Getting Started
What is Medicare?

Medicare is a federally funded health insurance program available to:

- People 65 years of age or older
- People under 65 with certain disabilities
- People with end-stage renal disease (ESRD)

Medicare is managed by the Centers for Medicare & Medicaid Services (CMS), a division of the United States Department of Health and Human Services.

Medicare is divided into three distinct parts:

**Part A – Hospital Insurance**
- Hospital inpatient care
- Skilled nursing facility (SNF) inpatient services
- Some home health care
- Hospice care

*Part A may cover up to 120 days of medically necessary costs for hospitalization with coinsurance.*

**Part B – Medical Insurance**
- Certain doctors’ services
- Medical supplies
- Outpatient care
- Preventive services

*Part B covers non-hospital costs for certain specified product categories. Application must be made and a monthly premium paid to obtain and keep coverage. (Part B pays 80% of the "reasonable charge" allowed by Medicare with a yearly deductible.)*

**Part D – Medicare Prescription Drug Coverage**
- Prescription drug option run by Medicare-approved private insurance companies
- Helps cover prescription drug costs
How does ProMedB work?

In nursing homes, Medicare Part B coverage is limited primarily to prosthetic devices.

These include:

- Enteral therapy
- Urologicals
- Ostomy
- Tracheostomy
- Surgical and wound dressings
  (not part of the prosthetic device coverage)

ProMedB features include:

- Tracking of Medicare supply usage via rosters that move between ProMed and facility before every delivery
- Delivery of supplies scheduled according to the provider’s/supplier's storage area
- Emergency supplies available 24 hours a day, seven days a week
- Medicare Part B billing via electronic claim submission directly to a regional carrier
- All filed claims comply with Medicare Part B standards using Uniform Electronic Data Transmission Standards and Privacy Standards of individually identifiable Protected Health Information with a signed HIPAA agreement between the facility and ProMed
- If no 20% coinsurance is available, ProMed will print an itemized statement reflecting the coinsurance balance and bill the resident
- Preparation of Medicare-mandated Certificate of Medical Necessity

How do invoices get paid?

Medicare sets an allowed charge (fee schedule) for any given justified service and pays 80% of that charge.

The outstanding 20% is billed to either:

- Medicaid state aid for the financially qualified
- Coinsurance secondary insurance carrier
- Resident, family, responsible party or person with power of attorney

We are required, by federal regulation, to make collection attempts on the outstanding 20% balance.

Featured service for certified Medicare providers

At Professional Medical (ProMed), we understand the difficulty of providing quality health care while running a viable business. We created the ProMedB Medicare Part B billing service to allow our partner facilities more time to devote to resident care.

Our account managers are among the most progressive in the fields of public aid and Medicare billing. They have a vast knowledge of consolidated billing, PPS and managed care. They are dedicated to ethical billing practices and a high level of ongoing customer service satisfaction, including:

- Resident-specific product ordering and billing to Medicare Part B for the contracted facility
- Retrospective billing cycle for Medicare Part B

Prosthetic devices

A prosthetic device is described in the Part B carrier manual as that which replaces “all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices.” If the clinical record, including the judgment of the attending physician, indicated the condition will be long and of an indefinite duration, the test of permanence will be considered met. Therefore, tubes for feeding purposes, urinary catheters, traches and colostomy products are reimbursable only when used in place of or because of a dysfunctioning body part.
Claim filing
A great concern for CMS and the Office of Inspector General (OIG) is the need of all healthcare providers to have in place a Compliance Plan that meets all HIPAA regulations. The purpose of the Compliance Plan is to establish the basis that every healthcare provider participating in federal programs (such as Medicare and Medicaid) should eagerly embrace the concept of voluntary compliance programs.

Goals of the Compliance Plan include:
- Speed and proper payment of claims
- Minimal billing mistakes
- Reduced chances of an audit by CMS or OIG
- Evidence of a good faith attempt to bill appropriately

Self-auditing procedures
Prior to submitting any claim, files are put through an internal auditing system to guarantee that ProMed has all the necessary documentation to file a successful claim. These audits are conducted by our billing specialists and are reviewed on a routine basis.

In addition to re-verifying that all of the required information is completed and accurate, there are a few additional steps we take:
1. Validate products, diagnoses and modifiers (numeric and alpha numeric).
2. Check that dates of service are within normal limits.
3. Check that products billed match diagnosis to justify medical necessity of products provided. We utilize a custom-built database to ensure minimal denials.
4. We use various sources to obtain vital resident information such as ID numbers, etc. Examples include insurance companies, help lines and IVR systems.

Electronic billing service
ProMed’s online electronic billing uses uniform electronic data transmission standards and privacy standards of individually identifiable protected health information.

