LCD for Pressure Reducing Support Surfaces - Group 3 (L5069)

Contractor Information

Contractor Name

NHIC

Contractor Number

16003

Contractor Type

DME MAC

LCD Information

LCD ID Number

L5069

LCD Title

Pressure Reducing Support Surfaces - Group 3

Contractor's Determination Number

PRSS3

AMA CPT / ADA CDT Copyright Statement

CMS National Coverage Policy

CMS Pub. 100-3, (Medicare National Coverage Determinations Manual), Chapter 1, Section 280.8

Primary Geographic Jurisdiction

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

Oversight Region

Region III

DME Region LCD Covers

Jurisdiction A

Original Determination Effective Date

For services performed on or after 10/01/1993

Original Determination Ending Date

Revision Effective Date

For services performed on or after 01/01/2009

Revision Ending Date

Indications and Limitations of Coverage 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. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

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

1. The patient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcer (ICD-9 codes 707.23-707.24).
2. The patient is bedridden or chair bound as a result of severely limited mobility.
3. In the absence of an air-fluidized bed, the patient would require institutionalization.
4. The air-fluidized bed is ordered in writing by the patient's attending physician based upon a comprehensive assessment and evaluation of the patient 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 patient 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 patient 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.

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 patient 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 patient 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 physician 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 medically necessary under any of the following circumstances:

1. The patient has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions);
2. The patient 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 patient 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 medical necessity of an air-fluidized bed must be documented by the treating physician 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 medically necessary for wound management.

If the stated coverage criteria for an air-fluidized bed are not met, the claim will be denied as not medically necessary unless there is clear documentation which justifies the medical necessity for the item in the individual case

Coverage Topic

Durable Medical Equipment
Pressure Reducing Support Surfaces - Group 3

Coding Information

CPT / HCPCS Codes

The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIER:

EY – No physician or other health care provider order for this item or service

KX - Specific required documentation on file.

E0194	AIR FLUIDIZED BED

ICD-9 Codes that Support Medical Necessity

The presence of an ICD-9 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on Indications and Limitation of Coverage and/or Medical Necessity for other coverage criteria and payment information.

707.23	PRESSURE ULCER, STAGE III
707.24	PRESSURE ULCER, STAGE IV

Diagnoses that Support Medical Necessity

All diagnoses that are specified in the preceding section.

ICD-9 Codes that DO NOT Support Medical Necessity

All ICD-9 codes that are not specified in the preceding section.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

All diagnoses that are not specified in the preceding section.

General 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 patient's medical records will reflect the need for the care provided. The patient's medical records include the physician'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.

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.

On a monthly basis, the treating physician 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 medically necessary for wound management.

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

For the initial claim, suppliers must add a KX modifier to a code only if all of the criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy have been met. If the requirements for the KX modifier are not met, the KX modifier must not be used.

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.

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

Appendices

The staging of pressure ulcers used in this policy is as follows:

Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Utilization Guidelines

Refer to Indications and Limitations of Coverage and/or Medical Necessity.

Sources of Information and Basis for Decision

National Pressure Ulcer Advisory Panel (NPUAP) Revised Staging Definitions for Pressure Ulcers accessed at NPUAP on August 28, 2008.

Advisory Committee Meeting Notes

Start Date of Comment Period

04/30/1993

End Date of Comment Period

06/14/1993

Start Date of Notice Period

08/01/1993

Revision History Number

009

Revision History Explanation

Revision Effective Date: 01/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added : ICD-9 codes 707.23 and 707.24.
ICD-9 CODES:
Added: 707.23 & 707.24 – Pressure ulcers, stages III and IV
APPENDICES:
Revised: Definitions of pressure ulcer stages.
SOURCES OF INFORMATION AND BASIS FOR DECISION:
Added: Reference to NPUAP guidelines for pressure ulcer staging.

03/01/2008- In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) LCD L5069 from DME PSC TriCenturion (77011) LCD L5069.

06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

Revision Effective Date: 01/01/2007
HCPCS CODES AND MODIFIERS:
Added KX modifier.
DOCUMENTATION REQUIREMENTS:
Removed requirement to submit a CMN.
Revised the monthly physician certification requirement.
Added the use of the KX modifier.

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective Date: 01/01/2006

LMRP converted to LCD and Policy Article
DOCUMENTATION REQUIREMENTS:
Removed requirement to submit additional documentation with the sixth month revised CMN.

This LCD was converted from an LMRP on 11/04/2005.

Revision Effective Date: 04/01/2003
HCPCS CODES AND MODIFIERS:
Added: EY modifier
INDICATIONS AND LIMITATIONS OF COVERAGE:
Adds standard language concerning coverage of items without a written order prior to delivery
DOCUMENTATION REQUIREMENTS:
Adds standard language concerning use of EY modifier for items without a written order prior to delivery.

The revision dates listed below are the dates the revisions were published and not necessarily the effective dates for the revisions.

12/01/2000 - Incorporated recent revisions made to the national policy in Coverage Issues Manual, section 60-19.

07/01/1998 - Effective August 1, 1998, the documentation requirements for this policy have been revised. A revised Certificate of Medical Necessity (CMN) will be required in the 6th month instead of on a monthly basis. The revised policy now specifies the contents of the monthly documentation from the treating physician which must be kept on file by the supplier.

10/01/1995 - Alternating Pressure Pads and Mattresses policy was separated into three policies – Pressure Reducing Support Surfaces, Group 1, Group 2, and Group 3. Added HCPCS code for Group 3 – E0194. Revised entire policy for information specific to Group 3 support surfaces.

12/01/1993 – Clerical corrections as follows: CMN for Group 2 corrected to 01 from 01.00; and HAO corrected to HA0 in Documentation section.

Reason for Change

Last Reviewed On Date

Related Documents

Article(s)
A37217 - Pressure Reducing Support Surfaces - Group 3 - Policy Article - Effective January 2009

LCD Attachments

There are no attachments for this LCD

Article for Pressure Reducing Support Surfaces - Group 3 - Policy Article - Effective January 2009 (A37217)

Contractor Information

Contractor Name

NHIC

Contractor Number

16003

Contractor Type

DME MAC

Article Information

Article ID Number

A37217

Article Type

Article

Key Article

Yes

Article Title

Pressure Reducing Support Surfaces - Group 3 - Policy Article - Effective January 2009

AMA CPT / ADA CDT Copyright Statement

Primary Geographic Jurisdiction

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

DME Region Article Covers

Jurisdiction A

Original Article Effective Date

01/01/2006

Article Revision Effective Date

01/01/2009

Article Text

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For an item addressed in this policy to be covered by Medicare, a written signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to receipt of a written order, it will be denied as 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.

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.

Coverage Topic

Durable Medical Equipment
Pressure Reducing Support Surfaces - Group 3

Coding Information

No Coding Information has been entered in this section of the article.

Other Information

Other Comments

03/01/2008- In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A37217 from DME PSC TriCenturion (77011) Article A37217.

Revision History Explanation

Revision Effective Date: 01/01/2009
CODING GUIDELINES:
Revised: Changed SADMERC to PDAC.

03/01/2008- In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A37217 from DME PSC TriCenturion (77011) Article A37217.

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Related Documents

LCD(s)

L5069 - Pressure Reducing Support Surfaces - Group 3