

MAV-PUB-001 / COVERAGE & ORDERING

Post-Surgical Dressing Coverage & Supply Guide

A practical starting point for the wound, the prescription, and the supply pathway.

Start with the patient and the benefit

A post-surgical dressing request begins with the treating provider's assessment and prescribed plan. Under Original Medicare, surgical dressings have their own benefit requirements. A surgical procedure can establish the qualifying-wound requirement, but it does not automatically establish coverage for every product, quantity, or application.

Three questions guide the review

Question	What to establish
Does the wound qualify?	The wound was caused or treated by surgery, or has undergone debridement.
Does the product qualify?	Its role as a primary or secondary dressing and its material-specific coverage requirements.
Is the supply supported?	The prescription, clinical findings, expected use, and applicable payer rules.

Primary dressings cover the wound directly. Secondary dressings help secure or protect the primary dressing. Common home supplies are not automatically covered simply because they are included in a pack. Product selection remains the treating provider's responsibility.

Review the actual plan

This guide summarizes Original Medicare concepts. Identify the patient's exact plan, responsible supplier, and setting before relying on a coverage pathway. Verification or authorization is not a promise of claim payment.

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Match the product and quantity to the wound

A collagen configuration is a starting point for discussion, not a standing prescription. The Medicare LCD describes collagen coverage for full-thickness wounds, wounds with light to moderate drainage, or wounds that have stalled or are not progressing toward a healing goal. It excludes collagen use for heavy drainage, third-degree burns, or active vasculitis.

- Confirm the exact product, dressing size, primary or secondary role, and clinical reason for use.
- For collagen fillers, including powder, confirm the open-wound use described in the policy article. Do not assume that every closed incision supports filler use.
- For collagen sheet codes requiring PDAC verification, confirm the exact product's listing and assigned code.
- Base quantities on the ordered amount per application, dressing-change schedule, expected need, and supplies already available.

Collagen dressings may remain in place for up to seven days under the LCD. That statement does not establish a universal daily-change schedule or an automatic quantity. The provider's documented plan and applicable policy determine the supported regimen.

Pack contents are not claim units

Evaluate each component individually. A pack is not a fixed Medicare allowance, and incision length alone does not establish a quantity of collagen powder or a reimbursement amount.

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Coordinate a complete supply request

Clarify whether dressings are being applied during a billed professional service or supplied for use at the patient's residence. Under the policy article, dressings applied as part of a Medicare professional service are included in that service. Eligible take-home dressings may follow a separate supply pathway when the applicable requirements are met.

- Identify who will furnish and bill for the supplies; confirm that party's enrollment and other applicable requirements.
- Provide the order and relevant clinical records, including wound characteristics, drainage, dressing type, amount per use, and change frequency.
- Confirm payer-specific requirements and the patient's estimated responsibility before presenting a supply plan as covered.
- Retain delivery records and maintain follow-up information supporting continued use and any refill request.

For recurring Medicare supplies, monitor actual utilization and document the patient's or caregiver's affirmative refill request. Ordinarily, no more than a month's supply is furnished at once; an exception requires individualized documentation supporting greater home-setting quantities.

Make the next step clear

MAVRAN market access staff can assist with verification and prior authorization as needed. Send patient information only through your authorized workflow. Keep the order, supporting records, and current request status connected.

Official sources

[CMS LCD L33831 - Surgical Dressings \(open source\)](#)

[CMS Policy Article A54563 - Surgical Dressings \(open source\)](#)

[CMS Surgical Dressings - Compliance Education \(open source\)](#)

[CMS - Surgical Dressings Benefit and Payment Overview \(open source\)](#)

Use the policy version effective for the actual date of service. Sources reviewed October 22, 2026.

MAV-PUB-002 / DOCUMENTATION

Clinical Documentation & Order Checklist

A practical preparation guide for prescribed surgical dressing supplies.

1. Build the clinical record

Begin with the patient's clinical assessment and prescribed care plan. A surgery schedule, pack selection, diagnosis code, or signed order alone does not establish that every dressing or quantity qualifies for payment. The treating clinician's contemporaneous record should explain the wound and the need for the products ordered.

