

Pressure Reducing Support Surfaces

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[↪ Terms and Conditions](#)

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Related Medicare Advantage Policy Guidelines
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Related Medicare Advantage Coverage Summary
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Policy Summary

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Overview

Pressure reducing support surfaces are a type of durable medical equipment (DME) used for the care of pressure sores, also known as pressure ulcers. Pressure ulcers are lesions caused by unrelieved pressure resulting in damage of underlying tissue. A major distinction between support surfaces is that some are powered by electricity and others are not. They may be categorized into the following three groups:

- 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).
- 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.
- Group 3 support surfaces are complete bed systems, known as air-fluidized beds, which use the circulation of filtered air through silicone beads. For additional information, please reference the UnitedHealthcare Medicare Advantage Policy Guideline titled [Air-Fluidized Bed \(NCD 280.8\)](#).

For any item to be covered by UnitedHealthcare, it must:

- Be eligible for a defined UnitedHealthcare benefit category
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable UnitedHealthcare statutory and regulatory requirements.

Guidelines - Group 1

A group 1 mattress overlay or mattress (E0181-E0189, E0196-E0199, and A4640) is covered if one of the following three criteria is met:

1. The member is completely immobile - i.e., member cannot make changes in body position without assistance, OR
2. The member has limited mobility - i.e., member cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions below, OR
3. The member has any stage pressure ulcer on the trunk or pelvis AND at least one of conditions 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):
 - Impaired nutritional status
 - Fecal or urinary incontinence
 - Altered sensory perception
 - Compromised circulatory status

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 member should be one in which the member 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 member's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the member 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.

Guidelines - Group 2

A group 2 support surface is covered if the member meets at least one of the following three Criteria (1, 2 or 3):

1. The member has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the member has been on a comprehensive ulcer treatment program including each of the following:
 - Use of an appropriate group 1 support surface, and
 - Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and
 - Appropriate turning and positioning, and
 - Appropriate wound care, and
 - Appropriate management of moisture/incontinence, and
 - Nutritional assessment and intervention consistent with the overall plan of care
2. The member has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis,
3. The member had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, 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 member 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 member should be one in which the member does not "bottom out".

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.

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:

- Other aspects of the care plan are being modified to promote healing, or
- The use of the group 2 support surface is reasonable and necessary for wound management.

Guidelines – Group 3

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

Coverage of a group 3 support surface is limited to bed-ridden or chair-bound patients with stage III or stage IV pressure ulcers that without the use of an air-fluidized bed would be institutionalized. For additional information, please reference the UnitedHealthcare Medicare Advantage Policy Guideline titled [Air-Fluidized Bed \(NCD 280.8\)](#).

KX Modifier

Suppliers must add a KX modifier to a code only if all of the criteria in the "Coverage Indications, Limitations and/or Medical Necessity" section of the related CMS Local Coverage Determination (LCD) have been met and evidence of such is maintained in the supplier's files. This information must be available upon request. For additional information, please reference the UnitedHealthcare Medicare Advantage Policy Guideline titled [KX Modifier](#).

Appropriate use of the KX modifier 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.

Related Clinical Information

A member needing a pressure reducing support surface should have a care plan which has been established by the member's physician or home care nurse, which is documented in the member's medical records, and which generally should include the following:

- Education of the member and caregiver on the prevention and/or management of pressure ulcers
- Regular assessment by a nurse, physician, or other licensed healthcare practitioner
- Appropriate turning and positioning
- Appropriate wound care (for a stage II, III, or IV ulcer/pressure injury)
- Appropriate management of moisture/incontinence
- Nutritional assessment and intervention consistent with the overall plan of care

Documentation Requirements

Suppliers are reminded that all UnitedHealthcare coverage and documentation requirements for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

Documentation Requirements - General

There are numerous CMS manual requirements, reasonable and necessary requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justified. In the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying payment. Refer to the LCD, NCD or other CMS Manuals for more information on what documents may be required.

See Article A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply 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. Other Policies and Guidelines may apply.

