

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)

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