DOCUMENTATION CHECKLIST

JURISDICTIONS B & C

SURGICAL DRESSINGS

REQUIRED DOCUMENTATION

- ☐ **Standard Written Order (SWO)**
  - ○ The SWO contains all of the following elements:
    - ☐ Beneficiary's name or Medicare Beneficiary Identifier (MBI)
    - ☐ Order Date
    - ☐ General description of the item
      - ○ The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
      - ○ For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (List each separately).
      - ○ For supplies – In addition to the description of the base item, the DMEPOS order/ prescription may include all concurrently ordered supplies that are separately billed (List each separately)
    - ☐ Quantity to be dispensed, if applicable
    - ☐ Treating Practitioner Name or NPI
    - ☐ Treating Practitioner's signature
  - ○ Any changes or corrections have been initialed/signed and dated by the ordering practitioner.
- ☐ Additional documentation, that may support the medical necessity of the item billed include:
  - ○ Frequency of change;
  - ○ Route of administration;
  - ○ Duration of need.
- ☐ The practitioner's signature on the written order meets **CMS Signature Requirements** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf

WRITTEN ORDER REMINDERS

- Suppliers should not submit claims to the DME MAC prior to obtaining a standard written order.
- Items billed to the DME MAC before a completed standard written order has been received must be submitted with modifier EY.
- A new order is needed if a new dressing is added or if the quantity of an existing dressing to be used is increased. A new order is required every 3 months for each dressing being used.

☐ **Refill Request**

For dates of service prior to January 1, 2024

Items Were Obtained In Person at a Retail Store	Written Refill Request Received from the Beneficiary	Telephone Conversation Between Supplier and Beneficiary
☐ Signed Delivery Slip ○ Beneficiary's name ○ Date ○ List of items purchased ○ Quantity received ○ Signature of person receiving the items **OR** ☐ Itemized Sales Receipt ○ Beneficiary's name ○ Date ○ Detailed list of items purchased ○ Quantity received	☐ Name of beneficiary or authorized rep (indicate relationship) ☐ Description of each item being requested ☐ Date of request ☐ Quantity of each item beneficiary still has remaining ☐ Request was not received any sooner than 14 calendar days prior to the delivery/ shipping date ☐ Shipment/delivery occurred no sooner than 10 calendar days prior to the end of usage for the current product	☐ Beneficiary's name ☐ Name of person contacted (if someone other than the beneficiary include this person's relationship to the beneficiary) ☐ Description of each item being requested ☐ Date of contact ☐ Quantity of each item beneficiary still has remaining ☐ Contact was not made any sooner than 14 calendar days prior to the delivery/shipping date ☐ Shipment/delivery occurred no sooner than 10 calendar days prior to the end of usage for the current product

For dates of service on and after January 1, 2024

Items Were Obtained In Person at a Retail Store	Delivered Refill Communications
☐ Signed delivery slip or copy of itemized sales receipt ☐ Delivery slip/receipt should indicate items were picked up at store front	☐ Beneficiary name and/or authorized representative (Suggested: if someone other than the beneficiary include this person's relationship to the beneficiary) ☐ Date of Request ☐ Description of each item requested ☐ Documentation of affirmative response indicating a need for the refill ☐ Contact must occur no sooner than 30 calendar days prior to the expected end of the current supply ☐ Shipment/delivery occur no sooner than 10 calendar days prior to expected end of current supply

☐ **Delivery Documentation**

Direct Delivery	Shipped/Mail Order Tracking Slip	Shipped/Mail Order Return Post-Paid Delivery Invoice
☐ Beneficiary's name ☐ Delivery address ☐ Quantity delivered ☐ A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number. ☐ Delivery date ☐ Signature of person accepting delivery ☐ Relationship to beneficiary	☐ Shipping invoice ○ Beneficiary's name ○ Delivery address ○ A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number. ○ Quantity shipped ☐ Tracking slip ○ References each individual package ○ Delivery address ○ Package I.D. #number ○ Date shipped ○ Date delivered ☐ A common reference number (package ID #, PO #, etc.) links the invoice and tracking slip (may be handwritten on one or both forms by the supplier)	☐ Shipping invoice ○ Beneficiary's name ○ Delivery address ○ A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number. ○ Quantity shipped ○ Date shipped ○ Signature of person accepting delivery ○ Relationship to beneficiary ○ Delivery date

