

Obtaining MIST Therapy® Coverage



Begin the process of securing coverage for MIST Therapy® by:

- Submitting a Prior Authorization request
- Contacting the Celleration Reimbursement Hotline at (866) 307-MIST, Option 3 about a payer's medical coverage policy

Prior Authorizations

You want the option of treating non-healing wounds with MIST Therapy. Prior Authorization requests are extremely important for payers to begin recognizing and approving MIST Therapy. These requests demonstrate a demand for MIST Therapy from you, the clinician, showing the payer that you and your patients want MIST Therapy and will benefit from MIST Therapy.

Payers generally require Prior Authorization for surgeries, expensive diagnostic tests, or procedures the payer considers "investigational." Most payers publish their Prior Authorization requirements on their website. Traditional fee-for-service Medicare, however, does not provide prior authorization; coverage and reimbursement is based on whether the service or item is "reasonable and necessary."

Celleration offers several tools to support the medical necessity of your Prior Authorization request:

- Prior Authorization Request Form – An electronic document you can customize
- Suggested information for the prescribing physician's Letter of Medical Necessity (LMN), if required by the payer
- Therapy Summary of noncontact, non-thermal low frequency ultrasound
- Summary of published, peer-reviewed studies with bibliography

Submit a Prior Authorization request any time you expect a fee-for-service reimbursement (e.g., a payment for your claim showing that CPT 0183T for MIST Therapy was performed).

Questions to include on your Prior Authorization request:

- Will CPT 0183T be covered for this patient?
- What is the allowable payment for 0183T?
- How many treatments of 0183T are covered?
- Are there any diagnosis restrictions or documentation requirements when the provider files a claim?
- How many treatments are authorized for this one-month period?

Celleration also recommends that you submit Prior Authorization requests even if the payer has a non-coverage statement for MIST Therapy. These requests help educate the payer on your use of MIST Therapy – including when it is appropriate in treating non-healing wounds – and shows your continued interest in offering the therapy to your patients.

For treatments deemed "investigational" by the payer, their policies may offer coverage via the Prior Authorization process.

Obtaining MIST Therapy[®] Coverage

Appealing a Denied Prior Authorization

As a clinician, you have determined that MIST Therapy[®] is medically necessary and will facilitate the healing of the patient's wound. As a result, you should appeal each Prior Authorization denial.

Appeals of denied Prior Authorizations generally are reviewed at a higher level within the payer organization. These appeals will generate a closer look at the evidence and efficacy of MIST Therapy.

Please contact Celleration's Reimbursement Hotline when starting an appeal of a denied Prior Authorization. We will provide you with customized tools to refute the denial based on the reason given by the payer.

Advocating for Coverage

Network providers are important to payers. Payers want to hear from clinicians who use MIST Therapy as well as clinicians who want to use it but are limited by non-coverage.

Prior Authorization is one way you can advocate for your patients. Celleration also is working with payers to establish MIST Therapy coverage, but we need your support to demonstrate demand for MIST Therapy.

It also is important that patients advocate for themselves by speaking up about their desire to be treated with MIST Therapy. Encourage patients to contact their insurance company and employer when coverage is denied.

Patient advocacy information is available upon request from your Celleration representative or by emailing a request to reimbursement@celleration.com.

PRIOR AUTHORIZATION REQUEST & MEDICAL NECESSITY DOCUMENTATION LOW FREQUENCY, NON-CONTACT, NON-THERMAL ULTRASOUND FOR WOUND HEALING				
PROVIDER INFORMATION				
Provider Name:	Provider ID #:			
Address:	City/ST/ZIP:			
Ordering Physician:	Phone:			
Treating Clinician:	Phone:			
PATIENT INFORMATION				
Patient Name:	ID #:	DOB:		
Gender: M F	Policy#:	Group#:		
WOUND, PATIENT & TREATMENT HISTORY				
Diagnoses: <input type="checkbox"/> I07.1 <input type="checkbox"/> I07.8 <input type="checkbox"/> I07.2 <input type="checkbox"/> Other:				
Location of wound:				
Area: ____ sq cm	Depth: ____ cm	Tunneling: Present Absent	Undermining: Present Absent	Duration: ____ day(s)
Exposed structures: Bone Tendon Ligament Muscle		Appearance of bacteria, biofilm, bioburden: Y N		
Circulatory compromise: arterial venous lymphatic mixed		ABI: >0.7 0.4 - 0.7 0.1 - 0.3	TcPO ₂ (mm Hg): >30 20-30 <20	
Exudate: clean persistent	Exudate: ____ ml / day	Wound surface: eschar slough granulation ____ %		
Comorbidities:		Diabetes: Present Absent		
Dressings:		Prior Treatments (debridement, surgical debridement, graft, flap, etc.):		
STATEMENT OF MEDICAL NECESSITY				
Based on the above wound characteristics, medical history of the patient, and wound treatment history, I am requesting Prior Authorization for ____ treatments of non-contact, non-thermal low frequency ultrasound for wound healing beginning _____. After two (2) weeks / six (6) treatments, progress toward healing will be evident. If the wound has progressed toward healing as expected, the remainder of the treatments in this Prior Authorization request will be performed. In the absence of treating the patient with non-contact, non-thermal low frequency ultrasound, I expect _____.				
BILLING INFORMATION				
CPT 01837 Low frequency, non-contact, non-thermal ultrasound, including topical application(s) when performed, wound assessment, and instructions(s) for ongoing care, per day				Estimated billed charge per unit: \$
I certify that I am the treating clinician identified above, and I certify that the medical necessity information contained in this document is true, accurate, and complete, to the best of my knowledge.				
Signature: _____		Date: _____		
TO BE COMPLETED BY INSURANCE COMPANY				
Prior Authorization approval for ____ (number) treatments of non-contact, non-thermal low frequency ultrasound between beginning ____ (date) and ____ (date).				
Approved by: _____		Date: _____	Authorization Reference #:	
Please return this document or other confirmation of Prior Authorization approval to my attention at: _____				

Prior Authorization Request Form

See page 1D of this document for an example of a Prior Authorization Request Form that you can reproduce.