HCPCS Code	Description
Group 1 Codes	
A4640	<p>Replacement pad for use with medically necessary alternating pressure pad owned by patient</p> <p>Characterized as:</p> <ul style="list-style-type: none"> • An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and • Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and • Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out <p>Code A4640 should only be billed when provided as a replacement component for a member-owned (E0181) mattress overlay system.</p>
A9270	<p>Noncovered item or service</p> <p>A foam overlay or mattress which does not have a waterproof cover should be coded using A9270. (Status Indicator of "N", Not Covered)</p>
E0181	<p>Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy-duty</p> <p>Characterized as:</p> <ul style="list-style-type: none"> • An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and • Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and • Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out
E0182	<p>Pump for alternating pressure pad, for replacement only</p> <p>Characterized as:</p> <ul style="list-style-type: none"> • An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and • Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and • Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out <p>Code E0182 should only be billed when provided as a replacement component for a member-owned (E0181) mattress overlay system.</p>
E0184	<p>Dry pressure mattress</p> <p>Characterized as:</p> <ul style="list-style-type: none"> • Foam height of 5 inches or greater, and • Foam with a density and other qualities that provide adequate pressure reduction, and • Durable, waterproof cover, and • Can be placed directly on a hospital bed frame
E0185	<p>Gel or gel-like pressure pad for mattress, standard mattress length and width</p> <p>Characterized as a gel or gel-like layer with a height of 2 inches or greater.</p>
E0186	<p>Air pressure mattress</p> <p>An air, water or gel pressure mattress' (E0186, E0187, E0196) are characterized by all of the following:</p> <ul style="list-style-type: none"> • Height of 5 inches or greater of the air, water, or gel layer (respectively), and • Durable, waterproof cover, and • Can be placed directly on a hospital bed frame
E0187	<p>Water pressure mattress</p> <p>An air, water or gel pressure mattress' (E0186, E0187, E0196) are characterized by all of the following:</p> <ul style="list-style-type: none"> • Height of 5 inches or greater of the air, water, or gel layer (respectively), and • Durable, waterproof cover, and • Can be placed directly on a hospital bed frame

HCPCS Code	Description
Group 1 Codes	
E0188	Synthetic sheepskin pad
E0189	Lambswool sheepskin pad, any size
E0196	Gel pressure mattress An air, water or gel pressure mattress' (E0186, E0187, E0196) are characterized by all of the following: <ul style="list-style-type: none"> • Height of 5 inches or greater of the air, water, or gel layer (respectively), and • Durable, waterproof cover, and • Can be placed directly on a hospital bed frame
E0197	Air pressure pad for mattress, standard mattress length and width Characterized by interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump.
E0198	Water pressure pad for mattress, standard mattress length and width Characterized by a filled height of 3 inches or greater.
E0199	Dry pressure pad for mattress, standard mattress length and width Characterized by all of the following: <ul style="list-style-type: none"> • Base thickness of 2" or greater and peak height of 3" or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least 3 inches if it is a non-convoluted overlay, and • Foam with a density and other qualities that provide adequate pressure reduction, and • Durable, waterproof cover
Group 2 Codes	
E0277	Powered pressure-reducing air mattress (alternating pressure, low air loss, or powered flotation without low air loss) Characterized by all of the following: <ul style="list-style-type: none"> • An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, and • Inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and • Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out, and • A surface designed to reduce friction and shear, and • Can be placed directly on a hospital bed frame. Either alternating pressure mattresses or low air loss mattresses are coded using code E0277.
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width Characterized by all of the following: <ul style="list-style-type: none"> • Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out, and • Total height of 3 inches or greater, and • A surface designed to reduce friction and shear, and • Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces.
E0372	Powered air overlay for mattress, standard mattress length and width Characterized by all of the following: <ul style="list-style-type: none"> • An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and • Inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and • Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out, and • A surface designed to reduce friction and shear

