifier when DME is to be rented)</td>
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### Questions and Answers

1. Q: Does every claim for a pressure reducing support surface have to have a written order and be submitted with a modifier?
### Pressure Reducing Support Surfaces

| **A:** | Yes, 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 delivered before a signed written order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code. Suppliers must add a KX modifier on the initial claim only if all the criteria in the "Reimbursement Guidelines" section of this policy have been met and evidence of such is retained in the supplier's files and available upon request. For each subsequent month's claim use a KX modifier only if the physician'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. |
| **Q:** | How often does the treating physician have to document the need for the equipment? |
| **A:** | On a monthly basis, the treating physician must document the need for the equipment with a written statement specifying:  
- The size of the ulcer  
- If the ulcer is not healing, what other aspects of the care plan are being modified to promote healing  
- Continued use of the bed is reasonable and necessary for wound management |

### References Included (but not limited to):

- **CMS NCD(s)**  
  - NCD 280.1 Durable Medical Equipment Reference List  
  - NCD 280.7 Hospital Beds  
  - NCD 280.8 Air Fluidized Beds  

- **CMS LCD(s)**  
  - Numerous LCDs

- **CMS Article(s)**  
  - Numerous Articles

- **CMS Claims Processing Manual**  
  - Chapter 5, Items and Services Having Special DME Review Considerations  
  - Chapter 23, Fee Schedule Administration and Coding Requirements  
  - Chapter 26, Completing and Processing Form CMS-1500 Data Set

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

- **UnitedHealthcare Reimbursement Policies**  
  - Air Fluidized Beds (NCD 280.8)  
  - Durable Medical Equipment Charges in a Skilled Nursing Facility  
  - Hospital Beds (NCD 280.7)  
  - KX Modifier

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

- **Others**  
  - Decision Memo for Air-Fluidized Beds for Pressure Ulcers, CMS Website  
  - 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  
  - Department of Health and Human Services; Office Of Inspector General; Inappropriate Medicare Payments for Pressure Reducing Support Surfaces

### History

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<tr>
<th>Date</th>
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<tr>
<td>05/28/2014</td>
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