The Practice Management of Evidence Based Wound Care

It’s essential to put the best possible modalities into practice.

BY JEFFREY D. LEHRMAN, DPM

A Long Way from A to B

Doctor A begins a relationship with a patient with a plantar first metatarsal head diabetic foot ulcer. Dr. A chooses a rigid bottom surgical shoe as the means by which to attempt to offload this ulcer despite the fact this patient has no contraindications for a total contact cast. A study done by Fleischli, Lavery, et. al. shows that there is six times the amount of mean peak pressure in Newtons per square centimeter absorbed to plantar foot ulcer sites in a surgical shoe than there is in a total contact cast. Despite deciding on an offloading modality which evidence argues is not best for the patient, Dr. A gets paid for this evaluation and management service (99203). Dr. A sees this patient every two weeks for the next 12 weeks, and at each visit a sharp debridement is performed. Over these six visits Dr. A bills a subcutaneous level debridement (11042) twice and a full thickness level debridement (97597) four times. The doctor is reimbursed for each of these debride-ments and receives a total of six total contact casts. During the course of her treatment Dr. B bills for an initial evaluation and management (99203) and six total contact casts (29445) and gets reimbursed for all of that. No debride-ments are billed because ulcer debride-ment cannot be billed at the same time as a total contact cast application to the same ulcer.

Adding up these reimbursements for each treatment protocol, according to the Medicare Part B Fee Schedule, Dr. A will be paid about $2,057 for his care and Dr. B will be paid about $1184 for her care. That is according to our current fee-for-service reimbursement model. Does this make sense? No! Dr. A’s care led to a poor result, a hospitalization which was very costly to the payer, and two surgeries, which were also costly to the payer. Dr. B followed an evidence based protocol, achieved an excellent result, and all at a much lower cost to the payer, yet earned about half as much for her care as did Dr. A.

This will soon change.

The Push to Incentivize EBM

The fee-for-service days are coming to an end and we need to prepare our practices for this. Excellent practice management means not only excelling today but preparing for the future as well. The United States Secretary of Health and Human Services
said that her agency plans to use “incentives to motivate higher-value care.” She went on to say one of the goals of the agency is to have 30% of Medicare payments tied to quality or value by the end of 2016, and 50% of Medicare payments tied to quality or value by the end of 2018. The push to incentivize evidence based care and better results has gone so far that at one point the National Commission on Physician Payment Reform called for eliminating the fee-for-service model altogether in favor of a model that encourages cost effective, high-quality care.

The changes have already started. As of January 1, 2015 most CMS carriers are not reimbursing for removable cast walkers with a diagnosis of foot ulcer. Why not? A study done by Armstrong et al. showed that among patients with diabetic foot ulcers who were given removable cast walkers as a means to attempt to achieve offloading, those patients had removed the cast walker for a total of 72% of daily activity. This leads to the thinking that if an offloading device is removable, patients will remove it the majority of the time. This also helps explain why a study done by Armstrong et al. showed that only 65% of diabetic foot ulcers that were offloaded with a removable cast walker were healed at 12 weeks. These statistics are not a secret. CMS, as well as other payers, have access to these statistics just like we do. They don’t want to pay for services that have been shown to yield poor results.

Another example of recent changes that incentivize evidence based wound care is the reimbursement to wound care centers for the application of a total contact cast. Total contact cast application is assigned an APC of 0058 under the Hospital Outpatient Perspective Payment System (HOPPS). In 2014, an outpatient hospital facility received $122.26 when a total contact cast was applied. In 2015, that has increased to $223.30. Why the change? Why the significant increase? Why does CMS want total contact casts being applied? This answer can be found in part in a study done by Fife, et. al. Upon survey of a large wound care registry, only six percent of patients with diabetic foot ulcers received a total contact cast. However, of those that did receive total contact casting, the average cost of care was half that of those that did not receive total contact casting. This is the kind of data that is driving reimbursement changes.