Record the facts that support the request

- Identify the qualifying wound and the relevant surgical procedure or debridement.
- Describe each wound's location, number, and size, and record the amount of drainage and other relevant findings.
- Identify the dressing type, its primary or secondary role, the amount used per change, and the prescribed change frequency.
- Explain patient-specific product selection and quantities, including the need for additional supplies.

Use actual clinical findings

Do not insert assumed measurements or default drainage levels. Incision length alone does not establish wound area. Obtain the clinician's assessment when information needed to support the prescribed dressing is missing.

Keep the assessment current

The surgical dressing policy generally requires monthly clinical updates. Weekly evaluations are expected for patients in nursing facilities and those with heavily draining or infected wounds. Ongoing evaluations include wound type, location, length x width and depth, drainage, and other relevant status. If evaluation cannot occur within the required timeframe, document why and the alternative monitoring used.

MAV-PUB-002 / DOCUMENTATION

2. Prepare the written order

The standard written order (SWO) identifies what the treating practitioner has prescribed. Keep it distinct from the clinical evidence supporting medical necessity. The supplier must receive a completed SWO before submitting the claim.

Minimum SWO element	Preparation check
Patient identification	Beneficiary name or Medicare Beneficiary Identifier
Order date	Date of the order
Item description	Description identifying the prescribed item
Quantity	Quantity to dispense, when applicable
Treating practitioner	Practitioner name or NPI
Authentication	Treating practitioner's signature

Identify the prescribed supplies clearly, including individually listed items that will be billed separately. A pack nickname without enough product detail may not identify the ordered items. The practitioner must sign; signature and date stamps are not permitted.

If the treating practitioner is also permitted to furnish the item as its supplier, a separate order exception may apply; the medical record must still contain the required order elements.

Check delivery timing separately

Some DMEPOS items have an additional written order prior to delivery (WOPD) requirement. Check the current applicable item list and policy. Do not assume the SWO-before-claim rule means delivery is always permitted before receiving an order.

Review changes and renewal

For surgical dressings, obtain a new order when a dressing is added or an existing dressing quantity increases. A new order is required every three months for each dressing still used. A renewal order does not replace the required clinical reassessment.

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3. Blank preparation worksheet

Use this worksheet to identify gaps before transferring records through your authorized clinical or supplier workflow. It is a preparation aid, not a prescription, a substitute for the medical record, or a payer approval.

Clinical record date and source:	Qualifying wound / relevant procedure or debridement:
Wound location and number:	Actual length, width, and depth assessment, as applicable:
Drainage and other clinical findings:	Prescribed dressing type and primary / secondary role:
Amount per change and change frequency:	Quantity and anticipated supply period:
SWO complete and authenticated:	Applicable WOPD / payer requirements checked:
Missing information and responsible follow-up person:	

Before sending the request

- Reconcile product descriptions, quantities, and frequency across the order and clinical notes.
- Confirm current clinical information and any renewal or changed-order requirements.
- Send only the patient-specific records needed through an authorized channel.

Keep patient information in the right place

Do not enter or upload patient information on the public website. Complete patient-specific records within your approved systems and use authorized MAVRAN ACCESS channels when available to your practice.

This guide describes Original Medicare documentation principles. Other plans may impose different requirements. Coverage and payment remain subject to the applicable benefit, policy, and claim review.

Official sources

CMS LCD L33831 - Surgical Dressings (open source)

CMS Policy Article A54563 - Surgical Dressings (open source)

CMS A55426 - Standard DME MAC Documentation (open source)

Use the policy version effective for the actual date of service. Sources reviewed October 22, 2026.

MAV-PUB-003 / REIMBURSEMENT RESOURCES

Payer Verification & Authorization Checklist

A practical preparation guide and blank payer-call worksheet for surgical dressing supplies.

Verify the pathway before fulfillment

Verify the patient's exact plan, intended service date, prescribed supplies, and furnishing and billing entities. An active member card or a previous paid claim does not answer every coverage question.