NOTE: If a supplier utilizes a shipping service or mail order, suppliers have two options for the DOS to use on the claim:

1. Suppliers may use the shipping date as the DOS. The shipping date is defined as the date the delivery/shipping service label is created or the date the item is retrieved by the shipping service for delivery. However, such dates should not demonstrate significant variation.
2. Suppliers may use the date of delivery as the DOS on the claim.

- ☐ **All of the Following Criteria Are Met:**
  - ○ The medical records confirm that the surgical dressings are required for one of the following reasons:
    - ☐ The treatment of a wound caused by, or treated by, a surgical procedure; or
    - ☐ When required after debridement of a wound, regardless of the debridement technique.
  - ○ The surgical dressing code was billed with modifiers A1-A9
- ☐ **Medical Records** can be documentation from the physician, nursing home, or home care nurse and should include:
  - ○ For initial wound evaluations, the treating practitioner's medical record, nursing home, or home care nursing records must specify:
    - ☐ The type of qualifying wound (see above); and,
    - ☐ Information regarding the location, number, and size of qualifying wounds being treated with a dressing; and,
    - ☐ Whether the dressing is being used as a primary or secondary dressing or for some noncovered use (e.g., wound cleansing); and,
    - ☐ Amount of drainage; and,
    - ☐ The type of dressing (e.g., hydrocolloid wound cover, hydrogel wound filler, etc.); and,
    - ☐ The size of the dressing (if applicable); and,
    - ☐ The number/amount to be used at one time; and,
    - ☐ The frequency of dressing change; and,
    - ☐ Any other relevant clinical information.
    - ☐ Evaluation of the beneficiary's wound(s) performed at least on a monthly basis unless there is documentation in the medical record which justifies why an evaluation could not be done within this timeframe and what other monitoring methods were used to evaluate the beneficiary's need for dressings.
    - ☐ Evaluation is expected on a more frequent basis (e.g., weekly) in beneficiaries in a nursing facility or in beneficiaries with heavily draining or infected wounds.
    - ☐ The weekly or monthly evaluation must include:
      - ○ The type of each wound (e.g., surgical wound, pressure ulcer, burn, etc.),
      - ○ Wound(s) location, Wound size (length x width) and depth,
      - ○ Amount of drainage, and
      - ○ Any other relevant wound status information.
- ☐ **Basic Coverage Criteria** above plus the following specific criteria below must be met for Alginates (A6196 - A6199):
  - ○ Alginate or other fiber gelling dressing covers are covered for moderately to highly exudative full thickness wounds (e.g., stage 3 or 4 ulcers)
  - ○ Alginate or other fiber gelling dressing fillers for moderately to highly exudative full thickness wound cavities (e.g., stage 3 or 4 ulcers).
  - ○ They are not reasonable and necessary on dry wounds or wounds covered with eschar.
  - ○ Dressing change is up to once per day.

- One wound cover sheet of the approximate size of the wound or up to 2 units of wound filler (1 unit = 6 inches of alginate or other fiber gelling dressing rope) is used at each dressing change.
- It is not appropriate to use combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing (e.g., hydrogel and alginate).