The following is a list of the categories billed under Medicare Part B medical supplies:
- Enteral therapy
- Urologicals
- Ostomy
- Tracheostomy
- Surgical and wound dressings

Medical services
Enteral feedings
- Digital pumps
- N.G. tubes
- Feeding containers
- Syringe pole holders
- 35 cc syringes
- G-tubes
- Administration sets
- "Y" connectors
- 60 cc syringes
- I.V. poles

Urologicals
- Foley catheters
- Urethral trays
- Leg bags
- External catheters
- Insertion trays
- Drain bags
- Foley irrigation trays
- Straight cath kits

Ostomy care
- Stoma care items
- Ileostomy supplies
- Ostomy belts
- Skin cleansers
- Deodorizers
- Colostomy pouches
- Urostomy supplies
- Karaya products
- Drainable bags
- Pastes/adhesives

Tracheostomy care
- Trach care trays
- Inner cannula
- Trach tubes

Wound care
- Surgical and wound dressings (primary and secondary)
In order to bill in a proper and timely fashion, ProMed’s territory managers and billing specialists work closely with our customers to obtain the following required information:

- Face sheet
- Signed and dated doctor’s orders
- Copy of Medicare card
- Copy of any secondary insurance card
- Signed assignment of benefits
- Signed monthly roster
- Signed Patient Acceptance Packet Survey

A resident roster will be sent to a designated person at the facility. This roster contains eligible residents who received qualified supplies. The facility needs to verify the information and make any changes to the roster and then return it to ProMedB. The facility will receive their product order based on the information supplied on the resident roster.

After receiving all of the necessary documentation, Medicare Part B will be billed for the qualified list of residents. Any Medicare Part B product used in excess of the eligible amount will be billed to the facility’s house account, under the residents’ names. This is to ensure that there is no overutilization billed to Medicare.

### Definitions

Enteral nutrition is the provision of nutritional requirements through a tube into the stomach or small intestine.

Indications: Enteral nutrition is covered for a resident with normal gastrointestinal (G.I.) absorptive capacity who, due to permanent nonfunction or disease of the structures that normally permit food to reach the small bowel, requires tube feeding to provide sufficient nutrients to maintain weight and strength commensurate with the resident’s overall health status.

### Coverage and payment rules

**General:** The resident must have a permanent impairment. Permanence does not require that the impairment necessitating therapy will persist through the resident’s remaining life. If the judgment of the attending physician, substantiated in the medical record, is that the impairment can reasonably be expected to exceed three months (90 days), the test of permanence is considered met. Enteral nutrition will be denied as non-covered in situations with temporary impairments.

The resident must have a condition involving the gastrointestinal tract somewhere between the mouth and duodenum, inclusive, that prevents adequate ingestion. This condition could be either anatomic (e.g., obstruction due to head and neck cancer or reconstructive surgery, etc.) or due to a motility disorder (e.g., severe dysphasia following a stroke, etc.). Enteral nutrition is non-covered for residents with a functioning G.I. tract whose need for enteral nutrition is due to a lack of appetite or a cognitive problem.

The resident must require tube feedings to sustain life. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

The resident must experience sufficient nutritional benefit and rehabilitation so that the therapy makes sense for both the resident and family.

### Enteral tube feeding allowables

**What is covered?**

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>As prescribed by the physician, 20-35 calories per day per kg of body weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasogastric tubes</td>
<td>One per month</td>
</tr>
<tr>
<td>Gastrostomy tubes</td>
<td>One every 90 days</td>
</tr>
<tr>
<td>Administration kits</td>
<td>Generally include the following:</td>
</tr>
<tr>
<td>– Pump supply kit</td>
<td>1 spike set or bag per day; 1 syringe per day</td>
</tr>
<tr>
<td>– Gravity supply kit</td>
<td>1 spike set or feeding bag/day; 1 syringe per day</td>
</tr>
<tr>
<td>Pumps</td>
<td>Rental up to 15 months</td>
</tr>
<tr>
<td>I.V. poles</td>
<td>Rental for gravity or pump residents</td>
</tr>
</tbody>
</table>

*covered when medical justification is documented*
Covered enteral nutrition services provided by SNFs to Part A residents are billed by the SNF to the fiscal intermediary. No payment from Part B is available to a SNF when the SNF furnished enteral nutrition services to a beneficiary in a stay covered by Part A. Enteral nutrients are classified as food and are included as a component of the SNF’s routine costs. If a beneficiary is not covered by Part A, but is eligible for Part B coverage, enteral nutrition services are covered under Part B regardless of whether they are furnished by a SNF or an outside supplier.

Nutrients: Enteral formula consisting of semi-synthetic intact protein/protein isolates (B4150) is appropriate for the majority of residents requiring enteral nutrition. Formula consisting of natural intact protein/protein isolates (B4149) is covered for residents with an allergy or intolerance to semi-synthetic formula (B4150). Calorically dense formulas (B4152) are covered if they are needed. The medical necessity for special enteral formula (B4153-4154) will need to be justified for each resident. If the medical necessity for codes B4149 or B4153-4154 is not substantiated, payment could be denied.

