Mattress – HCPC Coded Pressure Reducing Support Surfaces
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Mattress – HCPC Coded Pressure Reducing Support Surfaces		
MNG #: 093	**☒ SCO ☒ One Care** **☒ MA Medicare Premier** **☒ MA Medicare Value** **☒ RI Medicare Preferred** **☒ RI Medicare Value** **☒ RI Medicare Maximum**	**Prior Authorization Needed?** **☐ Yes (always required)** **☒ Yes (only in certain situations. See this MNG for details)** **☐ No**
Clinical: ☒	**Operational: ☐**	**Informational: ☐**
Benefit Type: **☒ Medicare** **☒ Medicaid**	**Approval Date:** 11/04/2021;	**Effective Date:** 2/6/2022;
Last Revised Date: 5/30/2022;	**Next Annual Review Date:** 11/04/2022; 5/30/2023;	**Retire Date:**

OVERVIEW:

Pressure reducing support surfaces are durable medical equipment (DME) that are used primarily for the care of pressure ulcers. Pressure ulcers are lesions caused by unrelieved pressure resulting in damage of underlying tissue. A support surface is defined as a mattress, mattress replacement, overlay, or seat cushion designed for management of tissue loads, microclimate, or other therapeutic functions. These products are either powered or nonpowered and may be categorized as follows:

- **Group 1 (E0181, E0182, E0184, E0185, E0186, E0187, E0188, E0189, E0196, E0197, E0198, E0199)** 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 (E0193, E0277, E0371, E0372, E0373)** 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 (E0194)** Support surfaces are complete bed systems, known as air-fluidized beds, which use the circulation of filtered air through silicone beads.

DECISION GUIDELINES:

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses InterQual Smart Sheets, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists.

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Clinical Eligibility:

Pressure reducing support surfaces are provided to members who require pressure redistribution due to an existing pressure ulcer, history of pressure ulcer, high risk of pressure ulcer or to alleviate pain. Members usually have impairments in mobility and/or sensation and are unable to effectively relieve pressure independently.

Determination of need:

A pressure reducing support surface is indicated if the member needs to decrease/relieve pressure over body parts to prevent tissue damage or to alleviate pain. These surfaces are usually used with beds but can also be used with sitting surfaces.

- **GROUP 1 (E0181, E0182, E0184, E0185, E0186, E0187, E0188, E0189, E0196, E0197, E0198, E0199) -** A group 1 support surface is provided when the member is partially or completely immobile, has any stage pressure ulcer, impaired nutritional status, incontinence, altered sensory perception, compromised circulatory status, or experiences pain and/or numbness from present surface.
- **GROUP 2 (E0193, E0277, E0371, E0372, E0373)** - A group 2 support surface is provided when the member is partially or completely immobile, has a stage II pressure ulcer located on the trunk or pelvis, has been on a comprehensive pressure ulcer treatment program (which has included the use of an appropriate group 1 support surface for at least one month) and has ulcers which have worsened or remained the same over the past month. It is also provided if the member has large or multiple stage III or IV pressure ulcers on the trunk or pelvis, had a recent myocutaneous flap or skin graft, or has a history or serious risk of pressure ulcers.
- **GROUP 3 (E0194)** – A group 3 support surface is provided to members who are completely immobile (bedridden or chair-bound), have altered sensory perception, have a stage III or stage IV pressure ulcer, is under close supervision of medical team, at least one month of conservative treatment has been administered (including the use of a group 2 support surface), a caregiver is available and willing to assist with care and all other alternative equipment has been considered and ruled out.

LIMITATIONS/EXCLUSIONS:

Pressure reducing support surfaces are not provided to members who:

- Are mobile without sensory impairment
- Already have equipment that serves the same purpose and is able to meet their need
- Are able to use less costly equipment to meet their need
- Are not reasonably expected to obtain a meaningful contribution to the treatment of their illness or injury from its use

KEY CARE PLANNING CONSIDERATIONS:

- Member or care giver are able to maintain the support surface
- If powered there is an adequate power source available in the area it is to be used
- Member or care giver understand and agree with the treatment plan including the support surface and repositioning schedule if appropriate

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AUTHORIZATIONS:

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

PRIOR AUTHORIZATION:

The Following HCPCS codes are covered when medically necessary, **without prior authorization**:

Code	Description
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
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
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

The following HCPCS Codes **require a prior authorization**.

Code	Description
E0193	Powered air flotation bed (low air loss therapy
E0194	Air fluidized bed
E0277	Powered pressure-reducing air mattress
E0373	Non-powered advanced pressure reducing mattress

Documentation Requirements:

- Group 1 & 3: Require a Standard Written Order (SWO) and face to face examination notes, that are within (6) months prior to the written order.
- Group 2: Require a Standard Written Order and Medical Record Information.

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REGULATORY NOTES:

Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria. This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

Medicare Local Coverage Determination (LCD): Pressure Reducing Support Surfaces - Group 1 (L33830)
Medicare Local Coverage Determination (LCD): Pressure Reducing Support Surfaces – Group 2 (L33642)
Medicare Local Coverage Determination (LCD): Pressure Reducing Support Surfaces – Group 3 (L33692)
MassHealth Guidelines for Medical Necessity Determination for Support Surfaces; MassHealth; 130 CMR 450.204: Medical Necessity; 130CMR 428.402 Definitions; 130CMR 409.402: Definitions; 130CMR 409.414 Non-covered services

RELATED REFERENCES:

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

CCA has the mission to address all of our complicated members' health needs. Care partners can identify members with Behavioral Health and HOPE (*) challenges who may benefit from extending these guidelines to support our at-risk members' unique health challenges. CCA encourages our clinicians to clearly document our members' unique health contexts when requesting care which does not meet this formal MNG's conditions and recommendations.

*High Opiate Patient Engagement = members with high doses of opiates whom we hope to help by treating their pain alternatively and reducing their exposure to dangerous opiates.

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REVISION LOG:

REVISION DATE	DESCRIPTION
12/31/23	Utilization Management Committee approval
5/30/2022	Template changed to include PA requirements and benefit type.

APPROVALS:

David Mello	Senior Medical Director, Utilization Review and Medical Policy
CCA Senior Clinical Lead [Print]	**Title [Print]**
	12/31/23
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Nazlim Hagmann	Chief Medical Officer
CCA CMO or Designee [Print]	**Title [Print]**
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