Recorded Webinar: Surgical Dressings

Contract	DME MAC Jurisdictions B & C
Educator:	Tausha Duncan
Date Recorded:	09.12.2023

Good morning, my name is Tausha Duncan. I am a Provider Outreach and Education Senior Representative with CGS DME, which is the Durable Medical Equipment, Medical Administrative Contractor for Jurisdictions B and C and today we're going to be covering the surgical dressings.

This is the agenda for our webinar today. We'll discuss the coverage criteria, billing and modifiers, the documentation requirements, and we are going to look at some of the most common errors that are found by CERT. We'll provide resources for more information after that.

So first we're going over that coverage criteria. There are 2 basic situations when surgical dressings are covered. The first is when they're required for the treatment of a wound caused by, or treated by, a surgical procedure, or the second one, they are required after debridement of the wounds. The surgical procedure debridement must be performed by a practitioner or other health care professional to the extent permissible under the state law. So again, you'll need to look at your state laws to see who is allowed to perform those debridements or surgical procedures.

Surgical dressings are covered for as long as they are reasonable and necessary. Some wound covers have an adhesive border and, if no other dressing is needed on top of it, additional tape is not usually required and therefore, it's not considered reasonable and necessary. If, for some reason, additional tape is needed the medical record documentation has to show why. An adhesive border is usually more binding than what you get with separate taping so it should be used with wounds that need less frequent dressing changes. Because the adhesive is stronger, you would want to avoid removing and reapplying as much as necessary.

Debridement of a wound can be any type of debridement. It can be surgical and that would be with a sharp instrument or laser. It could be mechanical and that would be irrigation or wet to dry dressings. It could be chemical, and that would be a topical application of enzymes, or it can be autolytic and that's the application of occlusive dressings to an open wound. So this list again is, as you can see, it's not all inclusive, but it does just include the most common types of debridement.

Keep in mind that any dressing you used for mechanical debridement to cover chemical de breeding agents or to cover wounds to allow for autolytic debridement are covered but the agents themselves are not. Remember that the debridement itself is not covered under this policy.

One of the most frequent questions is "How big should the wound cover be?". Well, that depends on the size of the wound. Generally speaking, the pads, the pad size, should be about 2 inches greater than the size of the wound itself. You see an example on this slide. We have a 2-inch by 2-inch or 5-centimeter by 5-centimeter wound and that would require a 4-inch by 4-inch pad size.

It is important to keep in mind that using more than one type of wound filler or wound cover for a single wound is not reasonable and necessary. The exception to this is an alginate or other fiber-

gelling dressing. That would be a wound cover or saline, water, or hydrogel impregnated gauze dressing which might need an additional wound cover.

It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing (such as your hydrogel and alginate). And it wouldn't make much sense to apply one that is hydrating the wound and another that's trying to dry it out.

Some secondary dressings such as composite dressings, foam, and the hydrocolloid wound covers, and transparent film are meant to be changed less than daily, so you should avoid using them with primary dressings which would require more frequent dressing changes. If you submit a claim for these dressings for changes more than once every other day, the extra, or the overage, would be denied as not reasonable and necessary.

Now, a highly exudative wound might require such a combination to start with, but with proper management the wound usually gets to a point where less frequent dressing changes are needed, more in line with the allowed quantities of supplies. An example of an inappropriate combination is the use of a specialty absorptive dressing on top of non-impregnated gauze being used as primary dressing.

The quantity and type of dressings dispensed at any one time depends on the current status of the wounds, how likely is it to change, and what other dressings have been used recently. Dressings, dressing needs can change frequently, sometimes weekly, in the early phases of wound treatment and with heavily draining wounds. You're expected to determine the quantity of dressings that the patient is actually using so that you can adjust their supply of dressings accordingly. No more than one month's supply of dressings can be provided at one time unless there is documentation to support the need for greater quantities. Surgical dressings have to be tailored to the individual beneficiary and his or her specific needs. So on the next slide, we'll look at specific coverage guidelines for individual products. The medical necessity for a more frequent change of dressings must be documented in the patient's medical record and submitted with the claim.

And this is where the surgical dressings get really interesting. When you're talking about which specific types of dressings and when to use it.