A total daily caloric intake of 20-35 cal/kg/day is considered sufficient to achieve or maintain appropriate body weight for most residents. The ordering physician must document the medical necessity for a caloric intake outside this range in an individual resident.

Equipment and supplies: Enteral nutrition may be administered by syringe, gravity or pump. Some enteral residents may experience complications associated with the syringe or gravity method of administration. If a pump (B9000-B9002) is ordered, there must be documentation on the accompanying Certificate of Medical Necessity (CMN) to justify its use (e.g., gravity feeding is not satisfactory due to aspiration, severe diarrhea, dumping syndrome, etc.). If the medical necessity of the pump is not documented, the pump will be denied as not medically necessary.

The feeding supply kit (B4034-B4036) must correspond to the method of administration. If a pump supply kit (B4035) is ordered and the medical necessity of the pump is not documented, payment will be based in the allowance for the least costly alternative, B4036.

More than three nasogastric tubes (B4081-B4083), or one gastrostomy or jejunostomy tube (B4087) every 90 days is rarely medically necessary.

Documentation: An order for all nutrients, equipment and supplies that has been signed and dated by the ordering physician must be kept on file by the facility. The prescription (order) for the nutrients must include the brand name of the product, the amount to be administered, the frequency of administration and the duration of administration. The CMN for enteral nutrition must be completed.

After the initial certification of enteral nutrition items, recertification is required only where there is a change to the calorie amount or change in supplement type. If enteral nutrition services are not medically required for two consecutive months, a new initial certification would be required.

A revised certification would be required when (1) different nutrients are ordered, or (2) calories per day are changed, or (3) number of days per week administered, or (4) the method of infusion (syringe, gravity, pump) changes.
What support documentation is required?

**Urological allowables**

<table>
<thead>
<tr>
<th>What is covered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheters (all types)</td>
<td>One per month</td>
</tr>
<tr>
<td>Insertion trays</td>
<td>One per month</td>
</tr>
<tr>
<td>Drain bags</td>
<td>Two per month</td>
</tr>
<tr>
<td>Leg bags</td>
<td>Two per month</td>
</tr>
<tr>
<td>Irrigation trays</td>
<td>Per prescription</td>
</tr>
<tr>
<td>Catheter leg straps</td>
<td>One per month</td>
</tr>
<tr>
<td>Male external catheters</td>
<td>35 per month</td>
</tr>
<tr>
<td>Sterile intermittent catheters</td>
<td>Per prescription</td>
</tr>
</tbody>
</table>

**Coverage and payment rules**

Indwelling catheters, Foley-type, two-way: No more than one catheter per month is covered for routine catheter maintenance. Non-routine catheter changes are covered when documentation substantiates medical necessity, such as for the following indications:

1. Catheter is accidentally removed (e.g., pulled out by resident)
2. Malfunction of catheter (e.g., balloon does not stay inflated, hole in catheter)
3. Urine leaks around catheter
4. Catheter is obstructed by encrustation or mucous plug
5. Urinary tract infection
6. Hematuria with obstruction due to clots
7. History of recurrent obstruction of infection of which it has been established that an acute event is prevented by a scheduled change at less than monthly intervals

**Permanency:** The physician must certify that the condition resulting in the need for the device is of long and indefinite duration (at least three months).
Ostomy allowables

What is covered?

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity/Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adhesive liquid</td>
<td>4 oz per month</td>
</tr>
<tr>
<td>Appliance cleaner</td>
<td>16 oz per month</td>
</tr>
<tr>
<td>Bedside drainage bag</td>
<td>2 per month</td>
</tr>
<tr>
<td>Catheter for continent stoma</td>
<td>1 per month</td>
</tr>
<tr>
<td>Continent plug</td>
<td>30 per month</td>
</tr>
<tr>
<td>Ostomy lubricant</td>
<td>4 oz per month</td>
</tr>
<tr>
<td>Ostomy pouch, drainable w/faceplate</td>
<td>10 per month</td>
</tr>
<tr>
<td>Ostomy pouch, open (drainable)</td>
<td>20 per month</td>
</tr>
<tr>
<td>Ostomy pouch, closed (non-drainable)</td>
<td>60 per month</td>
</tr>
<tr>
<td>Ostomy ring</td>
<td>10 per month</td>
</tr>
<tr>
<td>Skin barrier solid 4x4</td>
<td>20 per month</td>
</tr>
<tr>
<td>Skin barrier</td>
<td>4 oz per month</td>
</tr>
<tr>
<td>Skin barrier with flange</td>
<td>20 per month</td>
</tr>
<tr>
<td>Stoma cap</td>
<td>31 per month</td>
</tr>
<tr>
<td>Tape</td>
<td>720 inches</td>
</tr>
</tbody>
</table>

Definitions: Ostomy supplies are covered for use on residents with a surgically created opening (stoma) to divert urine or fecal contents outside the body. Ostomy supplies are appropriately used for colostomies 569.62, V44.3, V55.3, ileostomies V44.2, V55.2 or urinary ostomies V44.6, V55.6. Use for other conditions will be denied as non-covered.

