

Clinical Policy: Powered Pressure Reducing Air Mattress/Support Surfaces

Reference Number: FL.CP.MP.13
Date of Last Revision: 06/26

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Description

This policy describes the medical necessity requirements for a powered pressure reducing air mattress/support surface as an expanded benefit for Sunshine Health's Managed Medical Assistance (MMA) product.

Policy/Criteria

- I. It is the policy of Sunshine Health that a powered pressure reducing air mattress as an expanded benefit is **medically necessary** for the following indications:
 - A. Group 1 support surface; *at least one* of the following:
 1. Member is completely immobile;
 2. Member has limited mobility;
 3. Member has any stage pressure ulcer on the trunk or pelvis and at least one of the following:
 - a. Impaired nutritional status;
 - b. Fecal or urinary incontinence;
 - c. Altered sensory perception;
 - d. Compromised circulatory status.
 - B. Group 2 support surface; all of the following:
 1. Member has *at least one* of the following:
 - a. Stage II pressure sore located on the trunk or pelvis, has been on a comprehensive pressure sore treatment program (which has included the use of an appropriate group 1 support surface for at least one month), and has sores which have worsened or remained the same over the past month, despite trial and failure of routine and/or aggressive wound care therapy and the member must be regularly assessed by a nurse, physician, or other licensed healthcare practitioner;
 - b. Large or multiple stage III or IV pressure sores on the trunk or pelvis, or a recent myocutaneous flap or skin graft for a pressure sore on the trunk or pelvis and has been on a group 2 or 3 support surface.
 2. Member should have a care plan established by their physician or home care nurse, which is documented in their medical records.
 - C. Group 3 support surface; *all* of the following:
 1. The member has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcer;
 2. The member is bedridden, or chair bound as a result of severely limited mobility;
 3. The member would require institutionalization without the use of a group 3 support surface;
 4. There is a detailed written order based on a comprehensive assessment and evaluation of the member;

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5. The member has tried and failed use of a group 2 support surface and has necessary treatment in place to resolve any worsening of the wound or infection;
6. The member has a trained adult caregiver available to assist with management and support of the group 3 support surface and any problems such as leaking, in addition to assist with member's repositioning, activities of daily living, skin care, dietary needs, and prescribed treatments.

Note: Coverage continues until the member's pressure ulcer is healed, as long as the member remains eligible with Sunshine Health.

- II.** It is the policy of Sunshine Health that a Group 3 support surface as an expanded benefit is considered **not medically necessary** when any of the following indications are met:
- A. Member no longer meets medical necessity criteria;
 - B. Member withdraws from treatment against medical advice;
 - C. Member has co-existing pulmonary disease (the lack of back support hinders coughing and dry air inhalation thickens pulmonary secretions);
 - D. Member requires wound care with wet soaks or moist wound dressings that are not protected with a waterproof covering such as plastic wrap or other occlusive material;
 - E. Caregiver is unwilling or unable to provide the care needed by the member on a group 3 support surface;
 - F. Treatment goals are achieved.

Background

Pressure reducing support surfaces are a type of DME used for the care of pressure sores, also known as pressure ulcers. Pressure ulcers are lesions caused by unrelieved pressure resulting in damage to underlying tissue. A major distinction between support surfaces is that some are powered by electricity and others are not.

Categories of Support Surfaces:

Group 1 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).³

Group 2 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.⁴

Group 3 support surfaces are complete bed systems, such as air fluidized beds, which use the circulation of filtered air through silicone beads.⁵

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are

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included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Pressure Reducing Support Surfaces – Group 1 Codes

HCPCS Codes	Description
E0181	Powered pressure reducing mattress overlay/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
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
E1399	Durable medical equipment, miscellaneous

Pressure Reducing Support Surfaces - Group 2 Codes

HCPCS Codes	Description
E0193	Powered air flotation bed (low air loss therapy)
E0277	Powered pressure-reducing air mattress
E0372	Powered air overlay for mattress, standard mattress length and width
E1399	Durable medical equipment, miscellaneous

Pressure Reducing Support Surfaces – Group 3 Codes

HCPCS Codes	Description
E0194	Air fluidized bed

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		07/18
Annual review; Added individual criteria for Groups 1, 2, 3 support surfaces.		07/19
Annual review; expanded policy.		12/19
Annual review; updated referenced policy		02/20
Annual review; no changes		07/21
Annual review; no changes		07/22

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
Transitioned policy to new state specific template and sent to market for approval; policy number changed from FL.UM.29.00 to FL.CP.MP.13.	06/23	
Annual review. Minor rewording to I.B. and I.C. with no impact to criteria. Added requirement for member to have trained adult caregiver available to I.C.6. Added the following indications to Section II. as not medically necessary: C. Member has co-existing pulmonary disease; D. Member requires wound care with wet soaks or moist wound dressings that are not protected with a waterproof covering such as plastic wrap or other occlusive material; and E. CG is unwilling or unable to provide the care needed by the member on a group 3 support surface. Background updated. HCPCS codes added. References reviewed and updated.	07/24	
Annual review. Codes reviewed. References reviewed and updated.	06/25	
Annual review. Codes reviewed. Minor rewording with no clinical significance. References reviewed and updated.	06/26	

References

1. Agency for Health Care Administration. Statewide Medicaid Managed Care Expanded Benefits.
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2. Agency for Health Care Administration. HL Durable Medical Equipment and Medical Supplies Fee Schedule.
<https://ahca.myflorida.com/content/download/28258/file/HL%202026%20Durable%20Medical%20Equipment%20and%20Medical%20Supplies%20Fee%20Schedule.pdf>. April 7, 2025. Accessed May 5, 2026.
3. Local coverage determination: pressure reducing support surfaces – group 1 (L33830). Centers for Medicare and Medicaid Services Website. <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=33830&ver=22>. Published October 1, 2015 (revised May 1, 2021). Accessed May 5, 2026.
4. Local coverage determination: pressure reducing support surfaces – group 2 (L33642). Centers for Medicare and Medicaid Services Web site. <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=33642&ver=26>. Published October 1, 2015 (revised May 1, 2021). Accessed May 5, 2026.
5. Local coverage determination: pressure reducing support surfaces – group 3 (L33692). Centers for Medicare and Medicaid Services Web site. <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=33692&ver=21>. Published October 1, 2015 (revised May 1, 2021). Accessed May 5, 2026.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

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approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take

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precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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