HCPCS Code	Description
Group 2 Codes	
E0373	Nonpowered advanced pressure reducing mattress Characterized by all of the following: <ul style="list-style-type: none"> • Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out, and • Total height of 5 inches or greater, and • A surface designed to reduce friction and shear, and • Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces, and • Can be placed directly on a hospital bed frame
Both Group 1 and 2	
E1399	Durable Medical Equipment, Miscellaneous Group 1 or 2 support surfaces which do not meet the characteristics specified in the Definitions above, should be coded using code E1399 When code E1399 is billed, the claim must include the manufacturer and the product name/number

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Modifier	Description
EY	No physician or other health care provider order for this item or service
KX	Requirements specified in the medical policy have been met
RR	Rental (use the RR modifier when DME is to be rented)

Place of Service Code	Description
01	Pharmacy
04	Homeless shelter
09	Prison/Correctional Facility
12	Home
13	Assisted living facility
14	Group home
16	Temporary lodging
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
65	End Stage Renal Disease (ESRD) Treatment Facility

Diagnosis Code	Description
Codes for HCPCS codes E0277, E0371, E0372 and E0373	
L89.100	Pressure ulcer of unspecified part of back, unstageable
L89.102	Pressure ulcer of unspecified part of back, stage 2
L89.103	Pressure ulcer of unspecified part of back, stage 3
L89.104	Pressure ulcer of unspecified part of back, stage 4
L89.110	Pressure ulcer of right upper back, unstageable
L89.112	Pressure ulcer of right upper back, stage 2
L89.113	Pressure ulcer of right upper back, stage 3

Diagnosis Code	Description
Codes for HCPCS codes E0277, E0371, E0372 and E0373	
L89.114	Pressure ulcer of right upper back, stage 4
L89.120	Pressure ulcer of left upper back, unstageable
L89.122	Pressure ulcer of left upper back, stage 2
L89.123	Pressure ulcer of left upper back, stage 3
L89.124	Pressure ulcer of left upper back, stage 4
L89.130	Pressure ulcer of right lower back, unstageable
L89.132	Pressure ulcer of right lower back, stage 2
L89.133	Pressure ulcer of right lower back, stage 3
L89.134	Pressure ulcer of right lower back, stage 4
L89.140	Pressure ulcer of left lower back, unstageable
L89.142	Pressure ulcer of left lower back, stage 2
L89.143	Pressure ulcer of left lower back, stage 3
L89.144	Pressure ulcer of left lower back, stage 4
L89.150	Pressure ulcer of sacral region, unstageable
L89.152	Pressure ulcer of sacral region, stage 2
L89.153	Pressure ulcer of sacral region, stage 3
L89.154	Pressure ulcer of sacral region, stage 4
L89.200	Pressure ulcer of unspecified hip, unstageable
L89.202	Pressure ulcer of unspecified hip, stage 2
L89.203	Pressure ulcer of unspecified hip, stage 3
L89.204	Pressure ulcer of unspecified hip, stage 3
L89.210	Pressure ulcer of right hip, unstageable
L89.212	Pressure ulcer of right hip, stage 2
L89.213	Pressure ulcer of right hip, stage 3
L89.214	Pressure ulcer of right hip, stage 4
L89.220	Pressure ulcer of left hip, unstageable
L89.222	Pressure ulcer of left hip, stage 2
L89.223	Pressure ulcer of left hip, stage 3
L89.224	Pressure ulcer of left hip, stage 4
L89.300	Pressure ulcer of unspecified buttock, unstageable
L89.302	Pressure ulcer of unspecified buttock, stage 2
L89.303	Pressure ulcer of unspecified buttock, stage 3
L89.304	Pressure ulcer of unspecified buttock, stage 4
L89.310	Pressure ulcer of right buttock, unstageable
L89.312	Pressure ulcer of right buttock, stage 2
L89.313	Pressure ulcer of right buttock, stage 3
L89.314	Pressure ulcer of right buttock, stage 4
L89.320	Pressure ulcer of left buttock, unstageable
L89.322	Pressure ulcer of left buttock, stage 2
L89.323	Pressure ulcer of left buttock, stage 3
L89.324	Pressure ulcer of left buttock, stage 4

Diagnosis Code	Description
Codes for HCPCS codes E0277, E0371, E0372 and E0373	
L89.42	Pressure ulcer of contiguous site of back, buttock and hip, stage 2
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.45	Pressure ulcer of contiguous site of back, buttock and hip, unstageable

Definitions

Air Fluidized Bed: Combines air fluidized therapy and low air loss therapy on an articulating frame providing patients with relief from bed pressure sores.