Barriers: A solid barrier (wafer) is an interface between the resident's skin and the pouching system, has measurable thickness and has an adhesive property. Barriers may be integrated into a one-piece pouch, they may be manufactured with a flange and be part of a two-piece pouch system (skin barrier with flange, e.g., A4414) or they may be used independently (e.g., A4362), usually with a pouch that does not have its own integral skin barrier. An extended-wear barrier (e.g., A4409) is a pectin-based barrier with special additives that achieve a stronger adhesive seal, resist breakdown by urine or bowel effluent and permit longer wear times between changes and normal wear times for those who cannot achieve them with standard barriers. There are distinct codes for extended-wear compared to standard-wear barriers.

A barrier with built-in convexity (e.g., A4407) is one in which an outward curve is usually achieved with plastic embedded in the barrier, allowing better protrusion of the stoma and adherence to the skin. There are distinct codes for barriers with built-in convexity compared to flat barriers.

Ostomy skin barriers greater than 4x4 inches (e.g., A4408) refer to the size of the skin barriers themselves, and not to the area of any surrounding tape.

Faceplates: A faceplate is a solid interface between the resident's skin and the pouch. It is usually made of plastic, rubber or encased metal. It does not have an adhesive property and there is no pectin-based or karaya material that is an integral part of the faceplate. It can be taken off the skin and reattached repeatedly. It is held on by means of a separate adhesive and/or an elastic belt. The clips for attaching the belt are usually a part of the faceplate. There is no coding distinction between flat and convex faceplates.

Pouches: A pouch is a device for collecting stomal output. A pouch for collecting bowel effluent may be either "drainable" with an opening at the bottom through which the fecal contents are emptied, or "closed" with a sealed bottom and no outlet. A urinary pouch normally incorporates anti-reflux devices and a tap or spigot to empty the urine contents.

A pouch with barrier attached is one type of one-piece system in which a solid barrier is part of the pouch. There are distinct codes for one-piece pouches with convex barriers and extended-wear barriers (see "Barriers" on left).

A pouch without a barrier attached is a pouch with or without a thin adhesive coating that is applied either directly to the skin or to a separate barrier. It is also described as a one-piece system.

A pouch that is part of a two-piece system has a flange that enables it to be coupled to a skin barrier with flange.

A pouch with a faceplate attached or for use on a faceplate is generally rubber or heavy plastic. It is drainable, cleanable and reusable for periods of weeks to months, depending on the product.
A high output pouch (A4412, A4413) has a capacity of greater than or equal to 0.75 liters, is drainable with a large bore solid spout with cap or plug and is part of a two-piece system.

Codes for pouches with filters (e.g., A4416) describe pouches that have an opening that allows venting of trapped gas. They typically include materials such as charcoal to deodorize the vented gas. Code A4368 describes replacement filter material.

Code A4366 describes a separate ostomy vent that can be added by the resident to a pouch to allow the release of gas. This code must not be used for pouches in which a vent with a filter is incorporated in the pouch by the manufacturer. Those products are described by the codes for ostomy pouches with a filter (A4416-A4419, A4423-A4425, A4427).

Absorbent material (A4422) that is added to the ostomy pouch may come as sheets, pads or crystals.

An ostomy pouch with faucet-type tap with valve (e.g., A4429) has a valve for draining urine.

A locking flange (e.g., A4420) is a lever-type flange locking mechanism. It differs from simple push-on pouch-securing mechanisms. The mechanism may be incorporated either in the pouch flange or skin barrier flange (two-piece system).

Pastes: A paste is used as a protective layer and sealant beneath ostomy appliances and is applied directly on the skin. It may be primarily pectin-based (A4406), or non-pectin based, e.g., karaya (A4405).

Code A4400 (ostomy irrigation set), for an irrigation kit, is not valid for claims submitted to the durable medical equipment regional carrier (DMERC). If an irrigation kit is supplied, the individual components should be billed using individual codes A4397, A4398 and A4399.

Ostomy clamps (A4364) are used with drainable pouches and are not used with urinary pouches. Ostomy clamps are only payable when ordered as a replacement. Claims for ostomy clamps billed with ostomy pouches will be denied as not separately payable with ostomy pouches.

**Coverage and payment rules**

The quantity of ostomy supplies needed by a resident is determined to a great extent by the type of ostomy, its location, its construction and the condition of the skin surface surrounding the stoma. There will be variation according to individual resident needs, and their needs may vary over time.

The medical necessity for use of a greater quantity of supplies than the amounts listed on page 9 must be clearly documented in the resident’s medical record and may be requested by the DMERC. If adequate documentation is not provided when requested, the excess quantities will be denied as not medically necessary.

