

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.

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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.