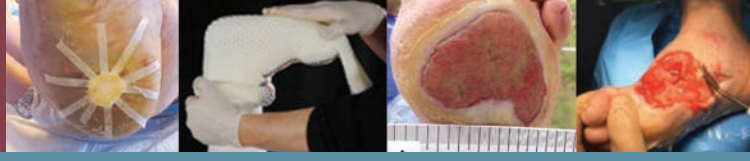

A Step-by-Step Approach to Billing Wound Care Products Through Your Office

Follow these rules and you'll pass any and every pre-payment audit that may come your way.

BY JONATHAN MOORE, DPM

This article is written exclusively for PM and appears courtesy of the American Academy of Podiatric Practice Management. The AAPPM has a forty-plus year history of providing its member DPM's with practice management education and resources. Visit www.aappm.org for more information.

All of us have the desire to provide excellent care, convenience and customer service to our diabetic patients, but the challenge is putting together the protocols and the necessary staff to make sure the system can run on 'cruise control'.

The 'Center of Excellence' (COE) approach to patient care is essential, in my opinion, in order to not only achieve the best outcomes, but moreover to provide the convenience and quality our diabetic patients expect. With the advent of measurable quality of care, the COE approach is critical for survival.

While in previous articles I've explored the COE concept in relationship to diabetic footwear, vascular testing, radiology/MRI, Bracing/AFO's among other components, one area that still eludes many of you is mastering the ability to provide patients with wound care supplies in your office. Among the products that I'm referring to are primary topical wound care agents like alginates, foams, collagens, hydrogels, secondary dressings like bordered gauze, and even graduated compression garments (which are covered with the diagnosis of an open venous stasis ulcer).

While it is second nature for us to provide our diabetic patients with therapeutic shoes and in some cases a pneumatic removable cast walker, few unfortunately provide their patients with wound supplies. Part B Medicare Utilization Data (BMAD) without question demonstrates this fact.

It is often the case that many, without exploration into the reimbursement schedule for common topical wound care supplies, may scoff at the idea of going to the trouble and expense of stocking and providing wound care supplies for their patients. Doing so, however, is well worth your time, both for your patients and your bottom line.

Why would you want to supply your patients with their wound care supplies? Here are ten good reasons:

1) Convenience for your patients
2) The patient gets the wound dressing you recommend without substitution
3) No delay in treatment of the wound
4) You and your staff can demonstrate how to apply the dressings
5) No worry about the patient NOT picking up or filling his/her prescription for the supplies you prescribed
6) Reimbursement to your practice
7) Simple documentation requirements
8) Prepackaged kits can be used to make dispensing simple
9) Lower cost to stocking
10) Staff-driven

The key to being successful in any audit situation is being proactive in using the correct information prior to an audit and not after.

Removing the Obstacles

While I could spend the entirety of this article continuing to pontificate on the financial and clinical virtues of dispensing wound dressings, this is not my purpose here.

The purpose of this article is to remove the most common obstacles lying in the way of starting to dispense wound dressings to your patients out of your office.

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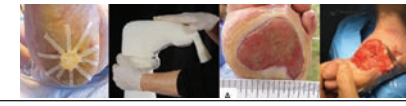

Billing *(from page 85)*

It is certainly the case that nothing is easy anymore in running our practices. Dispensing DME as an ancillary service to our patients used to be a lot easier than it is now; and as a side effect of the increased scrutiny and prepayment audits by CMS and other payers, utilization of certain services has significantly declined.

Prepayment audits for AFO's, diabetic footwear and other DME services has not only deeply impacted utilization, but in my view, they have also negatively impacted patient care.

While faithful readers of *PM News* and members of the AAPPM have striven to learn now to navigate and overcome the ever-changing and often-illogical rules when it comes to documentation and compliance for DME, many simply just stop dispensing.

Knowing there is increased scrutiny and audit potential by providing a legitimate service to your patient will invoke one of two responses by the physician:

1) Avoid the potential headache by simply avoiding the use and dispensation of said service

2) Continue to provide the service with the 'best guess' approach when it comes to documentation and compliance rules

3) Searching out, finding the rules and simply complying with the rules for dispensement of said service with the help of your entire staff and team.