Coverage	What to verify
Original Medicare	Current dressing coverage, documentation, exact HCPCS codes and supplier eligibility.
Medicare Advantage	The exact plan's network, benefit, medical policy, authorization and referral requirements.
Commercial or Medicaid	The member's benefit, medical policy, supplier contract and state or program requirements.

Confirm who is doing what

The treating practitioner documents the clinical need and orders supplies. The furnishing supplier handles supplier requirements, delivery records and claims. A referring practice and a practice furnishing or billing supplies have different responsibilities; confirm the actual arrangement.

- Verify applicable enrollment, state licensing, network and contract requirements for the furnishing and billing entity.
- Check the exact code against current written-order, face-to-face and prior-authorization lists for the service date.
- Ask whether the plan limits quantity, supply period, refill timing or the permitted supplier.
- Confirm the route for missing clinical information, authorization requests and patient-cost questions.

Keep the checks separate

Accreditation exemptions do not automatically establish enrollment or state-license exemptions. Likewise, an authorization response does not replace eligibility, benefit, medical-necessity, coding, documentation or supplier checks.

MAV-PUB-003 / REIMBURSEMENT RESOURCES

Blank payer-call worksheet

Use this blank worksheet in your practice's approved workflow. Record the source and reference for the answer, and resolve conflicting information before fulfillment. Do not enter patient information into a public website form.

Patient or internal record reference:

Payer, exact plan and member identification:

Eligibility checked for intended service date:

Furnishing supplier and billing entity:

Network status and benefit category:

Product, HCPCS code, billing unit and requested quantity:

Applicable medical policy and effective date:

Quantity, supply-period or refill limits:

Authorization or referral required? Source of answer:

Authorization number, approved codes, quantity and dates:

If authorization is not required, response and reference:

Required order and clinical documentation:

Deductible, cost sharing and patient-cost follow-up:

Representative, contact channel, date and reference number:

Unresolved questions, responsible person and follow-up date:

Official sources

CMS LCD L33831 - Surgical Dressings (open source)

CMS Policy Article A54563 - Surgical Dressings (open source)

CMS A55426 - Standard DME MAC Documentation (open source)

CMS - Enroll as a DMEPOS Supplier (open source)

CMS - DMEPOS Prior Authorization Program and Lists (open source)

CMS - DMEPOS Order Requirements and Required Lists (open source)

Use the policy version effective for the actual date of service. Sources reviewed October 22, 2026.

MAV-PUB-004 / REIMBURSEMENT RESOURCES

Dressing Coding & Fee Schedule Reference

Understand product descriptions, billing units and official fee lookup without assuming reimbursement.

Start with the actual product

Match the individual product's composition, sterility, dimensions, construction and package labeling to the current HCPCS description and policy. A pack name, brand name or product family does not establish a billing code or coverage. The examples below are selected references, not code assignments for a MAVRAN product.

HCPCS	Selected description and unit
A6010	Dry sterile collagen wound filler; per gram of actual collagen.
A6021	Sterile collagen dressing, 16 square inches or less; each.
A6022	Sterile collagen dressing, over 16 through 48 square inches; each.
A6023	Sterile collagen dressing, over 48 square inches; each.
A6219	Sterile non-impregnated bordered gauze dressing, pad area 16 square inches or less; each.
A6220	Sterile non-impregnated bordered gauze dressing, pad area over 16 through 48 square inches; each.
A6446	Sterile non-elastic conforming bandage, width 3 to under 5 inches; per yard.
A6447	Sterile non-elastic conforming bandage, width 5 inches or greater; per yard.
A4452	Waterproof tape; per 18 square inches.

Verify dimensions and classification

For the bordered gauze examples, use the pad area rather than the outer border dimensions. Collagen products billed under A6021-A6024 require the applicable PDAC coding verification and Product Classification List check. Do not infer an A6222 assignment from a similar-looking product.