For an electronic version that you can customize and send to payers, please contact reimbursement@celleration.com

Frequently Asked Questions

Does Medicare cover MIST Therapy?

Several Medicare contractors cover CPT 0183T. Local Medicare contractors determine coverage for providers in their jurisdiction. For specific Medicare coverage in your state, please contact the Celleration Reimbursement Hotline.

We were told that MIST Therapy is experimental. Is that true?

MIST Therapy is not experimental; it was cleared by the FDA in 2004 and it is supported by over 20 peer-reviewed published articles. It has been used to treat over 35,000 patients in over 800 locations throughout the United States. CPT 0183T describes a low frequency ultrasound treatment and is one of many “emerging technology” codes issued by the American Medical Association. Both the AMA and CMS (Medicare) write that these codes are not investigational or experimental, but are rather more specific, more functional versions of unlisted codes that many payers cover.

What is the Medicare Advance Beneficiary Notice (ABN) and how should it be used?

This written notice may be given to patients before receiving certain items or services and notifies the patient that Medicare may deny payment for that procedure or treatment. For more information, please contact our Reimbursement Hotline.

Do you have documentation of specific payer coverage policies for MIST Therapy?

Yes. Celleration has researched this extensively and has coverage/medical policy documents from local Medicare contractors and commercial payers.

Our clinic researched CPT 0183T and discovered that we will not be reimbursed. What should we do now?

Request a Prior Authorization, and appeal the Prior Authorization if denied. Ask the patients to advocate for their health care by contacting their insurance company or employer. Complaints about non-coverage coupled with clinical evidence can prompt payers to overturn their non-coverage policy.

How can we treat all patients equally when some payers will not cover MIST Therapy?

As a healthcare provider, you have chosen to prescribe MIST Therapy to your patients. It is the insurance company, not you, that is restricting access. Offer MIST Therapy to your patients as an out-of-pocket expense and make them aware of their insurance company's non-coverage.

We are worried about denied claims if we bill MIST Therapy treatments. What should we do?

Please refer to the section titled “Prior Authorizations” on page 1A of this document.

Do you have a simple Prior Authorization Request Form?

See page 1D of this document for an example of a Prior Authorization Request Form. For an electronic version that you can customize and send to payers, please contact reimbursement@celleration.com.

What have other new wound care technologies done to gain coverage?

A combination of clinician advocacy, patient advocacy, and clinical research is critical to gaining insurance coverage for new technologies. Over 500 patients who have benefited from MIST Therapy are included in peer-reviewed, published studies. Clinicians and patients must advocate for coverage by contacting payers, requesting Prior Authorization, and appealing any non-coverage determinations.

PRIOR AUTHORIZATION REQUEST & MEDICAL NECESSITY DOCUMENTATION
 LOW FREQUENCY, NON-CONTACT, NON-THERMAL ULTRASOUND FOR WOUND HEALING

PROVIDER INFORMATION				
Provider Name:		Provider ID #:		
Address:		City/ST/ZIP:		
Ordering Physician:		Phone:		
Treating Clinician:		Phone:		
PATIENT INFORMATION				
Patient Name:		ID #:	DOB:	
Gender: M F	Policy#:	Group#:		
WOUND, PATIENT & TREATMENT HISTORY				
Diagnoses:	<input type="checkbox"/> 707.1	<input type="checkbox"/> 707.8	<input type="checkbox"/> 707.2__	<input type="checkbox"/> Other:
Location of wound:				
Area: ___ sq cm	Depth: ___ cm	Tunneling: Present Absent	Undermining: Present Absent	Duration: ___ days
Exposed structures: Bone Tendon Ligament Muscle		Appearance of bacteria, biofilm, bioburden: Y N		
Circulatory compromise: arterial venous lymphatic mixed	ABI: >0.7 0.4 – 0.7 0.1 – 0.3		TcPO ₂ (mm Hg): >30 20-30 <20	
Exudate: clean purulent	Exudate: ___ ml / day		Wound surface: eschar slough granulation ___ %	
Comorbidities:			Diabetes: Present Absent	
Dressings:		Prior Treatments (debridement, surgical debridement, graft, flap, etc):		
STATEMENT OF MEDICAL NECESSITY				
Based on the above wound characteristics, medical history of the patient, and wound treatment history, I am requesting Prior Authorization for ___ treatments of non-contact, non-thermal low frequency ultrasound for wound healing beginning _____. After two (2) weeks / six (6) treatments, progress toward healing will be evident. If the wound has progressed toward healing as expected, the remainder of the treatments in this Prior Authorization request will be performed. In the absence of treating the patient with non-contact, non-thermal low frequency ultrasound, I expect _____ _____ _____ _____				
BILLING INFORMATION				
CPT 0183T Low frequency, non-contact, non-thermal ultrasound, including topical application(s) when performed, wound assessment, and instruction(s) for ongoing care, per day			Estimated Billed Charge per unit: \$	

I certify that I am the treating clinician identified above, and I certify that the medical necessity information contained in this document is true, accurate, and complete, to the best of my knowledge.

Signature: _____

Date: _____

TO BE COMPLETED BY INSURANCE COMPANY		
Prior Authorization approval for _____ (number) treatments of non-contact, non-thermal low frequency ultrasound between beginning _____ (date).		
Approved by:	Date:	Authorization Reference #:

Please return this document or other confirmation of Prior Authorization approval to my attention at: _____