MEDX
medical equipment

What's needed for a new referral:

- Demographics
- Detailed Written Order Signed/Dated by physician
- Most recent Face-To-Face note discussing the item the patient is needing as well as the diagnosis

* LOW AIR LOSS *

Medicare does not automatically assume payment for a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) item that was covered prior to a beneficiary becoming eligible for the Medicare Fee For Service (FFS) program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary, may be required upon request of the DME MAC.

For these items to be covered by Medicare, a written order prior to delivery (WOPD) is required. Refer to the DOCUMENTATION REQUIREMENTS section of this LCD and to THE NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article for information about WOPD prescription requirements.

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 (described by the diagnosis codes listed in the table below) 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
   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 (described by the diagnosis codes listed in the table below),

3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days (described by the diagnosis codes listed in the table below), 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" (see Appendices section).

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.

A support surface which does not meet the characteristics specified in the Coding Guidelines section of the Pressure Reducing Support Surfaces - Group 2 Policy Article will be denied as not reasonable and necessary. (See Coding Guidelines and Documentation sections concerning billing of E1399.)

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.

k to Top

Coding Information

MEDX
medical equipment

Detailed Written Order

Group II Support Surface

Patient Name: _____ **Length of need:** _____

HICN: _____ **Diagnosis:** _____

Equipment Ordered:

___ E0277 Low Air Loss Mattress **___ E0371 Air Mattress**

___ Other (please specify) _____

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier:

Indicate which of the following conditions describe the patient. (must have documentation to support)

Circle **Y** for **Yes**, **N** for **No**, and D for Does not apply, unless otherwise noted:

1. Y N D Does the patient have multiple stage II pressure ulcers on the trunk of pelvis?
2. Y N D Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an alternating pressure or low air loss overlay which is less than 3.5 inches, or a non-powered pressure reducing overlay or mattress.
3. Y N D Over the past month, the patient's ulcer(s) has/have: 1) improved, 2) remained the same, 3) worsened?
4. Y N D Does the patient have large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis?
5. Y N D Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? If yes, give date of surgery:
6. Y N D Was the patient on an alternating pressure of low air loos mattress or bed or an air fluidized bed immediately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility?

Physician Name (Printed or typed): _____

Physicians Signature: _____ **Date:** _____

Physicians **NPI:** _____

GEL OVERLAY

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

Needs to have 1 of these qualifying conditions in the note as well if 2 or 3.

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

MEDX

medical equipment

Detailed Written Order

Group 1 Support Surfaces

Patient Name: _____ Length of Need:_____

HIC#_____ Diagnosis:_____

Equipment Order:

___E0181 Alternating Pressure Pad & Pump _____E0185 Gel Overlay

___Other Please Specify_____

Indicate which of the following conditions describe the patient. Check all that apply:

1.____Completely Immobile-i.e. patient cannot make changes in the body position without assistance.

2.____Limited mobility-i.e. patient cannot independently make changes in body position significant enough to alleviant pressure.

3.____Any pressure ulcer on trunk or pelvis

4.____Impaired nutritional status

5.____Fecal or urinary incontinence

6.____Altered sensory perception

7.____Comprised circulatory status

Physician name (printed or typed):_____

Physician Signature: _____

Physician NPI: _____

Date Signed: _____