Blue Cross and Blue Shield of Minnesota medical policies do not imply that members should not receive specific services based on the recommendation of their provider. These policies govern coverage and not clinical practice. Providers are responsible for medical advice and treatment of patients. Members with specific health care needs should consult an appropriate health care professional.

PRESSURE-REDUCING SUPPORT SURFACES

Description: Pressure-reducing support surfaces are used to prevent or promote the healing of specific types of pressure ulcers by reducing or eliminating tissue interface pressure.

Policy:

Group 1 Pressure Reducing Support Surfaces (A4640, E0181, E0182, E0184, E0185, E0186, E0187, E0196, E0197, E0198 and E0199)
A Group 1 mattress overlay or mattress may be considered MEDICALLY NECESSARY when ONE of the following criteria are met:

- Member is completely immobile; OR
- Member cannot independently make changes in body position significant enough to alleviate pressure and has one of the following conditions:
  1. Current pressure ulcer on the trunk or pelvis;
  2. History of pressure ulcers on the trunk or pelvis;
  3. Impaired nutritional status;
  4. Fecal or urinary incontinence;
  5. Altered sensory perception;
  6. Compromised circulatory status.

Group 2 Pressure Reducing Support Surfaces (E0193, E0277, E0371, E0372 and E0373)
A Group 2 pressure reducing support surface (i.e., alternating pressure and low air loss mattress and overlay) may be considered MEDICALLY NECESSARY when any ONE of the following criteria are met:

- Large stage III (full thickness tissue loss) or IV (deep tissue destruction) pressure ulcer(s) on the trunk or pelvis and member cannot be positioned off the ulcer areas;
- Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) and member
has been on a pressure reducing support surface immediately prior to discharge from a hospital or long-term care facility; OR

- The member has been on a Group 2 or Group 3 support surface immediately prior to a recent discharge from a hospital or long-term care facility (discharge within the past 30 days).

- For multiple stage II pressure ulcers located on the trunk or pelvis; member has been on a comprehensive ulcer treatment program for at least one month and has used lower level support surface and ulcers have worsened. The comprehensive ulcer treatment program should generally include:
  1. Education of the individual and caregiver on the prevention and/or management of pressure ulcers
  2. Regular assessment by a nurse, physician or other licensed healthcare practitioner (usually at least weekly for an individual with a stage III or IV ulcer)
  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

Continued use of a Group 2 support surface after the initial approval may be considered MEDICALLY NECESSARY when

- the member continues to meet all medical necessity criteria for a group 2 support surface listed above, AND
- there is documentation in the medical record to show that other aspects of the care plan are being modified to promote healing, AND
- alternative treatments have been considered.

When a Group 2 pressure reducing support surface is prescribed following a myocutaneous flap or skin graft, continued use may be considered MEDICALLY NECESSARY for up to 60 days from the date of surgery.

**Group 3 Pressure Reducing Support Surfaces (E0194)**

A Group 3 pressure reducing support surface (i.e., air-fluidized bed) may be considered MEDICALLY NECESSARY when ALL of the following criteria are met:

- The member has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcer on the trunk or pelvis; AND
- The member is bedridden or chair-bound as a result of severely limited mobility; AND
- A trained adult caregiver is available to assist the member with activities of daily living (ADLs), 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; AND
• A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis; **AND**
• All other alternative equipment has been considered and ruled out; **AND**
• The air-fluidized bed is ordered by the member’s attending physician based upon a comprehensive assessment and evaluation of the member after conservative treatment has been tried for at least one month without progression toward wound healing. Conservative treatment must include:
  1. Frequent repositioning of member with particular attention to relief of pressure over bony prominences (usually every two hours); **AND**
  2. Use of a Group 2 support surface to reduce pressure and sheer forces on healing ulcers and to prevent new ulcer formation; **AND**
  3. Necessary treatment to resolve any wound infection; **AND**
  4. Optimization of nutrition status to promote wound healing; **AND**
  5. Debridement by any means, including wet-to-dry gauze dressings; **AND**
  6. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals.

**Continued Use of a Group 3 Device**
The continued use of a Group 3 device (i.e., air-fluidized bed) must have healing as the goal of treatment, and may be considered **MEDICALLY NECESSARY** when the treating physician re-certifies the following on a monthly basis:
• Stage III or IV pressure sore on the trunk or pelvis;
• Member is bedridden or chair bound as a result of severely limited mobility; and
• All other alternative equipment has been considered and ruled out.

After **six months** on a Group 3 support surface with no improvement in the member’s condition, alternative treatments must be considered before additional monthly authorization.

An air-fluidized bed is considered **NOT MEDICALLY NECESSARY** under any of the following circumstances:
• The member has co-existing pulmonary disease; **OR**
• The member requires treatment with wet soaks or moist wound dressings not protected with an impervious covering unless the member is undergoing aggressive treatment in a wound clinic and is showing measurable improvement.

**Coverage:**
Rental vs. purchase information:
Group 1 items are eligible for rental or purchase.
Group 2 items are eligible for rental only and are considered purchased after 10 months of medically necessary rental. Group 3 items are eligible for medically necessary rental only.

Blue Cross and Blue Shield of Minnesota medical policies apply generally to all Blue Cross and Blue Plus plans and products. Benefit plans vary in coverage and some plans may not provide coverage for certain services addressed in the medical policies.

Medicaid products and some self-insured plans may have additional policies and prior authorization requirements. Receipt of benefits is subject to all terms and conditions of the member’s summary plan description (SPD). As applicable, review the provisions relating to a specific coverage determination, including exclusions and limitations. Blue Cross reserves the right to revise, update and/or add to its medical policies at any time without notice.

For Medicare NCD and/or Medicare LCD, please consult CMS or National Government Services websites.

Refer to the Pre-Certification/Pre-Authorization section of the Medical Behavioral Health Policy Manual for the full list of services, procedures, prescription drugs, and medical devices that require Pre-certification/Pre-Authorization. Note that services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial of claims may result if criteria are not met.

**Coding:**

*The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.*

**HCPCS:**

A4640 Replacement pad for use with medically necessary alternating pressure pad owned by patient
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
E0193 Powered air flotation bed (low air loss therapy)
E0194 Air fluidized bed
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
E0277 Powered pressure-reducing air mattress
E0371 Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width
E0372 Powered air overlay for mattress, standard mattress length and width
E0373 Non-powered advanced pressure reducing mattress

Policy History: Developed April 8, 2009

Most recent history:
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Cross Reference: Durable Medical Equipment (DME), VII-07

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