The first one is that gelling dressings and we're looking at the A6196 through the A6199. Those are alginate or other fiber-gelling dressings and they're covered for moderately to highly exudative full thickness wounds. They're not reasonable, necessary on dry wounds or wounds covered with the scar, escar. Usual dressing change is up to once per day and one wound, one wound cover sheet of the appropriate size of the wound, or up to 2 units of wound filler is usually used at each dressing change. And it's usually inappropriate to use alginates or other fiber-gelling dressings in combination with the hydrogels. And there's one thing I do want to make sure that you know is that when you are submitting that medical documentation or your documentation for your dressings, make sure that you do, um, put in the records or have in the records, have the doctor put in the records how highly exudative the wound is. Is it moderate? Is it high? That needs to be in the records. We get a lot of denials for that information not being there.

So collagen dressing or wound filler, and that's the A6010, A6011, and the A6021 through 24. That's a collagen based dressing or wound filler and it's covered for full thickness wounds. It's also covered for wounds with light to moderate exudate or wounds that have stalled or have not progressed towards a healing goal. They can stay in place up to 7 days depending on the specific product. Collagen based dressings are not covered for wounds with heavy exudate, third degree burns or when an active vasculitis is present.

Then we move on to that composite dressing that you see here. That's the A6203 through the A6205. Usual composite dressing change is up to 3 times per week and that is one wound cover per dressing change.

Moving onto your contact layer, that's the A6206 through the A6208. Those are contact layer dressings and they're used to line the entire wound. They're not intended to be changed with each dressing change. Usual dressing change is up to once per week for those.

Finally, on this slide, we have the foam dressings. Those are the A6209 through the A6215. Foam dressings are covered when used on full thickness wounds with moderate to heavy exudate. Usual 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. But the usual dressing change for fumwound, excuse me getting tongue tied, the usual dressing change for foam wound fillers is up to once per day.

One moment, please.

On this slide, we're talking first about the gauze or the non-impregnated, and that would be the A6216 through the A6221, the A6402 through the A6404, and the A6407. Usual non-impregnated gauze is basically plain and simple gauze without anything added to it. The dressing change for this gauze is up to 3 times per day for a dressing without a border and once for day for a dressing that has a border. It's usually not necessary to stack more than 2 gauze pads on top of each other in any one area. If 2 gauze pads are used, then there needs to be a record to show clearly why.

We'll move on to the impregnated gauze dressings, that would be your A6222 through A6224, and the A6266. These are woven or non-woven materials into which certain substances have been incorporated by the manufacturer. These include things such as petroleum, zinc paste, sodium chloride, etc. Things like, iodinated agents, petrolatum, zinc pace, crystalline sodium chloride, and more. Now keep in mind that gauze impregnated with silver does not fall under any of these HCPCS codes.

And then we have the gauze that's impregnated with anything other than that water, normal saline, hydrogel, or zinc paste, and those are the A6228 through the A6230. These are usually not reasonable and necessary compared to the non-impregnated gauze that's moistened with the saline or the sterile water. So those are, again, considered not reasonable and necessary. And that's because they serve the same function as the non-impregnated gauze, moistened with bulk saline or sterile water. So when these dressings are billed, again, they will be denied as not reasonable or necessary. Impregnated dressings that are listed in the FDA orange book must be billed using the code A9270 as a prescribed drug, not as a surgical dressing. So for that reason, they're not covered under the surgical dressings, but as a prescribed drug.

We have some more dressings to cover here. We've got the hydrocolloid dressing and hydrocolloid dressings are covered for use on wounds with light to moderate exudate. Usual dressing change for hydrocolloid wound covers or hydrocolloid wound fillers is up to 3 times per week.

And that hydrogel dressing. Notice that there are 3 rows covering hydrogel dressings, simply because there's so much information that's required. Hydrogel dressings are covered when they're used on full thickness wounds with minimal or no exudate. Hydrogel dressings are not reasonable and necessary for stage 2 and 3 ulcers, excuse me, for stage

2 ulcers. If they are, the medical record must well document why it is medically necessary, such as the location of the ulcer. It may be in the sacrococcygeal area. Let me try to pronounce that word. Sacrococcygeal. Excuse me. Sacrococcygeal area. Usual dressing change for hydrogel wound covers without adhesive border or hydrogel wound fillers is up to once per day. And usual dressing change for hydrogel wound covers with adhesive border is up to 3 times per week. So again, we see that those that include the adhesive border are expected to change less.

Now we have that specialty absorptive dressing and these are covered when used for moderately or highly exudative wounds such as your stage 3 or 4 ulcers. Usual specialty absorptive dressing change is once per day, or up to once per day for a dressing without an adhesive border and up to every other day for a dressing with a border.

And then that transparent film. Those dressings are covered when they're used on those open partial thickness wounds with minimal exudate or closed wounds. Usual dressing change for those is up to 3 times per week.