All of us have faced prepayment audits and if you haven't, just wait. While some may not see many audits, some regions have been heavily targeted more than others (and you know who you are).

Though living in a rural area versus a city like Orlando may impact the number of audits you see annually, we all get them and because we know what CMS is looking for in an audit and have the team to make sure the rules are being followed, we have consistently passed audits for AFO's, diabetic shoes, wound dressings among other services, despite the fact that we are outliers in many of these areas.

The key to being successful in any audit situation is being proactive by documenting the correct information prior to an audit and not after. Whether through *PM News* or through your association with the AAPPM, searching out what is required is unfortunately NOT a one-time effort. It has to be an ongoing activity.

Confronted with "take back" demands for claims filed 2-3 years ago or lengthy post-delivery/pre-payment information demands, podiatric physicians must quickly adapt their internal processes and expand their skills beyond patient care if they want to survive.

If you are treating wounds routinely without debridement, this falls below the standard of care for wound treatment.

Whether you receive a Recovery Audit Contractor (RAC) audit letter or a MAC notice of prepayment claim review, the painful impact on your practice is the same until you can convince the contractor that your claim has all the necessary elements required by Medicare (which is often difficult if your note is grossly missing components required). The time and energy it takes from our practices to provide written responses trying to convince the RAC or MAC to approve your claim is daunting, but it HAS to be done.

Now, as mentioned above, my goal is to provide key information for every practice to be able to be prepared and thrive in this age of audits, specifically regarding wound/surgical dressings.

Why focus on wound dressings?

Because I believe in the value of this service for our patients (and their outcomes) and furthermore, overcoming the obstacles is NOT hard if you follow the rules and train your team to help you avoid the common denial pitfalls.

The Top 6 Denial Reasons

Jurisdiction B recently conducted a widespread prepayment probe review of surgical dressings, which included the following Healthcare Common Procedure Coding System (HCPCS) codes: A6197 (Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing) and A6199 (Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches).

Between 1/12/2016 and 5/8/2016, the Medical Review Department performed a complex review of 100 claims. A total of 8 claims were allowed and 92 claims were denied, resulting in a claim error rate of 92 percent.

A total of 37 claims denied because documentation was not received in a timely manner.

One would think that with an incredible 92% error rate the documentation and compliance requirements for wound dressings must be terribly complicated!

In reality, they are not. Here are the top 6 denial reasons as compiled by the Region B Medical review department:

1) Wound debridement was not seen in the document.

For those in podiatric medicine, especially those who dispense wound dressings, this simple rule is not complicated and in fact is rather obvious. Debridement, either mechanical or chemical, must be documented as a part of the wound treatment regimen. If you are treating wounds routinely without debridement, this falls below the standard of care for wound treatment.

2) Documentation does not support moderate-high exudative full thickness wounds (stage III-IV).

Again, as you noticed above, alginate dressings (as targeted by CMS) are dressings indicated for wounds that produce heavy drainage. Why would CMS pay for a foam or an alginate dressing if there

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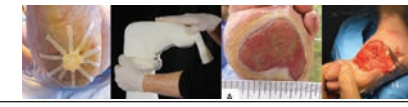

Billing *(from page 86)*

is not documentation of drainage or exudate in the wound? The same can be said of the use of a hydrogel. Should CMS pay for a hydrogel if there is no documentation of excessive dryness in the wound? In the era of EHR, there is simply no excuse for not templating and documenting the characteristics of the wounds. In our offices, paper templates are still used in the treatment rooms (partially completed by staff and partially by the physician) that upon completion are given to the documentation scribe who then records the findings documented on the template into the medical record. If the characteristics of the wound or if the size, depth and staging are missing for some reason, the scribe hands the template back to the physician to complete (To view a sample wound template, see Appendix A.)

3) Wound evaluation missing type, location, size, depth, and/or drainage amount.

These simple and painfully obvious findings should be recorded whether you are dispensing dressings or not. Again, using the simple wound template described above can assure that these basic clinical findings are recorded. As it is the case that wound/surgical dressings are reimbursable ONLY if the wound is a full thickness wound, it goes without saying that the depth and staging must be recorded.

4) Order did not specify quantity to be used at one time.

Why would CMS pay for a foam or an alginate dressing if there is not documentation of drainage or exudate in the wound?

