Priority Health	BILLING POLICY No. 032
SURGICAL DRESSINGS	
Effective date: Aug. 1, 2024 **Date of origin: May 2024**	**Review dates: 11/2024, 12/2024, 2/2025**

APPLIES TO
Commercial products. Medicare will continue to follow Medicare policy and Medicaid will continue to follow MDHHS/CHAMPS.

DEFINITION
Surgical or wound care dressings are used after surgery to help control bleeding, prevent infection and promote healing. Proper organization of care helps maintain the rules of asepsis and decreases the risk of contamination of the wound or transmission of organisms from one patient to another.

Surgical dressings are covered when they are required to treat a qualifying wound, which is defined as either of the following:

1. A wound caused by, or treated by, a surgical procedure; or
2. After debridement of the wound, regardless of the debridement technique

POLICY SPECIFIC INFORMATION

Qualifications

Qualifying wound
Surgical dressings are covered when a qualifying wound is present. A qualifying wound is defined as either of the following:

1. A wound caused by, or treated by, a surgical procedure; or
2. After debridement of the wound, regardless of the debridement technique

The surgical procedure or debridement must be performed by a treating practitioner or other health care professional to the extent permissible under State law. Debridement of a wound may be any type of debridement (examples given aren't all inclusive):

- **Surgical** (i.e., sharp instrument or laser) or **Mechanical** (i.e., irrigation or wet-to-dry dressings)
- **Chemical** (i.e., topical application of enzymes) or **Autolytic** (i.e., 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 debridement agents themselves aren't covered.

Qualifying dressing requirements
Products that are eligible to be classified as a surgical dressing are defined as:

- **Primary dressings** – Therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin

- **Secondary dressings** – Materials that serve a therapeutic or protective function and that are needed to secure a primary dressing. Items such as adhesive tape, roll gauze, bandages and disposable compression material are examples of secondary dressings.

Some items, such as transparent film, may be used as a primary or secondary dressing.

Limits

Quantity of surgical dressings
No more than a 1-month's supply of dressings is considered medically necessary at one time unless there's documentation to support the medical necessity of greater quantities in the home setting in an individual case. An even smaller quantity may be appropriate in the situations described above.

The medically necessary quantity and type of dressings dispensed at any one time must consider the current status of the wound(s), the likelihood of change and the recent use of dressings. Dressing needs may change frequently (i.e., 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 person is actually using and to adjust their provision of dressings accordingly.

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 (i.e., ½ 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) ½ oz. tubes of a wound filler are dispensed, bill 6 units (11 x ½ = 5.5; round to 6).

Usual maximum quantity of supplies

Code	# per month (unless noted)
A4364	4
A4402	4
A4450	40
A4452	40
A4456	50
A4481	62
A4623	62
A4625	31
A4626	2
A4629	31
A5120	150
A7501	1
A7502	1

A7503	1 per 6 months
A7504	62
A7505	2 per 3 months
A7506	62
A7507	62
A7508	62
A7509	62
A7520	1 per 3 months
A7521	1 per 3 months
A7522	1 per 12 months
A7524	1 per 3 months
A7526	31
A7527	2 per 3 months

Modifiers

Modifiers A1-A9 are used to indicate the number of qualifying wounds on which a specific dressing HCPCS code is being used. The modifier number must correspond to the number of qualifying wounds on which the dressing HCPCS code is being used, not the total number of wounds treated.

Modifiers A1-A9 aren't used with codes A6531 and A6532.

Claims lines for A6010, A6011, A6021, A6022, A6023, A6024, A6154, A6196, A6197, A6198, A6199, A6203, A6204, A6205, A6206, A6207, A6208, A6209, A6210, A6211, A6212, A6213, A6214, A6215, A6217, A6218, A6219, A6220, A6221, A6222, A6223, A6224, A6228, A6229, A6230, A6231, A6232, A6233, A6234, A6235, A6236, A6237, A6238, A6239, A6240, A6241, A6242, A6243, A6244, A6245, A6246, A6247, A6248, A6251, A6252, A6253, A6254, A6255, A6256, A6257, A6258, A6259, A6261, A6262, A6266, A6402, A6403, A6404, A6441, A6442, A6443, A6444, A6445, A6446, A6447, A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455, A6456, A6457 billed without A1-A9 modifiers will be rejected as missing information.

Claim lines for A4450 and A4452 billed without AW and A1-A9 modifiers will be rejected as missing information.

Claim lines for A6531, A6532 and A6545 without an AW modifier (A1-A9 modifiers aren't required for these codes) will be rejected for missing information.

When surgical dressings are billed, the appropriate modifier (A1-A9 or AW) must be added to the code when applicable. If modifier A9 (dressing for 9 or more wounds) is used, information must be submitted with the claim indicating the number of wounds.

If the dressing isn't being used as a primary or secondary dressing on a surgical or debrided wound, don't use modifiers A1-A9.

When tape codes A4450 and A4452 are used with surgical dressings, they must be billed with the AW modifier (in addition to the appropriate A1-A9 modifier).

When gradient compression stocking codes A6531 and A6532 or the gradient compression wrap code A6545 are used for an open venous stasis ulcer, the code must be billed with the AW modifier (but not an A1-A9 modifier).

For this policy, codes A4450, A4452, A6531, A6532 and A6545 are the only codes for which the AW modifier may be used.

Place of service

Review specific information regarding DME place of service billing requirements in our Durable Medical Equipment (DME) place of services (POS) billing policy.

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Nov. 11, 2024	Added "Place of service" section
Dec. 2, 2024	Removed code A4649 as a code that, when billed without modifiers A1-A9, would be rejected as missing information.

Feb. 13, 2025	Added “Disclaimer” section