And we have that wound filler that's not elsewhere classified, and usual dressing change for that's up to one per day.

And for a wound pouch. That dressing change is usually up to 3 times per week.

Now this chart shows other specific types of bandages. We have the light compression bandages, self-adherent bandages, and conforming bandages, and they're covered when they are used to hold wound cover dressings in place over any wound type.

Moderate or high compression bandages, conforming bandages, self-adherent bandages and padding bandages are covered when they're part of a multi-layer compression bandage system used to treat a venous stasis ulcer. All of these bandages are non-covered if they're used for strains, sprains, edema, or situations other than as a dressing for a wound. Most compression bandages are reusable. Usual frequency of replacement would be no more than one per week unless they're part of a multi-layer compression bandage system.

Conforming bandage dressing change is determined by the frequency of change of the selected underlying dressing.

Wound fillers are dressing materials which are placed into open wounds to eliminate dead space, absorb exudate, or maintain a moist wound surface. Usual dressing change for those is up to once per day.

The units of service for wound fillers are 1 gram, 1 fluid ounce, 6-inch length or 1 yard, depending on the product. If the individual product is packaged as a fraction of a unit, like maybe half of a fluid ounce, you'll need to determine the units billed by multiplying the number dispensed times the individual product size and then rounding to the nearest whole number. For example, if 11 half-ounce tubes of a wound filler are dispensed, then you would bill 6 units because the 11 times the half would be 5.5 so you'll need to round that to 6. Our review nurses see a lot of documentation where the conversion has not been taken into consideration, which may affect the claim determination so be sure to check that prior to dispensing your items.

For some wound fillers, the units on the package don't correspond to the units of the code. For example, some pastes or gels are labeled as grams instead of fluid ounces. Some wound fillers are labeled as CC or ML instead of fluid ounces or grams. Some are described by linear dimensions instead of grams. In these situations, the supplier must contact the manufacturer to determine the appropriate conversion factor, or unit of service, which corresponds to the code.

Use of more than one type of wound filler, or more than one type of wound cover, in a single wound is rarely medically necessary and if it is, those reasons must be well documented. An exception is an alginate or other fiber gelling dressing wound cover, or a saline, water, or hydrogel impregnated gauze dressing which might need an additional wound cover.

Wound fillers come in many different forms including hydrated, dry, or some other forms such as ropes, spiral, pillows, etc. For certain materials, unique codes have been established like the collagen wound filler alginate or the other fiber gelling wound filler, the foam wound filler and things like that. Wound fillers that are not falling into any of these categories are coded as A6261 or A6262 and they require a narrative on the claim.

Fillers comprised of substances that are not recognized as being effective will be coded as the A9270.

We have gradient compression stockings or wraps. Those are the A6531, A6532, and the A6545. A gradient compression stocking, those codes A6531 or A6532, or the non-elastic gradient compression wrap, coded A6545 are covered when it's used to treat an open venous stasis ulcer.

These same codes are not covered for conditions such as venous insufficiency without stasis ulcers, prevention of stasis ulcers or a prevention of the reoccurrence of stasis ulcers that have healed, treatment of lymphedema in the absence of ulcers. In these situations, since there is no ulcer, the stockings/ wraps do not meet, they don't meet the definition of a surgical dressing. The gradient compression stockings described by codes A6530, A6533 through A6544, A6549, and surgical stockings described by codes A4490 through A 5, A 4, excuse me, A4510 are not covered either, for the same reason, they're not considered surgical dressings. A non-elastic binder for an extremity such as the A4465 is non covered for all indications because it doesn't meet the definition of a surgical dressing.

The gradient compression wrap, the A6545, that's the non-elastic gradient compression wrap. It's limited to 1 per 6 months per leg. Any more than this will be denied as not reasonable and necessary. You'll need to refer to the policy article for statement concerning non-coverage if that ulcer has healed.

Then we have the compression burn garments, which is the A6501 through the A6513, and they're covered under the surgical dressings benefit when they're used to reduce hypertrophic scarring and joint contractures following a burn injury.

Some multi-component surgical dressings contain materials for which there is no specific HCPCS code. Now keep in mind that multi-component products may not be unbundled and billed as the separate components of the dressing. Products containing multiple materials are categorized according to the clinically predominant component. So if it's maybe alginate or collagen, foam or gauze, hydrocolloid or hydrogel. Other multi component wound dressings that don't contain these specified components would be classified as composite or specialty absorptive dressings if the definition of these categories has been met.