This is information that should be recorded both in the patient's medical record and in the detailed written order (DWO) and is no different than what is required in writing a prescription for an an-

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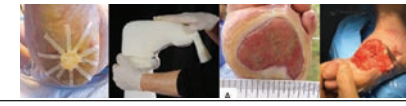
FIGURE 1:

Wound Product Matrix for DME Dispensing

Product Category & HCPCS Code	Wound Indications	Wound Type and Suggested Products for Lower Extremity Wound	Max. # Allowed to Dispense per Month per Wound	Approx. Cost vs. Medicare Reimbursement FOR ONE DRESSING
ALGINATES A6196–A6199	Moderate—Heavy Drainage, Infection, Tunneling	Any Draining Wound ------ Calcium Alginate 2x2	30	Cost: $1.75 Reimbursement: $8.13
COLLAGENS* A6021–A6024 - Dressing A6010 - Powder A6011 - Gel	Moderate—Heavy Drainage, Infection, Tunneling	Any Draining Wound that is Free of Slough/Necrosis ------	30	Dressing Cost: $10.00 Reimbursement: $23.24 Collagen Powder Cost: $12.00 Reimbursement: $34.24
FOAMS A6209–A6215	Moderate—Heavy Drainage, Infection	Any Draining Wound ------ Foam 2x2	12	Cost: $2.75 Reimbursement: $10.73
HYDROCOLLOID A6234–A6241	Light to Moderate Drainage, No Infection	Ankle Wounds ------ Hydrocolloid 4x4	12	Cost: $1.80 Reimbursement: $7.23
HYDROGELS A6231–A6233 - Gauze A6243–A6247 - Gauze A6248 - Gel	No Drainage, Infection	Diabetic/Neuropathic Ulcers ------ Wound Dressing ------ Hydrogel Gauze Dressing	Usual 3 oz. gel or 12 pads with adhesive border; 30 gauze pads	Gel Cost: $13.25 Reimbursement: $17.96/oz. Gauze Cost: $2.50 Reimbursement: $5.18

** Collagen Dressings A6021-A6024 require PDAC validation*

Disclaimer: Procurement costs are product, vendor and size-dependent. Reimbursement is based on product size and DME MAC fee schedule. Costs and Reimbursement are an average representation of Medicare ceiling.



Billing *(from page 88)*

tibiotic or any other prescription product (to view a sample wound dressing prescription order, see Appendix B.) Simply recording the information in a detailed written order and not having the identical information documented in the medical record will undoubtedly result in a claim rejection if your claims are subject to a complex medical review.

The number of wound dressings allowed for each wound is dictated by the type of dressing being used. (Figure 1)

For alginates, up to 30 pieces of dressing material are allowed per wound per month. For collagen powders/sheets, again 30 are allowed per wound, per month.

For foams, however, only 12 are allowed per wound, per month.

The bottom line is: payers want you to simply document how many wound dressings YOU think the patient needs.

If you document a wound that is 1 cm X 1cm, does the patient need 30 pieces (a 1 month supply) to heal that wound? If so, simply document it.

5) No medical records were submitted.

6) Order did not specify dressing change frequency.

Again, this is information should be recorded in the patient's medical record and in the detailed written wound dressing prescription order described above.

In most cases, the order should indicate that the patient is to change the dressing 1 time per day (collagen powder/alginate) or 1 time every 3 days (foam). Again, this should be templated on the detailed written order form that is embedded into your EHR.

The people reviewing your appeal are not wound care specialists, so keep your language simple and direct.

Writing an Effective Reply

If you are facing an audit of any kind (AFO's, therapeutic shoes, or wound dressings) writing an effective reply rests on presenting your arguments clearly and effectively. Keeping these points in mind when drafting your reply can help you to be successful.

1) The people reviewing your appeal are not wound care specialists, so keep your language simple and direct. If you must use terminology that's specific to your specialty, define it so the reader knows what you're talking about.

2) State the main issue(s) immediately (e.g., "The MAC is withholding payment of the claim because it wants the following information, all of which we have supplied in this response: (1) ..." etc.).

3) Attach all necessary exhibits (i.e., everything you identified in your Evidence Checklist).

4) Avoid Templates and check-off boxes for your notes. Check box forms will routinely be rejected by CMS contractors. A narrative discussion of the necessary requirements as stipulated above and in the LCD is what is required.