Provision of ostomy supplies should be limited to a one (1) month supply for a resident in a nursing facility and a three (3) month supply for a resident at home. When a liquid barrier is necessary, either liquid, spray, individual wipes or swabs are appropriate. The use of both is not medically necessary.

Residents with continent stomas may use the following means to prevent/manage drainage: stoma cap, stoma plug or gauze pads. No more than one (1) type of supply would be medically necessary on a given day.

Residents with urinary ostomies may either use a bag or bottle for drainage at night. It is not medically necessary to have both.

**ICD-9 codes that are covered**

Note: The presence of an ICD-9 code listed in this section is not sufficient by itself to assure coverage.

<table>
<thead>
<tr>
<th>ICD-9 codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S569.62</td>
<td>Mechanical complication of colostomy and enterostomy</td>
</tr>
<tr>
<td>V44.2</td>
<td>Ileostomy status</td>
</tr>
<tr>
<td>V44.3</td>
<td>Colostomy status</td>
</tr>
<tr>
<td>V44.6</td>
<td>Status of other artificial opening of urinary tract</td>
</tr>
<tr>
<td>V55.6</td>
<td>Attention to ileostomy</td>
</tr>
<tr>
<td>V55.3</td>
<td>Attention to colostomy</td>
</tr>
<tr>
<td>V55.6</td>
<td>Attention to other artificial opening of urinary tract</td>
</tr>
</tbody>
</table>
Tracheostomy allowables

<table>
<thead>
<tr>
<th>What is covered?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trache tube</td>
<td>1 every 3 months</td>
</tr>
<tr>
<td>Trache care kit</td>
<td>1 per day</td>
</tr>
<tr>
<td>Inner cannula</td>
<td>Per prescription</td>
</tr>
</tbody>
</table>

Definitions: Tracheostomy care kits are covered for a resident following an open surgical tracheostomy that has been open or is expected to remain open for at least three months.

Coverage and payment rules
A tracheostomy care or cleaning starter kit (A4625) is covered following an open surgical tracheostomy. One tracheostomy care kit (A4625, A4629) per day is considered necessary for routine care of a tracheostomy. Claims for additional kits for non-routine tracheostomy care must have substantiating documentation available to the DMERC on request.

When billing for more than one tracheostomy care kit per day, documentation must be submitted explaining the medical necessity for the greater amount.

ICD-9 codes that are covered

Note: The presence of an ICD-9 code listed in this section is not sufficient by itself to assure coverage.

<table>
<thead>
<tr>
<th>ICD-9 codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S19.00</td>
<td>Tracheostomy complication unspecified</td>
</tr>
<tr>
<td>S19.01</td>
<td>Infection of tracheostomy</td>
</tr>
<tr>
<td>S19.02</td>
<td>Mechanical complication of tracheostomy</td>
</tr>
<tr>
<td>S19.09</td>
<td>Other tracheostomy complications</td>
</tr>
<tr>
<td>V44.0</td>
<td>Tracheostomy status</td>
</tr>
<tr>
<td>V55.0</td>
<td>Attention to tracheostomy</td>
</tr>
</tbody>
</table>
What support documentation is required?

### Surgical allowables

#### What is covered?

<table>
<thead>
<tr>
<th>Primary Dressings</th>
<th>Approved for Stage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impregnated gauze: all sizes</td>
<td>2-3-4</td>
<td>Daily</td>
</tr>
<tr>
<td>Hydrocolloid: all styles and shapes</td>
<td>2-3-4</td>
<td>Every 3 days</td>
</tr>
<tr>
<td>Transparent films: all sizes</td>
<td>2-3-4</td>
<td>Every 3 days</td>
</tr>
<tr>
<td>Packing strips: plain, all widths</td>
<td>2-3-4</td>
<td>12 bits/mo</td>
</tr>
<tr>
<td>Packing strips: impregnated, all widths</td>
<td>2-3-4</td>
<td>12 bits/mo</td>
</tr>
</tbody>
</table>

*Hydrogel is covered for Stage 2 wounds when wound site is in sacral area only*

| Hydrogel: 2x2, 4x4 impregnated dressing | 3-4 surgical | Daily |
| Hydrogel: tubes or packets             | 3-4 surgical | 3 oz/mo |
| Foam dressing: all sizes and shapes    | 3-4          | Every 3 days     |
| Alginites: all sizes and shapes        | 3-4          | Daily             |
| ABD pads: all sizes                    | 2-3-4 surgical | Daily |
| Bordered gauze: all sizes              | 2-3-4 surgical | Daily |
| Gauzes: 2x2, 4x4                       | 2-3-4 surgical | 6/day |
| Heel-it: specialty heel application    | 2-3-4 surgical | Daily |
| Island dressings/film plus pad         | 2-3-4 surgical | Every 3 days     |
| Roll gauze: all widths                 | 2-3-4 surgical | 15 rolls/mo       |
| Telfa pads: any size                   | 2-3-4 surgical | 6/day             |

### Definitions:
Surgical dressings are covered for as long as they are medically necessary. Those dressings used in conjunction with investigational wound healing therapy may be covered if all applicable coverage criteria are met based on the number and type of surgical dressings that are appropriate to treat the wound if the investigational therapy was not being used.