Multi-component dressings that are not composite dressings, again, are categorized according to the clinically predominant component - defined based on the proportion of material(s) in the

dressing. For example, a dressing that is 60 percent hydrocolloid and 40 percent alginates would be categorized as a hydrocolloid dressing. HCPCS coding is determined based on the following:

Products where a single material comprises greater than 50% by weight of a product composition are coded based upon the applicable specific HCPCS code for that material. If a specific HCPCS code does not exist for the predominant component, you need to use the A4649.

Products where no single material comprises greater than 50% by weight of the composition are also coded as the A4649.

Medicare recognizes the surgical dressing materials we have discussed in the various product types. Listed on the left-hand side of the slide as being effective. However, those materials that lack sufficient clinical evidence, and are not recognized as being effective, are not considered to be reasonable and necessary. The safety and the effectiveness of the product types listed on the right side of the slide have not been established. They include but are not limited to, silver, honey. Copper. Charcoal, carbon fiber, iodine - other than the iodoform gauze packing, Balsam of Peru in castor oil, and that rolled impregnated gauze we talked about earlier when it's used as a secondary dressing.

There are some situations in which dressings are non-covered under the surgical dressings benefit. Drainage from a cutaneous fistula, which has not been caused by or treated by a surgical procedure; or a stage one press pressure ulcer; or a first-degree burn; or wounds that have been caused by trauma, which do not require surgical closure or debridement, like a skin tear or an abrasion; a venipuncture or arterial puncture site, like for a blood sample, other than the side of an end dwelling catheter or needle. Surgical dressings code, excuse me, surgical dressing codes billed without modifiers A1 through A9 are non-covered under the surgical dressings benefit and some of those are covered under other benefits.

Small adhesive bandages like a band-aid or similar product are not primarily used for the treatment of wounds addressed in the surgical dressings policy and therefore these dressings are non-covered under the surgical dressings benefit.

We have a silicone gel sheet, which is the A6205, I'm sorry, excuse me, A6025, is for the treatment of keloids or other scars does not meet the definition of the surgical dressing benefit and will be denied as non-covered.

So let me look here. I think I; I apologize. I was going through this information earlier, so I'm just letting you look at this slide. And again, these are those wound care items that are not covered under that surgical dressings benefit.

For looking at some dressings covered under other benefits. Umm, payment for any type of dressing in these particular situations is included in the allowance for other codes. Some examples, and these are not all inclusive, are for dressings that are used within fusion pumps, and those are covered under the DME benefit but they're included in the allowance for the code A4221; the dressings that are used with the parental nutrition are covered under the prosthetic device benefit. Those are included in the allowance for code B4224; dressings used with gastronomy tubes, excuse me, gastrostomy tubes, for enteral nutrition are covered under the prosthetic device benefit. They are included in the allowance for codes B4034 through B4036. Dressings that are used with tracheostomies are covered under the prosthetic device benefit. They are included in the allowance for codes A4625 and A4629; and then the dressings that are used with dialysis access catheters are covered under the end stage renal disease benefit, and they're included in the composite rate for the outpatient facility dialysis or the payment cap method one home dialysis. Those are paid to the dialysis provider. So again, these cannot be billed separately when they're covered as they are covered under other categories.

If a treating practitioner applies surgical dressings as part of a professional service that's billed to Medicare, then those surgical dressings are considered to be incident to the professional services of the health care practitioner, and they are not separately payable. Claims for these dressings must not be submitted to the DME MAC. Claims for the professional service, which includes the dressings, must be submitted to the local carrier or the intermediate, or their intermediary, and if dressing changes are sent home with the beneficiary, then claims for those dressings maybe submitted. In this situation use the place of service corresponding to the beneficiary's residence, and that would be the place of service 11. I'm sorry, 12. Place of Service Office, which is the POS 11, must not be used.

Medicare does cover tape when it's used to keep something in place like a wound cover, elastic roll gauze, or non-elastic row gauze. If your wound cover has an adhesive border, additional tape is not usually needed and therefore it's not covered. If the beneficiary needs tape

on top of an adhesive dressing, then you need to make sure that the reason is fully documented. Why is the tape needed when there's an adhesive dressing? When there's an adhesive border? Maybe the wound's in an area of the body that flexes a lot, like an elbow or something and so it needs tape for additional security. When, or if, or how many times the wound covers change determines how much tape would be considered appropriate. Quantities of tape billed must reasonably reflect the size of the wound cover being secured. Usual use for wound covers measuring 16 square inches or less is up to 2 units of tape per dressing and, um, per dressing change, excuse me, and it is 18 square inches. So that would be 36 square inches. For wound covers measuring 16 to 48 square inches up to 3 units per dressing change, or 54 square inches; and for wound covers measuring greater than 48 square inches up to 4 units per dressing change. A unit is, again, 18 square inches.