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin

Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARS), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss

Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Bottoming out: Is the finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. This bottoming out criterion should be tested with the member 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.

References

CMS National Coverage Determinations (NCDs)

[NCD 280.1 Durable Medical Equipment Reference List](#)

Reference NCDs: [NCD 280.7 Hospital Beds](#), [NCD 280.8 Air Fluidized Beds](#)

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	DME MAC
L33830 Pressure Reducing Support Surfaces - Group 1	A52489 Pressure Reducing Support Surfaces - Group 1 - Policy Article	CGS	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX VA, VI, WI, WV
		Noridian	AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WY
L33642 Pressure Reducing Support Surfaces - Group 2	A52490 Pressure Reducing Support Surfaces - Group 2 - Policy Article	CGS	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX VA, VI, WI, WV
		Noridian	AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WY
N/A	A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs	CGS	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NC, NM, OH, OK, PR, SC, TN, TX VA, VI, WI, WV
		Noridian	AK, AS, AZ, CA, CT, DC, DE, GU, HI, IA, ID, KS, MA, MD, ME, MO, MP, MT, ND, NE, NH, NJ, NV, NY, OR, PA, RI, SD, UT, VT, WA, WY

CMS Benefit Policy Manual

[Chapter 15 §110 Durable Medical Equipment - General](#)

CMS Claims Processing Manual

[Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\)](#)

[Chapter 23 Fee Schedule Administration and Coding Requirements](#)

CMS Transmittal(s)

[Transmittal 834, Change Request 10984, Dated 10/12/2018 \(Order Requirements When Prescribing Practitioner is Also the Supplier and is Permitted to Furnish Specific Items of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\)\)](#)

[Transmittal 4052, Change Request 10422, Dated 05/17/2018 \(Removal of KH Modifier from Capped Rental Claims\)](#)

MLN Matters

[Article SE1014, Medicare Policy Regarding Pressure Reducing Surfaces](#)

UnitedHealthcare Commercial Policies

[Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies, and Repairs/Replacements](#)
[Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional](#)

Other(s)

[CGS DME Jurisdiction B Supplier Manual](#)

[CGS DME Jurisdiction C Supplier Manual](#)

[Decision Memo for Air-Fluidized Beds for Pressure Ulcers, CMS Website](#)

[Department of Health and Human Services; Office of Inspector General; Inappropriate Medicare Payments for Pressure Reducing Support Surfaces](#)

[Medicare Program Integrity Manual: Chapter 3 Verifying Potential Errors and Taking Corrective Action; § 3.4.1.1 Linking LCD and NCD ID Numbers to Edits](#)

[Medicare Program Integrity Manual: Chapter 5 Items and Services Having Special DME Review Considerations](#)

[Noridian DME Jurisdiction A Supplier Manual](#)

[Noridian DME Jurisdiction D Supplier Manual](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
0/01/2021	Template Update <ul style="list-style-type: none">Reformatted policy; transferred content to new template
05/13/2020	Policy Summary <i>Documentation Requirements</i> <ul style="list-style-type: none">Removed detailed documentation requirementsAdded language to indicate:<ul style="list-style-type: none">There are numerous CMS manual requirements, reasonable and necessary requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justifiedIn the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying paymentRefer to the Local Coverage Determination (LCD), National Coverage Determination (NCD) or other Centers for Medicare & Medicaid Services (CMS) manuals for more information on what documents may be requiredSee the Local Coverage Article (LCA) titled <i>Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)</i> <i>Repairs/Replacement</i> <ul style="list-style-type: none">Removed detailed guidelines [duplicative to the language outlined in the referenced LCA titled <i>Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)</i>] Supporting Information <ul style="list-style-type: none">Updated <i>References</i> section to reflect the most current informationArchived previous policy version MPG259.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

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 member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).