### Coverage and payment rules
An order for surgical dressings must specify the type of dressing, the size of the dressing, the number/amount to be used at one time (if more than one), the frequency of dressing change and the expected duration of need.

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 every three months for each dressing being used, even if the quantity used has remained the same or decreased.

Information defining the number of surgical/debrided wounds being treated with a dressing, the reason for dressing use (i.e., surgical wound, debrided wound, etc.) and whether the dressing is being used as a primary or secondary dressing for some noncovered use (i.e., wound cleansing) should be obtained from the physician, nursing home or nurse. The source of that information and the date obtained should be documented in the supplier’s records.

Current clinical information that supports the reasonableness and necessity of the type and quantity of surgical dressings provided must be present in the resident’s medical record.

When a wound cover with an adhesive border is being used, no other dressing is needed on top of it and additional tape is not usually required. Reasons for the use of additional tape must be well documented. An adhesive border is usually more binding than separate taping and is therefore indicated for use with wounds requiring less frequent dressing changes.

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 the 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 that 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 (e.g., hydrogel and alginate).
Because composite dressings, foam and hydrocolloid wound covers and transparent film, when used as secondary dressings, are meant to be changed at frequencies less than daily, appropriate clinical judgment should be used to avoid their use with primary dressings that require more frequent dressing changes. When claims are submitted for these dressings for changes greater than once every other day, the quantity in excess of that amount will be denied as not medically necessary. While a highly exudative wound might require such a combination initially, with continued proper management the wound usually progresses to a point where the appropriate selection of these products results in less frequent dressing changes. An example of an inappropriate combination is the use of a specialty absorptive dressing on top of non-impregnated gauze being used as a primary dressing.

Dressing size must be based on and appropriate to the size of the wound. For wound covers, the pad size is usually about two inches greater than the dimensions of the wound. For example, a 5 cm x 5 cm (2 in x 2 in) wound requires a 4 in x 4 in pad size.

The quantity and type of dressings dispensed at any one time must take into account the current status of the wound(s), the likelihood of change and the recent use of dressings.

Dressing needs may change frequently (e.g., weekly) in the early phases of wound treatment and/or with heavily draining wounds. Suppliers are also expected to have a mechanism for determining the quantity of dressings that the resident 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. An even smaller quantity may be appropriate in the situations described above.

Surgical dressings must be tailored to the specific needs of an individual resident.

Alginate or other fiber gelling dressing (A6196-A6199) covers are covered for moderately to highly exudative full thickness wounds (e.g., Stage III or IV ulcers) and alginate or other fiber gelling dressing fillers for moderately to highly exudative full-thickness wound cavities (e.g., Stage III or IV ulcers). They are not medically necessary on dry wounds or wounds covered with eschar. Usual dressing change is up to once per day. One wound cover sheet of the approximate size of the wound or up to two units of wound filler (one unit = six inches of alginate or other fiber gelling dressing rope) is usually used at each dressing change. It is usually inappropriate to use alginates or other fiber gelling dressings in combination with hydrogels.

Composite dressing (A6203-A6205): Usual composite dressing change is up to three times per week, one wound cover per dressing change.

Contact layer dressings (A6207) are used to line the entire wound; they are not intended to be changed with each dressing change. Usual dressing change is up to once per week.

Foam dressings (A6209-A6215) are covered when used on full-thickness wounds (e.g., Stage III or IV ulcers) with moderate to heavy exudate. Usual dressing change for a foam wound cover used as a primary dressing is up to three 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 three times per week. Usual dressing change for foam wound fillers is up to once per day.

Gauze, non-impregnated (A6216-A6221, A6402-A6404, A6407): Usual non-impregnated gauze dressing change is up to three times per day for a dressing without a border and once per day for a dressing with a border. It is usually not necessary to stack more than two gauze pads on top of each other in any one area.
What support documentation is required?

(Surgical allowables continued)

Gauze, impregnated, with other than water, normal saline, hydrogel or zinc paste (A6222-A6224, A6266): Usual dressing change for gauze dressings impregnated with other than water, normal saline or hydrogel is up to once per day.

Gauze, impregnated, water or normal saline (A6228-A6230): There is no medical necessity for these dressings compared to non-impregnated gauze that is moistened with bulk saline or sterile water. When these dressings are billed, payment will be based on the least costly medically appropriate alternative, sterile non-impregnated gauze.