When there's a primary and a secondary wound cover, then tape is considered to secure the secondary covering.

Claims for tape, A4450 and A4452. Which are billed without an AW modifier or another modifier indicating coverage under a different policy will be denied as not reasonable and necessary.

Okay, so now that we have gone over that coverage criteria, we're going to go over the billing and the modifiers.

Here're the modifiers A1 through A9 and they've been established to indicate that a particular item is being used as a primary or secondary dressing on a surgical or debrided wound, and also to indicate the number of wounds on which that dressing is being used. The modifier number must correspond to the number of wounds on which the dressing is being used,

not the total of wounds treated. For example, if the patient has 4 wounds but a particular dressing is only used on 2 of those wounds, then the A2 modifier must be used with that HCPCS code. The modifiers A1 through A9 are not used with codes A6531, um, through A6532, and the A6545 – and those are those compression stockings below the knee, um, for below the knee.

Now if the dressing is not being used as a primary or secondary dressing on a surgical or debrided wound then you would not use the modifiers A1 through A9. When dressings are provided in non-covered situations, like the use of gauze in the cleansing of a wound or intact skin, then a GY modifier must be added to the code and a brief description of the reason for the non-coverage does need to be included in the narrative. So you might put A6216GY and then put that it was used, in the narrative, that it was used for wound cleansing.

When dressings are provided in non-covered situations like, again, the use of gauze in the cleansing of a wound or intact skin, a GY modifier must be added to the code and a brief description of the reason for non-coverage included. Again, same example. A6216GY used for wound cleansing.

So again, you see here we have those modifiers, AW, and that's when it's furnished in conjunction with a surgical dressing. The EY lets us know that there wasn't an order for this item. The GY, again, lets us know that it was statutorily non-covered. It doesn't meet the definition of any Medicare benefit. And then that LT and RT for the left side or the right side.

Here we're looking at the, the AW modifier and we're looking at the tape. When tape codes A4450 and A4452 are used with surgical dressings, they do need to be billed with the AW modifier in addition to the appropriate A1 through A9 modifiers. When gradient compression stocking codes, A6531 and A6532, or the gradient compression wrap code A6545 are used for an open venous stasis ulcer, then that code must be billed with the AW modifier but not with the A1 through A9 modifiers. For this policy, codes A4450, A4452, A6531, A6532, and the A6545 are the only codes for which the AW modifier may be used.

We have the RT and LT modifiers and they're used with codes A6531, A6532, and the A6545 for the gradient compression stockings and wraps. So when that same code, for bilateral adems, bilateral items left and right, is billed on the same date of service then the supplier does need to bill each item on 2 separate claim lines using the RT and LT modifiers and one unit of service on each line. Claims that are billed without the modifiers RT and/or LT will be rejected as incorrect coding.

When surgical dressings are billed, the appropriate modifiers, the A1 through A9, AW, EY, or GY must be added to the code when it is applicable. Now if the A9 is used, information needs to be submitted with the claim indicating the number of wounds because A9, of course, is used for 9 wounds or more. So you would put that information in the narrative.

Now if the GY is used, you need to include a short explanation, again in the narrative, of why that item's not covered. Used for wound cleansing. Again, that's the example that we've been using and that goes in the narrative field again of the electronic claim.

When codes A4649, A6261 or A6262, um, are billed – these are miscellaneous or unspecified codes, you do need to have a narrative description of the item (including size of the product provided). The um, you also need to have the manufacturer, the product name and number, and the Supplier Price list amount. Since the HCPCS is so general, the narrative field of the claim does need to provide more information.

I apologize, I think I skipped through one.

Here we go. Okay, so we are going to move on to the, um, CR modifier and the COVID-19 narrative.

So to address concerns for continued claims payment of DMEPOS items initially provided during the PHE, and to identify claims for supplies and accessories that are associated with DMEPOS items provided during the PHE, the DME MACs shall instruct suppliers to continue to use the CR modifier, and that's that catastrophe/disaster related modifier, and the COVID-19 narrative for any DMEPOS item and related supply accessory for date of service to March 1st 2020 through May 11th of 2023, that were initially rendered or otherwise impacted by the non-enforcement of certain clinical indications of coverage referenced in the Interim Final Rules CMS-1744-IFC and CMS-5531-IFC. Now the reason we tell you that you do need to use that COVID-19 narrative is because that CR modifier is for more than just the COVID 19 PHE. That is, again, it's for disaster related coverage or catastrophe so it's also being used for instance for the hurricanes that happened in Florida and then the eastern part of the United States as well, also for, um, the fire that happened in Maui. So it is important that when you use that CR modifier that you use the appropriate narrative.