MAV-PUB-004 / REIMBURSEMENT RESOURCES

Look up the right fee for the right unit

Use the current official CMS DMEPOS fee-schedule resources for Original Medicare. A fee-schedule allowance is a reference amount for an eligible claim. It does not establish clinical coverage, an approved quantity, a patient's out-of-pocket cost or the payment terms of a different payer.

- Choose the file and quarter applicable to the actual date of service; check for corrected files or subsequent updates.
- Use the beneficiary's applicable location and the geographic details required by the fee-schedule instructions.
- Locate the exact HCPCS code and relevant payment category or modifiers rather than a nearby or similarly named code.
- Read the billing unit. A dressing, a yard, a gram and 18 square inches are different units.
- Calculate units from the verified product and quantity furnished, then assess the applicable coverage and documentation rules separately.
- Verify Medicare Advantage, commercial and Medicaid reimbursement through the applicable plan or contract rather than substituting a Medicare amount.

Keep allowances separate from coverage

Do not multiply a pack's contents by fee-schedule amounts and describe the result as guaranteed pack reimbursement. Each billed item must satisfy its own coding, benefit, medical-necessity and claim requirements, including any bundling or noncoverage rules.

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Keep an auditable reference record

A useful coding record explains why a product matches the selected code and which official source was used. Keep the product details, policy version and fee lookup together in the supplier's approved records so a later reviewer can follow the decision.

Product name, manufacturer and item identifier:

Composition, sterility, dimensions and package quantity:

Verified HCPCS code and billing unit:

PDAC listing or coding-verification evidence, when required:

Policy and fee-schedule version, service date and location:

Reviewer, review date and unresolved questions:

Before a claim is submitted

- Confirm that the order and clinical record support the supplies, frequency and quantity.
- Check the current surgical dressing LCD and policy article for item-specific requirements and exclusions.
- Verify the furnishing and billing supplier's applicable payer requirements.
- Retain the delivery evidence and other required claim documentation.
- Resolve a coding question through the appropriate official coding or payer channel before relying on an assumed assignment.

Educational reference

This guide is not an authorization, coverage determination, product coding verification or payment estimate. Official policy, current code descriptions and the facts of the individual claim control.

Official sources

CGS Supplier Manual - HCPCS Appendix (open source)

CMS LCD L33831 - Surgical Dressings (open source)

CMS Policy Article A54563 - Surgical Dressings (open source)

CMS A55426 - Standard DME MAC Documentation (open source)

CMS - DMEPOS Fee Schedules (open source)

CMS - Enroll as a DMEPOS Supplier (open source)

Use the policy version effective for the actual date of service. Sources reviewed October 22, 2026.

MAV-PUB-005 / CLAIMS AND FOLLOW-UP

Claim Readiness & Denial Follow-Up

A clear review path for prescribed surgical dressing claims.

1. Review before submission

Confirm who is furnishing and billing the supplies, which payer and benefit apply, and whether the product, setting, documentation, and quantity meet the relevant requirements. A verification response, authorization, or pack selection does not by itself establish payment.

- Match the billed patient, provider, supplying entity, and item to the supporting records.
- Have the completed SWO and applicable prior-to-delivery documentation available before the required deadline.
- Confirm the clinical record supports the wound, dressing choice, amount, frequency, and continued need.
- Use the correct code for the exact furnished product and supported billed units. Physical pack contents do not create an automatic covered allowance.
- Check for duplicate, bundled, or already supplied items and confirm the correct service setting.
- Retain delivery evidence linking the beneficiary, actual items, quantities, and receipt; apply the correct date-of-service rule for the delivery method.

Review refills individually

Do not automatically ship on a preset schedule. Before a refill is shipped, document the patient or caregiver's affirmative request and the items needed. Check current supply, expected utilization, and any changed care plan. Follow the surgical dressing policy's supply limits and refill timing.

Patient responsibility needs its own review

Do not assume a denial allows the patient to be billed. For Original Medicare, follow current CMS ABN instructions when an advance notice is required, including patient choice and applicable financial protections. An ABN is not a blanket payment waiver.