Hydrocolloid dressings (A6234-A6241) 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 three times per week.

Hydrogel dressings (A6231-A6233, A6242-A6248) are covered when used on full-thickness wounds with minimal or no exudate (e.g., Stage III or IV ulcers). Hydrogel dressings are not usually medically necessary for Stage II ulcers. Documentation must substantiate the medical necessity for use of hydrogel dressings for Stage II ulcers (e.g., location of ulcer is sacrococcygeal area). Usual dressing change for hydrogel wound covers without adhesive border or hydrogel wound fillers is up to once per day. Usual dressing change for hydrogel wound covers with adhesive border is up to three times per week.

The quantity of hydrogel filler used for each wound must not exceed the amount needed to line the surface of the wound. Additional amounts used to fill a cavity are not medically necessary. Documentation must substantiate the medical necessity for code A6248 billed in excess of three units (fluid ounces) per wound in 30 days.

Use of more than one type of hydrogel dressing (filler, cover or impregnated gauze) on the same wound at the same time is not medically necessary.

Transparent films (A6257-A6259) are covered when used on open partial-thickness wounds with minimal exudate or closed wounds. Usual dressing change is up to three times per week.

Wound filler, not elsewhere classified (A6261-A6262): Usual dressing change is up to once per day.

Wound pouch (A6154): Usual dressing change is up to three times per week.

Tape (A4450, A4452) is covered when needed to hold on a wound cover, elastic roll gauze or non-elastic roll gauze. Additional tape is usually not required when a wound cover with an adhesive border is used. The medical necessity for tape in these situations must be documented. Tape change is determined by the frequency of change of the wound cover. Quantities of tape submitted 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 two units per dressing change; for wound covers measuring 16 to 48 square inches, up to three units per dressing change; for wound covers measuring greater than 48 square inches, up to four units per dressing change.

Light compression bandage (A6448-A6450), moderate/high compression bandage (A6451, A6452), self-adherent bandage (A6453-6455), conforming bandage (A6442-A6447), padding bandage (A6441): Most compression bandages are reusable. Usual frequency of replacement would be no more than one per week unless they are part of a multi-layer compression bandage system. Conforming bandage dressing change is determined by the frequency of change of the selected underlying dressing.

Documentation requirements

Current clinical information that supports the reasonableness and necessity of the type and quantity of surgical dressings provided must be present in the resident’s medical records. Evaluation of a resident’s wound(s) must be performed at least on a monthly basis.
unless there is documentation in the medical record that justifies why an evaluation could not be done within this timeframe and what other monitoring methods were used to evaluate the resident's need for dressings. Evaluation is expected on a more frequent basis (e.g., weekly) in residents in a nursing facility or in residents with heavily draining or infected wounds. The evaluation may be performed by a nurse, physician or other healthcare professional. This evaluation must include the type of each wound (e.g., surgical wound, pressure ulcer, burn, etc.), its location, its size (length x width in cm) and depth, the amount of drainage and any other relevant information. This information does not have to be routinely submitted with each claim. However, a brief statement documenting the medical necessity of any quantity billed that exceeds the quantity needed for the usual dressing change frequency stated in the policy must be submitted with the claim.

Surgical dressings are covered when either of the following criteria are met:

1. They are required for the treatment of a wound caused by, or treated by, a surgical procedure or
2. They are required after debridement of a wound

Surgical dressings include both primary dressings (i.e., therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin) and secondary dressings (i.e., materials that serve a therapeutic or protective function and that are needed to secure a primary dressing).

Compression burn garments (A6501-A6513) are covered under the Surgical Dressings benefit when they are used to reduce hypertrophic scarring and joint contractures following a burn injury.

The surgical procedure or debridement must be performed by a physician or other healthcare professional to the extent permissible under state law. Debridement of a wound may be any type of debridement (examples given are not all-inclusive): surgical (e.g., sharp instrument or laser), mechanical (e.g., irrigation or wet-to-dry dressings), chemical (e.g., topical application of enzymes) or autolytic (e.g., application of occlusive dressings to an open wound). Dressings used for mechanical debridement, to cover chemical debriding agents or to cover wounds to allow for autolytic debridement are covered, although the agents themselves are non-covered.

Light compression bandage (A6448-A6450), moderate/high compression bandage (A6451, A6452), self-adherent bandage (A6453-6455), conforming bandage (A6442-A6447), padding bandage (A6441): Light compression bandages, self-adherent bandages and conforming bandages are 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 are part of a multi-layer compression bandage system used in the treatment of a venous stasis ulcer.

Coding guidelines

Composite dressings (A6203) are products combining physically distinct components into a single dressing that provides multiple functions. These functions must include, but are not limited to: (a) a bacterial barrier, (b) an absorptive layer other than an alginate or other fiber gelling dressing, foam, hydrocolloid, or hydrogel and (c) either a semi-adherent or non-adherent property over the wound site.