Okay, and now we're going to get into those documentation requirements.

Now on this slide you'll see all of the elements of the SWO. That is the beneficiary's name or the Medicare, by, beneficiary identifier; the order date; the general description of the item, and that can be as general as just the HCPCS code. It can be something like, if you were billing a wheelchair or hospital bed, it could just say that: wheelchair hospital bed. It could have your HCPCS code narrative, or you could actually be as specific as the brand name and the model number that you're going to use, but all we're requiring is a general description of that item.

So for equipment in addition to the description of the base item. The Standard written order may include all concurrently ordered options and accessories for additional features that are separately billed or require an upgrade code, and those all need to be listed separately.

For supplies, in addition to the description of the base item, the DMEPOS order or prescription may include all concurrently ordered supplies that are separately billed, and again, each of those supplies does need to be listed separately.

Next, we need the quantity to be dispense if that's applicable; the treating practitioner's name, or their national provider identifier, and we do need that treating practitioner signature. And when the prescribing practitioner is also the supplier, and they're permitted to furnish specific items, then a separate order is not required but the medical record does need to still contain all of those required order elements.

Here are some other requirements that are tailored to particular characteristics of surgical dressings. And this information is also required to be in the beneficiary's medical, medical record, excuse me.

To support the reasonable and necessary criteria of the type and quantity of dressings, there must be current clinical information in the patient's medical records. This includes an evaluation of the patient's wounds performed at least once a month. If an evaluation can't be made at least once a month, there does have to be documentation in the medical record, which justifies why an evaluation could not be done and what other monitoring methods were used to evaluate the patient's needs for dressings. Now, if a beneficiary is in a nursing facility, or they have a heavily draining or infected wound, then the evaluation would be expected on a more frequent basis. The evaluation can be performed by a nurse, physician, or other health care professional. This evaluation must include the type of each wound, such as a surgical wound, a pressure ulcer, a burn. What is it? It's location. It's size, and what they're looking for is that length and the width in centimeters, and the depth. The amount of drainage and any other relevant information. This information must be available upon request.

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 not routinely needed if the quantity of dressings used is decreased. However, a new order is required at least every 3 months for each dressing being used, even if the quantity used has remained the same or decreased.

Now here are the refill request requirements. As with most DME items, you need to contact, um contact of some kind with the beneficiary is required. You can't just ship supplies on the routine schedule, even if the beneficiary asks you to. There are 3 different scenarios to be considered when talking about refill requirements.

When the beneficiary or their authorized representative comes into the retail store. That meets the need for the beneficiary to request a refill. The very fact that they walk through your door is a request. Documentation can be either a signed delivery slip or itemized sales receipt, and we do suggest that if you use the same delivery slip for in-store pickup as you do for deliveries, make sure that there's a comment or a box to check that says "in-store pickup" so that the reviewer doesn't have any doubt about how the refill got into the beneficiary's hands. We've seen some forms where the reviewer just couldn't tell. So on that, you will also need to make sure that, um, the address of where they obtained the, where they obtained their supplies, is the store's address and not their home address because they came in and they picked it up.

For written refill requests as well as telephone contact, you do need to make sure how many of each item the beneficiary still has on hand and that actually is something that does get frequently overlooked. So you want to watch the date of contact and the date of delivery as well. Whether the beneficiary contacts you or you contact the beneficiary, that contact cannot occur any sooner than 14 days prior to the shipping or delivery and then that shipping or delivery date cannot occur any sooner than 10 days prior to the date when the beneficiary completely exhausts their supply. And here we have that we're showing, we need to make sure that we have the quantity of each item that the beneficiary still has remaining; and again, at least 14 days prior to the delivery. And 10 days prior to the exhaustion. That says at least 10 days. It's actually no sooner than 10 days.

Documentation for a proof of delivery does differ somewhat according to the method used and when you deliver directly to the patient, the date of service is the date of delivery, and that's the date when the beneficiary got the item. That documentation has to include the information shown here on this slide and pay particular attention to the description of the item being delivered. As you see here when we're looking at this, the order can actually be very general. But the description of the item being delivered actually does need to be specific. So what HCPCS code is it? You can use the long description of the HCPCS code. You can use the brand name or model number or, if it's a lightweight wheelchair base, it can be that. But it can't just say wheelchair or anything like so general as that.