Templates and check-off forms give you no opportunity to tell your patient's story. Use the patient's name to paint a picture about the real clinical needs of your patient. Demonstrating that you provided appropriate clinical care will be far more effective if you take the time to organize your facts into a compelling narrative using language they're more likely to understand.

See Figure 2 for a sample reply letter.

FIGURE 2:

Sample Reply Letter

NGS has requested 4 pieces of information from our practice in connection with the claim for wound care dressings (collagen powder) for Bob Jones. We have attached information responsive to each of the 4 items required for wound dressing claims

- Physician clinical assessment/progress notes (Wound notes)
- Physician's detailed written order (details related to the number of dressings prescribed along with directions for use)
- Clinical data supporting medical necessity
- Proof of Delivery

We request that NGS approve this claim following its review of this letter and the attached exhibits.

Additional Considerations

Documentation Details

Poor documentation certainly is the most common cause of denials with wound dressings. A properly prepared patient chart note should

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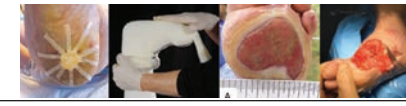

Billing *(from page 90)*

include the following information: Diagnosis Code, Procedural Code (i.e., Wound Debridement), Number of Wound(s), Wound Type-Location-Stage, Full or Partial Thickness, Wound Measurements (L x W x D), Type and Amount of Drainage, Wound base (% of fibrosis, % of granulation), a detailed written order (DWO) for Primary/Secondary Dressing(s) including Frequency and Duration of Dressing Changes and Written Instructions along with a proof of delivery (POD) document (to view a sample proof of delivery (POD) document, see Appendix C.)

What About Home Health Patients?

Unfortunately, it is not uncommon for a wound care patient to present to your clinic stating they are *not* receiving any home health when it fact they are. Of course you know that IF the patient is receiving home health for any reason, they can't also receive wound care dressings from ANY other source, as the home health agency is being paid under a Part A consolidated billing payment. So even if the beneficiary was NOT getting any wound care at all, the home health agency that receives the payment is responsible for the dispensing of all wound dressings (and this includes compression garments). CMS will not separately pay an outside provider for services covered under the consolidated billing rule.

Many clinics know this and try their best to quiz the patient on this, even checking with family, but anyone can get burned IF they rely solely on the word of the patient.

The home health status of your patients can be verified by your office prior to the dispensing of wound care products either through your software vendor eligibility program or government websites that store patients' active records. Our practice has been using this resource for years and it has saved us on multiple occasions from losing revenue by recognizing that the patient is still being classified as a Home Health Patient despite having been discharged. If your practice is not currently registered for these services, your will need to contact the local regional carrier for access.

- Region/Jurisdiction A—Noridian (Noridian Portal) https://med.noridianmedicare.com/web/jadme/contact. My CGS Portal—ph: IVR and CSR 866-419-9458
- Region/Jurisdiction B: CGS IVR ph: 877.299.7900 My CGS Portal http://www.cgsmedicare.com/jb/index.htm
- Region/Jurisdiction C: CGS (Celerian Group Company)—IVR 866.238.9650 http://www.cgsmedicare.com/jc/index
- Region/Jurisdiction D: Noridian Portal. IVR & CSR ph: (877)320-0390 https://med.noridianmedicare.com/web/jddme/

If after dispensing wound care products to your patient it is determined that Home Health will be required, after the patient has become enrolled in Home Health, dressing can no longer be supplied by your office for reimbursement.

If you supply a specific wound dressing that the Home Health agency cannot supply or if you desire a specific protocol to be implemented with a dressing (s) that you stock, the patient can be dispensed dressings prior to your referral to Home Health (for reimbursement) so long as orders are written to specify the directions for use of the dressings. If any dressings are dispensed AFTER a patient has become a Home Health patient, they will be denied coverage.

What About Deductibles?

As more private carriers are increasing deductible amounts and copays for DME services, it is imperative that patient benefits and deductible amounts be recorded prior to dispensing DME. If the patient's deductible has not been met, the amount for the wound dressings or their co-pay amount needs to be collected at the time of dispensing. Make sure that your patients are aware of these amounts as many products cannot be returned (e.g., any opened wound dressing or used compression garment).

