Priority Health	BILLING POLICY No. 161
PRESSURE REDUCING SUPPORT SURFACES	
Date of origin: Sept 2025	**Review dates: 07/26, 09/26**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation for pressure reducing support surfaces devices, ensuring claims are processed according to contractual agreements and industry standards."

DEFINITIONS

Pressure Reducing Support Surface: A mattress, mattress overlay, or bed system designed to prevent or manage pressure ulcers by redistributing pressure, reducing shear, or controlling microclimate.
Our policy is based on CMS classification as below:

- Group 1: Basic overlays/mattresses (foam, gel, air, water). These devices are used on top of a hospital bed or home mattress.
- Group 2: Powered or advanced non-powered surfaces (alternating pressure, low air loss).
- Group 3: Air-fluidized beds, used for advanced stage pressure ulcers.

MEDICAL POLICY

- Not applicable

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding specifics

The following list(s) of procedures is provided for reference purposes only and may not be all inclusive.

HCPCPS/CPT Code	Description
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
E0183	Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty
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
E0188	Synthetic sheepskin pad
E0189	Lambswool sheepskin pad, any size
E0193	Powered air flotation bed (low air loss therapy)

E0196	Gel pressure mattress (nonpowered)
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	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width
E0372	Powered air overlay for mattress, standard mattress length and width
E0373	Nonpowered advanced pressure reducing mattress

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI.

Place of Service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required.

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

- Clinical notes must support medical necessity, including relevant symptoms, history, or risk factors.
- Test results must be retained in the patient's records.
- For repeat testing, documentation must include reason for repeating and confirmation of adequate washout period after therapy.

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

LCD L33830 - https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33830#:~:text=A%20Group%201%20mattress%20overlay,body%20position%20without%20assistance%2C%20or

Group 1 - Policy Article A52489 - https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52489&ver=24

Group 2 - Policy Article A52490 - https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52490#:~:text=For%20any%20item%20to%20be,that%20also%20must%20be%20met.

Group 3– Policy article A52468 -https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52468

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity

requirements are appropriate to procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Sept 2025	New policy – effective Oct 16, 2025
July 2026	No updates
September 2026	Policy overview and coding specifics sections have been updated. Coverage criteria have been removed.