When you use a shipping service, your date of service changes. The date of service is the shipping date. Recently, CMS announced that they would accept the date that the shipping invoice was created as long as there was not a significant lag between the date on the invoice and the date that the item actually shipped. So you just need to be sure that you have a paper trail from the shipping invoice and the tracking slip.

This slide is just because we want to be very clear about the shipping date change.

If the beneficiary is in a Skilled Nursing Facility, your proof of delivery follows either of the 2 previous methods - whether it is direct delivery or using a shipping service. In this case, the nursing facility signs for the delivery as the beneficiary's designee and there does have to be some documentation showing that the item or the items were received and used by the beneficiary.

And now we're going to go into CERT, which is a big thing for us.

This is a chart where we're showing just our, 2022 improper payment rates and projected improper payments, and if you want to look specifically at that report, we have provided the link here on the slide. One of the exciting things for us as far as DME goes is that it is down from 28.5% to 25.2 4%. So it's exciting for us to bring that rate down.

The overall improper payment rate for the reporting period of July first of 2020 through June thirtieth of 2021 for surgical dressings was 41.8% And that, that, yes, that represents, excuse me, $116,000,939. I cannot speak today. $116,939,403. So as you can see that is to say a whole lot of money there and we'd like to get that improper payment rate down even more.

These are the top errors for that from that 2022 report. That very top, that insufficient documentation. So we do have a documentation checklist available on our website if you look on

the Guides and Forms page, and that will help you greatly with making sure that you have all of your documentation before you submit your claim.

Next is the medical necessity. There are no documents in the file. Incorrect coding and um, no documentation actually seemed to be kind of on a par with each other as far as the highest amount of errors, those top errors for surgical dressings. And then we have other, excuse me, other and no documents, looking at my colors wrong. But here we have other. Which is a fairly big piece of pie. And no documentation. So again, we do have the documentation checklists available for you to be able to look at.

How would you respond to a CERT audit? Pretty much you would respond the same way that you would any audit from any entity. Your first line of action is to make sure that you have a thorough intake process. It's easier to get everything that you need on the front end rather than having to go back months later to find things.

The CERT contractor changed their name just a little bit ago. So they are now the Empower AI incorporated. That is the CERT documentation center and we have provided their contacts on the slide. It's got their customer service line as well as their website, and then um ways to respond to any kind of request from start. And just remember that when you do get that information from them, you need to respond in a timely manner. Even if you don't have everything you need, make sure that you provide something so that they know, and then, and then maybe an explanation to let them know so that they don't think that you're just not responding to them at all.

So, if CERT does find errors with the claim, you're going to receive a revised remittance advice, or RA, and an Overpayment Demand Letter. If you disagree with a CERT decision, you do have appeal rights. And if the beneficiary meets medical need, we do encourage you to appeal.

To stop the offset or recruitment, you must submit your redetermination appeal to the applicable DMEMAC within 30 days of receipt of the Overpayment Demand Letter. However, if for some reason you cannot appeal within that thirty-day period, you have the maximum of 120 days from the Overpayment Demand Letter to request a written redetermination. Keep in mind you must request a written redetermination for all adjusted claims to the DME MAC who originally processed the claim. For CGS, these suggested claims or overpayment appeals must be submitted via fax or mail.

Now we're going to get into some frequently asked questions that we've had here.

The question was, "how do I use the A1 through A9 modifiers? Does each dressing on the claim need a separate A1 through A9 modifier depending on how many wounds each dressing is being used for or the total number of wounds?"

I remember that we talked about this a little bit earlier, that A1 through A9 indicates the number of wounds on which the specific dressing is being used and not that total number of wounds, and this is just what we talked about a little bit earlier.

The next frequently asked question that we get is "I've submitted a claim for one impregnated gauze dressing, and it keeps getting denied. But another impregnated gauze dressing has been paid with no problem. Why would one be paid and the other not?"

There could be several possible reasons for the denial of one and not the other. Sometimes you may submit and impregnated gauze dressing that is denied and there can, again, there can be different reasons for this - most commonly related to what the substance or agent is. Gauze impregnated with water or saline is never covered, and neither are certain substances like silver and honey. And then there are those impregnated with a drug that we have listed in the FDA orange book, and again, we talked about that again just a little bit earlier.

And those slides are there. of course you can use, um, keep this presentation and use that information, as, as you have it. But just remember that you'll need to make sure to check the policies because they do frequently change.