Allowable

The allowable number of dressings per wound is most often determined by Medicare and is based on a 30-day period. Each product has its own unique purpose and design and it is imperative that the physician make the determination of how many units are covered in a 30-day period. It's not always necessary to dispense items based on thirty days and each wound should be assessed individually to determine the frequency and duration of dressing changes. Making sure that the number of dressings dispensed and the type of dressing being utilized matches the description of the wound in your note is vital. It is appropriate to dispense a full month supply if you determine that the patient will need that amount based upon your description of the wound, among other contributing factors that could impact wound healing.

It is imperative that patient benefits and deductible amounts be recorded prior to dispensing DME.

Private Payers

Private insurance varies by state, plan and provider. When dispensing wound care products from your office, it's always best to obtain benefits for all services you offer in your practice prior to the patient visit, including wound care dressings, in order to smoothly and quickly expedite coverage determination. While

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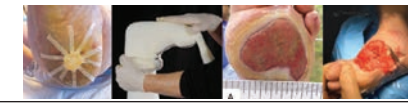
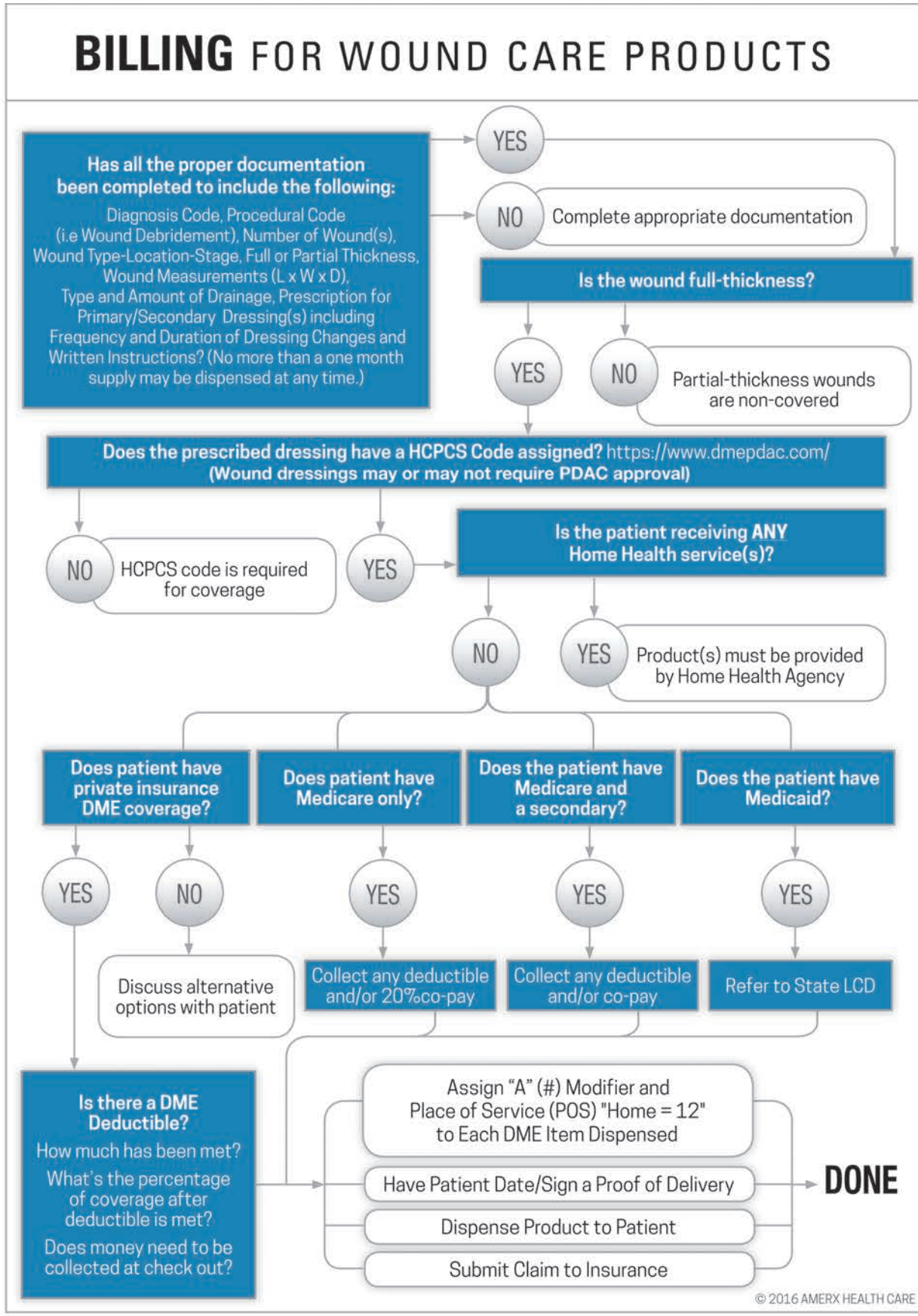