☐ **Basic Coverage Criteria** above plus the following specific criteria below must be met for foam dressings (A2609 - A2615):

- Foam dressings are covered when used on full thickness wounds (e.g., stage 3 or 4 ulcers) with moderate to heavy exudate.
- They are not reasonable and necessary when used with any dressing that has a non-adherent or semi-adherent layer as part of the dressing.
- Dressing change for a foam wound cover used as a primary dressing is up to 3 times per week. When a foam wound cover is used as a secondary dressing for wounds with very heavy exudate, dressing change may be up to 3 times per week.
- Dressing change for foam wound fillers is up to once per day.

☐ **Basic Coverage Criteria** above plus the following specific criteria below must be met for Collagen dressings (A6010, A6011, A6021-A6024):

- Collagen-based dressing or wound filler is covered for full thickness wounds (e.g., stage 3 or 4 ulcers) wounds with light to moderate exudate, or wounds that have stalled or have not progressed toward a healing goal.
- Collagen dressings can stay in place up to 7 days.
- Collagen based dressings are not covered for wounds with heavy exudate, third-degree burns, or when an active vasculitis is present.

☐ The signatures on the medical records meet **CMS Signature Requirements** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf

☐ Claims for Quantities above the normal allowance

- Suppliers are also expected to have a mechanism for determining the quantity of dressings that the beneficiary is actually using and to adjust their provision of dressings accordingly.
- No more than a one month's supply of dressings may be provided at one time, unless there is documentation to support the necessity of greater quantities in the home setting in an individual case.

REMINDERS

- When surgical dressings are billed, the appropriate modifier (A1 - A9, AW, EY, or GY) must be added to the code when applicable.
- If A9 is used, information must be submitted with the claim indicating the number of wounds on which that dressing is being used.
- If GY is used, a brief description of the reason of non –coverage (e.g., "A6216GY – used for wound cleansing") must be entered in the narrative field of the electronic claim.
- Items with no physician or other licensed health care provider order must be submitted with an "EY" modifier added to each affected HCPCS code.
- When tape codes A4450 and A4452 are used with surgical dressings, they must be billed with the AW modifier (in addition to the appropriate A1-A9 modifier).
- When gradient compression stocking codes A6531 and A6532 or the gradient compression wrap code A6545 are used for an open venous stasis ulcer, the code must be billed with the AW modifier (but not an A1-A9 modifier). For this policy, codes A4450, A4452, A6531, A6532, and A6545 are the only codes for which the AW modifier may be used.

- The RT and/or LT modifiers must be used with codes A6531, A6532, and A6545 for gradient compression stockings and wraps. Effective for claims with dates of service (DOS) on or after 3/1/2019, when the same code for bilateral items (left and right) is billed on the same date of service, bill each item on two separate claim lines using the RT and LT modifiers and 1 unit of service (UOS) on each claim line. Do not use the RTLT modifier on the same claim line and billed with 2 UOS. Claims billed without modifiers RT and/or LT, or with RTLT on the same claim line and 2 UOS, will be rejected as incorrect coding.

ONLINE RESOURCES

- **DME MAC Supplier Manual**
  - JB: https://www.cgsmedicare.com/jb/pubs/supman/index.html
  - JC: https://www.cgsmedicare.com/jc/pubs/supman/index.html
- **Surgical Dressing LCD and Policy Article**
  - JB: https://www.cgsmedicare.com/jb/coverage/LCDinfo.html
  - JC: https://www.cgsmedicare.com/jc/coverage/LCDinfo.html
- Staging of Pressure Ulcers is included in the Appendices of the LCD

NOTE: It is expected that the beneficiary's medical records will reflect the need for the care provided. These records are not routinely submitted to the DME MAC but must be available upon request. Therefore, while it is not a requirement, it is a recommendation that suppliers obtain and review the appropriate medical records and maintain a copy in the beneficiary's file.

DISCLAIMER

This document was prepared as an educational tool and is not intended to grant rights or impose obligations. This checklist may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either written law or regulations. Suppliers are encouraged to consult the *DME MAC Supplier Manual* and the Local Coverage Determination/Policy Article for full and accurate details concerning policies and regulations.