The next question was that "We have a patient whose wounds are being managed by their primary care physician. She's wheelchair bound and her provider's office is not able to facilitate transfer. Due to this, she cannot have all of her wounds evaluated by her provider. Her spouse is able to measure the wounds at home and they then discuss the wounds when she sees her provider. Does this reflect a situation in which 'other monitoring methods' are being appropriately used to evaluate ongoing need for dressing supplies?"

Even before COVID came along. The policy always permitted some flexibility about the wound monitoring. It just has to be well documented, both the reason why and the efforts to monitor as

well as they possibly can. Now this supplier had a record of how the beneficiary's husband was going to measure and record the wound status until such time as they could discuss it with the practitioner and maybe the practitioner is able to use telehealth in some way. So more and more now we're all having to be more creative.

The next question that we get, and this is a really big one, is "What are the required elements of a wound evaluation?"

You do need to keep in mind that there are 2 types of evaluation required. The initial evaluation does need to contain all of the elements that we have listed here on this slide. We talked about these a little bit earlier and I just wanted to make sure that you had time to look at that.

And the next slide.

We have the other type of evaluation that's weekly or the monthly evaluation, and as we discussed on the previous slide, this policy has always included this provision. It's always been there.

Next, we have "What dressing would I use for pressure ulcers?" A pressure ulcer has been treated by a surgical procedure or has been debrided. So pressure ulcers are never covered under the surgical dressing benefit.

I phrased that wrong, I apologize. Unless the pressure ulcer has been treated by a surgical procedure or has been debrided, they're never covered under the surgical dressing benefit.

And finally, we get to the resources part of our presentation.

Here we have some links, direct links for the LCD for surgical dressings as well as the policy article and the standard documentation requirements. You can get to those from the links that we have listed here on the slide, or you can go to your jurisdiction's landing page, Jurisdiction B or Jurisdiction C, and look over to the left-hand side of the page. There's going to be a navigation menu there. Find the LCD and policy articles as well as, again, that standard documentation requirements.

Although CGS does have both Jurisdiction B and Jurisdiction C, they are run as 2 separate contracts because they are 2 separate contracts. So when you are looking for information on a Jurisdiction B claim or a jurisdiction B beneficiary, then you would need to use the information that we have available on this slide.

And then if you need that information for a Jurisdiction C beneficiary, you would use the information that we have on this slide. Now of course, if you're looking at your jurisdiction's landing page, this contact information is available on that left-hand side navigation menu, and it's under just, it's just under contacts.

And then we have the other contractor resources. The Pricing, Data Analysis, and Coding, or PDAC, contractor is your contact for questions about coding. So if you have an item and you don't know the HCPCS code, you can locate the HCPCS code for that item by going to the PDAC website. It is important to note that just because an item has a HCPCS code does not mean that it's covered under medical guideline, Medicare guidelines, excuse me.

The National Supplier Clearinghouse, um, we don't have anymore. Instead we have the NPE now and that's the National Provider Enrollment contractor. There are 2 contractors for that; the NPE East, and that is for suppliers that are east of the Mississippi River. And then we have the NPE West, who are for suppliers west of the Mississippi River. And, you would contact them for any issues with your provider enrollment, for the issuance of your PTAN, and if you, again have any questions about enrollment or updates to your PTAN, you'll need to contact your NPE provider. Excuse me.

You should contact CEDI, or the Common Electronic Data Interchange contractor, for electronic claim submission inquiries. Those, they assist with the free low-cost software support, support for electronic claim formats, and support for claim rejection reports. And we do have a full list of resources under the "Other Contractors" tab on the JB and JC websites.

This is a new change and we wanted to make sure that everyone is aware. Electronic funds transfers are now being handled by the national provider enrollment, either NPE East or NPE West, just according to your location. So, do remember that up until November 19 of 2023, um, if we receive the form here at the DME Mac, we are going to forward that to the NPE contractor. But after November 20, we're going to start rejecting those and just returning to, returning them to you. So remember to contact and send that information to your appropriate NPE contractor.

If you are already enrolled with EFT, you don’t have to do anything for the transition from the paper checks. This is only for the suppliers who are not already signed up for EFT that must now enroll. The NPE will notify you when you must transition from your paper checks to the EFT.

Okay, we’ve reached the end of the, of the webinar portion, of the webinar today, of the educational portion of the webinar today, and I will be taking questions in just a minute but first, for those that have joined us for the recorded webinar, I would like to thank you for your time and please send us any questions that you have.