FIGURE 3:


BILLING FOR WOUND CARE PRODUCTS
Has all the proper documentation been completed to include the following:
Diagnosis Code, Procedural Code (i.e Wound Debridement), Number of Wound(s), Wound Type-Location-Stage, Full or Partial Thickness, Wound Measurements (L x W x D), Type and Amount of Drainage, Prescription for Primary/Secondary Dressing(s) including Frequency and Duration of Dressing Changes and Written Instructions? (No more than a one month supply may be dispensed at any time.)
YES
NO
Complete appropriate documentation
Is the wound full-thickness?
YES
NO
Partial-thickness wounds are non-covered
Does the prescribed dressing have a HCPCS Code assigned? https://www.dmepdac.com/
(Wound dressings may or may not require PDAC approval)
NO
HCPCS code is required for coverage
YES
Is the patient receiving ANY Home Health service(s)?
NO
YES
Product(s) must be provided by Home Health Agency
Does patient have private insurance DME coverage?
Does patient have Medicare only?
Does the patient have Medicare and a secondary?
Does the patient have Medicaid?
YES
NO
YES
YES
YES
Discuss alternative options with patient
Collect any deductible and/or 20%co-pay
Collect any deductible and/or co-pay
Refer to State LCD
Is there a DME Deductible?
How much has been met?
What's the percentage of coverage after deductible is met?
Does money need to be collected at check out?
Assign "A" (#) Modifier and Place of Service (POS) "Home = 12" to Each DME Item Dispensed
Have Patient Date/Sign a Proof of Delivery
Dispense Product to Patient
Submit Claim to Insurance
DONE
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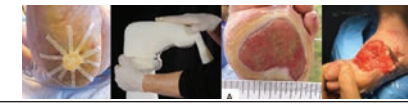


Billing *(from page 92)*

it's not a common scenario, some carriers will not cover wound dressings being dispensed by the physician. Learning which plans have these restriction is important. Adding wound care dressings to your list of items asked about when obtaining benefits will save a lot of time and frustration.

In the event a particular payer will not cover the items from your office, a local supplier should be able to accommodate your request. Make sure the patient has a prescription and it's clear the items cannot be substituted, as many of these companies try to reduce their cost by providing the cheapest product possible to maximize their profits. Even though products may be in the same category, not all products are created equal. If the supply house values your business, they should be able to supply the products you request and maintain a healthy bottom line.

Education

Patient education on how to properly use the dressing prescribed by the physician can be just as important as the dressing itself. Proper training and communication can determine not only potential for successful outcomes but also the patient's ability to perform the tasks required.

- How to perform proper dressing changes
- Utilizing gloves
- Creating a 'clean' space at home to change the dressings
- Making it clear as to the frequency of dressing change
- Does the patient need a Home Health Referral or can the patient or family adequately put the dressing on?
- Educating the patients NOT to use dressings from an already open package.
- When they are to return for follow-up

Summary

Dispensing dressings and supplies from your office to your patients is a key part of becoming a true Center of Excellence for your diabetic patients. Like any type of DME, the rules are constantly changing and yet they are not complicated if you keep up with rules and have the staff to help you document what you need to be compliant. Utilizing a scribe or training your documentation staff to help with the compliance tools can save time and insure compliance. It is often the case that changes in compliance rules are not widely circulated, so to keep up, stay in tune with publications like *PM News* and through the American Academy of Podiatric Practice Management.