Contact layers (A6207) are thin non-adherent sheets placed directly on an open wound bed to protect the wound tissue from direct contact with other agents or dressings applied to the wound. They are porous to allow wound fluid to pass through for absorption by an overlying dressing.

Impregnated gauze dressings (A6222-A6223, A6266, A6456) are woven or non-woven materials into which substances such as iodinated agents, petrolatum, zinc paste, crystalline sodium chloride, chlorhexidine gluconate (CHG), bismuthtribromophenate (BTP), water, aqueous saline, hydrogel or other agents have been incorporated into the dressing material by the manufacturer.
What support documentation is required?

(Surgical allowables continued)

Specialty absorptive dressings (A6251-A6256) are unitized multi-layer dressings that provide (a) either a semi-adherent quality or non-adherent layer, and (b) highly absorptive layers of fibers such as absorbent cellulose, cotton or rayon. These may or may not have an adhesive border.

A wound pouch (A6451) is a waterproof collection device with a drainable port that adheres to the skin around a wound.

Code A6025 should only be used for gel sheets used for the treatment of keloids or other scars. Hydrogel sheets used in the treatment of wounds are billed with codes A6242-A6247.

When dressings are covered under other benefits – e.g., durable medical equipment (infusion pumps) or prosthetic devices (parenteral and enteral nutrition, tracheostomy) – and are included in supply allowance codes – e.g., A4221 with a covered infusion pump, B4224 with parenteral nutrition, B4034-B4036 with enteral nutrition, A4625 or A4629 with a tracheostomy – they may not be separately billed using the surgical dressing codes. Dressings over infusion access entry sites not used in conjunction with covered use of infusion pumps or over catheter/tube entry sites into a body cavity (other than tracheostomy) are billed separately using the appropriate surgical dressing code.

Wound fillers are dressing materials that are placed into open wounds to eliminate dead space, absorb exudate or maintain a moist wound surface.

Wound fillers come in hydrated forms (e.g., pastes, gels), dry forms (e.g., powder, granules, beads) or other forms such as rope, spiral, pillows, etc. For certain materials, unique codes have been established – i.e., collagen wound filler (A6010, A6011, A6024), alginate or other fiber gelling wound filler (A6199), foam wound filler (A6215), hydrocolloid wound filler (A6240, A6241), hydrogel wound filler (A6248) and non-impregnated packing strips (A6407). Wound fillers not falling into any of these categories are coded as A6261 or A6262.

The units of service for wound fillers are 1 gram, 1 fluid ounce, 6 inch length or one yard depending on the product. If the individual product is packaged as a fraction of a unit (e.g., 0.5 fluid ounce), determine the units billed by multiplying the number dispensed times the individual product size and rounding to the nearest whole number. For example, if eleven (11) 0.5 oz tubes of a wound filler are dispensed, bill 6 units (11 x 0.5 = 5.5 round to 6).

For some wound fillers, the units on the package do not 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 that corresponds to the code.

Wound covers are flat dressing pads. A wound cover with adhesive border is one which has an integrated cover and distinct adhesive border designed to adhere tightly to the skin.

Some wound covers are available both with and without an adhesive border. For wound covers with an adhesive border, the code to be used is determined by the pad size, not by the outside adhesive border dimensions. For example, a hydrocolloid dressing with outside dimensions of 6 in x 6 in, which has a 4 in x 4 in pad surrounded by a 1 in border on each side, is coded as A6237, "...pad size 16 sq. inch or less...."

Products containing multiple materials are categorized according to the clinically predominant component (e.g., alginate, collagen, foam, gauze, hydrocolloid, hydrogel). Other multi-component wound dressings not containing these specified components may be classified as composite or specialty absorptive dressings if the definition of these categories has been met.
Technology drives efficiencies

Professional Medical’s exclusive Service Bureau Ancillary Systems can help you streamline the ancillary billing and tracking process. This unique alternative is ideal for customers seeking the benefits of an ancillary tracking system without the commitment of purchasing hardware and software licenses or dedicating time to teaching staff how to utilize the system.

Service Bureau Ancillary Systems can help by:
- Making implementation recommendations
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- Developing resident charge history
- Processing end-of-month billing and individual (discharged) billing as needed

There are a variety of Service Bureau packages available to fit your facility’s specific requirements!

For more information, please contact your territory manager or give us a call at (800) 648-5190.
Medicare DMEPOS Supplier Standards

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c). Effective July 2013.

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.

2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.

3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.

4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.

5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.

6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.

7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.

8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier’s compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.

9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.

10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier’s place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.

11. A supplier must agree not to initiate telephone contact with beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).

12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.

13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.

14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.

15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.

17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.

18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.

19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.

20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.

21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.

22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).

23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.

24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.

25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.

26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).

27. A supplier must obtain oxygen from a state-licensed oxygen supplier.

28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).

29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.

30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.
References


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