smith&nephew
PICO
Single Use
Negative Pressure
Wound Therapy System

Provider Checklist for Insurance Benefit Verifications and Prior Authorizations

1. **Determine coverage for PICO Single Use Negative Pressure Wound Therapy System**
   To determine how a specific payer is covering PICO for a particular patient, you should contact the payer prior to furnishing and applying the product.

   Below is a checklist to assist you in researching a patient's coverage

   - ✓ First, confirm that your facility/office/agency has consent from the patient
   - ✓ Obtain the patient's policy number and date of birth, your tax identification number and NPU, and call the payer's provider services line
   - ✓ Ask about the coverage criteria (typically through major medical) for:

     Negative pressure wound therapy using disposable, non-durable medical equipment when billed with the AMA verified CPT® codes 97607 or 97608

   - ✓ Verify that 97607 or 97608 is covered for the patient's diagnosis (provide all ICD-10-CM codes in order by rank)
   - ✓ Ask if the payer has set a maximum number of applications. If so, how many
   - ✓ Ask if any documentation should be submitted with the claim. If so, ask what documentation should be submitted and how should it be submitted
   - ✓ Ask if the payer has a medical policy pertaining to disposable negative pressure wound therapy. If yes, ask for the online link to the policy
   - ✓ Ask if a referral is required from the primary care physician
   - ✓ Ask if there are any prior authorization/pre-determination requirements, how to meet these requirements, and how to expedite the process
   - ✓ Inquire if the patient has any coverage limitations or policy exclusions
   - ✓ Verify your contracted reimbursement rate for 97607/97608 and how much the patient will be required to pay out-of-pocket
   - ✓ **FOR HOME HEALTH AGENCIES ONLY:** Ask if the agency should submit 97607/97608 on the claim with their home health visits or on a separate claim. Verify type of bill and items that should be included on the claim

NOTE: For each call to the payer, always remember to obtain the payer representative's first name, last initial and reference number

NOTE: Interactive Voice Response System (IVR)

Commercial Payers and Governmental Plans have begun to use Interactive Voice Response Systems (IVR) for benefit verification and eligibility confirmation, prior authorization, follow up on claim status, etc. These payer automated telephone systems enable the caller to initiate and confirm information required to comply with Payer/Patient Benefit plan requirements. Automated information is generally available 24 hours a day, seven days a week. In most instances a request can be approved while the caller is on the line. And further, the approval is generally given during the IVR call with the added benefit of having said authorization confirmation faxed to a fax number designated by the caller.

- If payer IVR is available, the technician generally can access the IVR system by dialing the number listed on the back of the member's identification (ID) card.
- Before calling into an IVR system, make certain you have the following information:
  - Nine-digit tax ID number
  - Member ID number (listed on member's ID card)
  - Member's date of birth (mm/dd/yy)
  - Anticipated date of service in mm/dd/yyyy format for benefit verification/eligibility

- Call center fax number (if a fax-back option is requested)
- Specific information to initiate a benefit verification/eligibility generally includes: CPT® - 4 (five-digit) codes for procedures and surgeries; ICD-10 codes for diagnoses; CPT® or HCPCS codes for outpatient procedures

2. Secure prior authorization or pre-determination

Some private payers, Medicare Advantage, Medicaid, etc. may require prior authorization. Other payers may not cover 97607/97608 on a particular plan, but may be willing to review a particular case via their pre-determination process. Because prior authorization requirements and pre-determination processes vary by payer, providers should contact each pertinent payer to ascertain their unique requirements.

NOTE: Medicare fee-for-service will not provide prior authorization or pre-determination for this procedure. See your Medicare contractor's local coverage determination (LCD), if one exists

Below is a checklist to assist you when attempting to obtain a prior authorization or pre-determination:

- ✓ Obtain prior authorization or pre-determination department phone number
- ✓ Identify appropriate contact person or department for prior authorization or pre-determination submission
- ✓ Obtain prior authorization or pre-determination requirements, method of submission, method of response, and turn-around time
  NOTE: If a special form is required, request the payer to fax or e-mail it to you
- ✓ Include a letter of medical necessity when appropriate (include product information, patient information, prior treatment notes, and any other documentation that will "paint the picture" of the rationale for disposable NPWT
- ✓ Follow-up with the payer until they render a decision
- ✓ Follow-up with an appeal letter if the prior authorization is not granted

3. Prepare appeals when claims are denied

If an appeal is necessary, you may wish to include the following in your letter to the payer:

- ✓ Patient's name, date of birth, and insurance information
- ✓ Patient's diagnosis, including the specific primary, secondary, and tertiary ICD-10-CM codes
- ✓ Name of the disposable negative pressure wound therapy system, eg, PICO Single Use Negative Pressure Wound Therapy System
- ✓ Medical rationale for why application of PICO◊ Single Use Negative Pressure Wound Therapy System is more appropriate than other treatment options for this patient
- ✓ Specifically address the payer's reason for denial and include clinical documentation (if appropriate) in the appeal letter
- ✓ Include reprints of clinical studies if the payer states the product is "experimental or investigational"
- ✓ Submit appeal documents to the payer via their preferred method (fax, mail, email)

For detailed product information, including indications for use, contraindications, precautions and warnings, please consult the product's Instructions for Use (IFU) prior to use.

The information contained in this document is provided for general informational purposes only and is not intended to be deemed as coverage or reimbursement advice or a guarantee of coverage or reimbursement. Smith & Nephew makes no representations or warranties as to selecting codes for procedures or compliance with any billing protocols or prerequisites. Individual healthcare providers are responsible for exercising their independent clinical judgment in selecting the codes that most accurately reflect the patient's condition and procedures performed.

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