Retain the underlying clinical, order, refill, and delivery records. Supplier claim and proof-of-delivery documentation generally must be kept for seven years from the date of service.

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2. Follow the reason, then the process

Start with the actual remittance advice, explanation of benefits, or denial notice. Record the affected item, service date, adjustment or remark codes, explanation, and response deadline. Keep patient-specific notices and records inside authorized systems.

Review question	Practical next step
Is information missing or incorrect?	Use the payer's correction, resubmission, or reopening process when appropriate.
Is a coverage decision disputed?	Review the stated appeal rights and submit evidence addressing the specific reason.
Is clinical support incomplete?	Locate the contemporaneous assessment and prescribed plan. Do not invent or backdate findings.
Is quantity or delivery disputed?	Reconcile the order, actual supplied units, refill record, and delivery evidence.

Original Medicare appeal timing

A first-level redetermination generally must be requested within 120 days after receipt of the initial determination. CMS generally presumes receipt five calendar days after the notice date unless evidence shows otherwise. Follow the notice and MAC instructions. Minor errors and omissions use correction or reopening procedures rather than the appeals process.

For an appeal, identify the specific items and dates, explain why the determination is disputed, and include the relevant supporting records. A generic appeal letter cannot replace case-specific evidence. Medicare Advantage and commercial plans have their own submission routes and deadlines.

Keep follow-up accountable

Assign an owner, record the due date, track the submission and response, and communicate the next step to the appropriate practice or supplier team. Do not upload claims, EOBs, or patient records to the public website.

Official sources

CMS LCD L33831 - Surgical Dressings (open source)

CMS A55426 - Standard DME MAC Documentation (open source)

CMS Policy Article A54563 - Surgical Dressings (open source)

CMS - Current Original Medicare ABN Forms (open source)

CMS - Current ABN Instructions (open source)

CMS - Original Medicare First-Level Redetermination (open source)

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MAV-PUB-006 / PATIENT INFORMATION

Patient Dressing Supply & Coverage FAQ

Clear questions to ask your care team and supply provider.

Before your supplies arrive

Who decides which dressing I need?

Your treating provider decides which dressing and supply plan are appropriate for you. The supply team helps coordinate the prescribed items. This guide does not replace your provider's instructions or tell you how to treat your incision.

Does having surgery mean every dressing is covered?

No. Medicare's surgical dressing benefit has requirements for the wound, the type of product, and the amount supplied. Other insurance plans can have different requirements. A product appearing in a pack does not mean that your plan will pay for it.

Will the supplies be free?

Do not assume there will be no cost. What you owe may depend on your coverage, deductible, coinsurance, other insurance, and whether the items are covered. Ask your supply provider and health plan for an estimate and an explanation of any noncovered items before accepting the supply arrangement.

A useful question

Ask: Who is supplying my dressings, who will bill my insurance, and whom should I contact about the order or an unexpected bill? Keep those contact details with your care instructions.

MAV-PUB-006 / PATIENT INFORMATION

Keep your supply plan in view

Why might the team ask for more information?

Your provider or supply team may need current insurance details, an order, wound information, or confirmation of your supply needs. A request for information does not itself mean that coverage has been denied. Ask what is missing and who can provide it.

Will refills arrive automatically?

For recurring Medicare supplies, the supplier must confirm that you or your caregiver want the refill before sending it. Tell the team what you still have and whether your provider has changed the plan. Do not accept extra supplies solely because a previous shipment contained that amount.

What if the delivery or bill looks wrong?

Contact the supply provider about missing, incorrect, damaged, or unexpected items. For a bill or coverage decision, ask for the explanation and contact your health plan using the number on your card. A verification result or authorization does not guarantee that every claim will be paid.

Clinical questions go to your care team

If you are unsure about the prescribed dressing, instructions, or a change in your condition, contact your treating provider. Keep medical and insurance information within the secure communication process your practice provides.

Official sources

Medicare.gov - Surgical Dressing Services (open source)

CMS LCD L33831 - Surgical Dressings (open source)

CMS Policy Article A54563 - Surgical Dressings (open source)

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