The Future of Wound Care

There is much room for improvement in the practice of wound care and limb salvage. Almost one third of patients in hospital based outpatient wound centers never heal their ulcers. This failure to heal and progression to amputation carries with it significant cost. Insurers know that wound care is an area where there is potential to both improve patient outcomes and decrease spending. Incentivizing evidence based treatments and improving outcomes can decrease morbidity and mortality associated with diabetic foot ulcers and result in a significant savings to our healthcare system.

Reimbursement for wound care services will look different than it does right now in the future. Some wound centers are already operating under the diagnosis related group model (DRG). Under this model a center establishes a relationship with an ulcer patient and gets one payment only. They get that same one payment regardless of how long they see the patient, what cost is expended, and what the result is. Under that system, the center is monetarily incentivized to provide evidenced based care and get the patient healed and discharged from the center as soon as possible. Related measures in the Physician Quality Reporting System (PQRS) will be another way to drive quality based care as the penalties for failure to report PQRS continue to escalate.

What can you do prepare? The first answer is to do your homework. Be aware of what the evidence and literature defines as excellent ulcer care. Read about the cost effectiveness of different offloading options, topical products, hyperbaric oxygen, and cellular and/or tissue based products (CTPs) for wounds. Being familiar with what works best will help you to provide excellent care, improve your outcomes, and be ready for a quality-based reimbursement model.

Following protocols that are evidence-based can help achieve excellent outcomes and insurance carriers look upon these protocols favorably. Supergroups often follow evidence-driven protocols to help ensure the best patient outcomes possible and find favor with potential insurance carriers.

In the near future, Dr. A isn’t going to get away with getting paid for those 6 debridements that resulted in no improvement. Don’t be Dr. A. Be the doctor who is putting the best possible modalities into practice. Doing so can save limbs, save lives, and prove profitable both now and in the future. That defines excellent practice management! PM

References

4. Total contact casting of the diabetic foot in daily practice: a prospective follow-up study Marrigje H. Nabuurs-Franssen, MD1, Ron Sleegers2, Maya SP Huijberts, MD, PHD1, Wiel Wijnen2, Antal P. Sanders, MD, PHD1, Wiel Wijnen2, Antal P. Sanders, MD

Continued on page 82
Pearls (from page 80)

MD, PHD3, Geert Walenkamp, MD, PHD4 and Nicolaas C. Schaper, MD, PHD1

1 APMA Coding Resource Center http://www.apmacodingrc.org/index.asp
2 Novitas Solutions Medicare Jurisdiction JL part B Physician Fee schedule http://www.novitas-solutions.com/webcenter/portal/MedicareJL/FeeLookup?_afrLoop=1458334820676000
# ! % 4 0 % 4 0 % 3 F _ a f r L o o p % 3D1458334820676000%26_adf.ctrl-state%3De6ixjsqgb_50
6 Diabetes Care. 2003 Sep;26(9):2595-7 Armstrong, et al Activity patterns of patients with diabetic foot ulceration: patients with active ulceration may not adhere to a standard pressure off-loading regimen.
8 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html Regulation No. CMS-1613-FC: Hospital Outpatient Prospective Payment- Final Rule with Comment Period and CY2015 Payment Rates
10 Wound Care Outcomes and Associated Cost Among Patients Treated in US Outpatient Wound Centers Caroline E. Fife, MD, CWS; Marissa J. Carter, PhD, MA; David Walker, CHT; Brett Thomson, BS Wounds. 2012;24(1)

Dr. Lehrman is in private practice outside Philadelphia, PA. He is a Diplomate of the American Board of Foot and Ankle Surgery, Fellow of the American College of Foot and Ankle Surgeons, Fellow of the American Society of Podiatric Surgeons, and a Fellow of the Academy of Physicians in Wound Healing. He is on the Board of Trustees and a Fellow of the American Academy of Podiatric Practice Management and is an expert panelist on Codingline.com. He sits on the Board of Directors of both the ASPS and APWCA.