For a quick reference and summary of the above protocols for billing wound care dressings, see the Flow Chart (Figure 3) on page 93. **PM**

Helpful Reminders

Detailed Written Order (DWO) should include:

- Patient's Name
- Detailed description of item(s) to be dispensed including each separately billed component (A Code and its full description)
- Number of dressings being dispensed
- Instructions for use of the wound dressing (how often dressing is to be changed and reapplied)
- Documentation of how many wounds are being treated
- Treating MD's signature
- Date treating MD signed the detailed written order
- Start date of the order (only required if different than the signature date)

(To view a sample wound dressing prescription order, see Appendix B.)

Proof of Delivery (POD) should include:

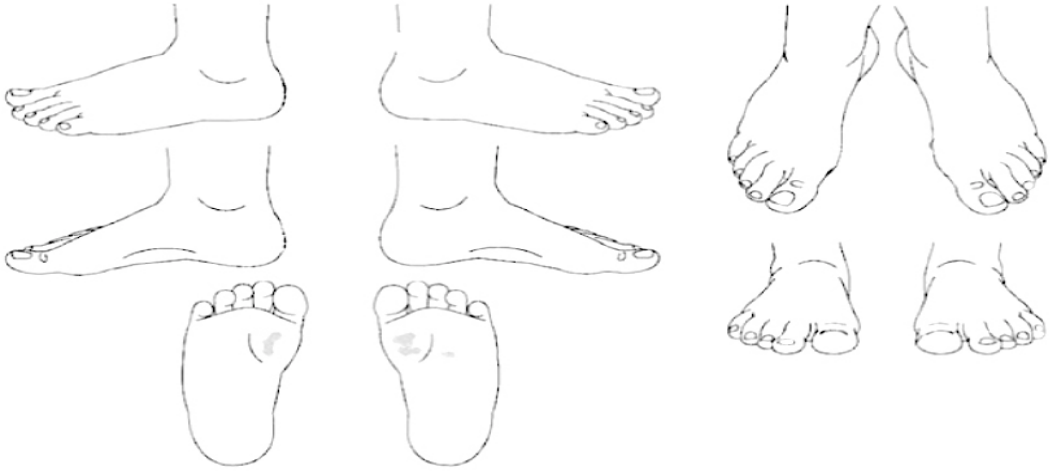
- Patient's name
- Date
- Detailed description of each item delivered (same as the detailed written order: The A code and its full description)
- Brand name and model number of item(s) delivered
- Patient signature above patient's printed name

(To view a sample Proof of Delivery form, see Appendix C.)

Jonathan Moore, DPM is a board certified member of the ABPM, a managing partner of Cumberland Foot and Ankle Centers of Kentucky, and Fellowship Director, Central Kentucky Diabetes Management Fellowship. He is a Fellow, Board of Trustees, American Academy of Podiatric Practice Management and Adjunct Faculty, Kent State University School of Podiatric Medicine.

Appendix A

Patient Name _____ Date_____ Wound visit # _____
Chief Complaint: Open Wound x _____days / _____months
Other Subjective Symptoms: ___pain ____numbness ____fever ___chills ____nausea
Combined Medical and Mental Condition:
___ mobility_____; ___ infection; ___diabetes type I or II; ___ chronic pressure; ___ arterial insufficiency/small vessel ischemia; ___venous stasis; ___ edema; ___ CPOD; ___ malnutrition; ___ CHF; ___ anemia; ___ Other: _____
Wound/ Dermatitis/ Pre-Ulcerative Lesion Status: ___improved (_____ %) ____declined (_____ %)
Medicines/Allergies: ____ Reviewed and in chart.
Compliance: Good Questionable Poor **Dressing Status**: Clean Exudates Dirty Odor
Associated Deformity(s):
Drainage: None Minimal Moderate Severe **Type**: _____
Wound 1: _____cm (length) X _____cm (width) X ____cm (depth)
Wound 2: _____cm (length) X _____cm (width) X ____cm (depth)
Wound 3: _____cm (length) X _____cm (width) X ____cm (depth)
Wound 4: _____cm (length) X _____cm (width) X ____cm (depth)



WOUND CHARACTERISTICS:
___PAINFUL ___ NOT PAINFUL
___SLOUGH
___ESCHAR TISSUE ____% OF WOUND
___NECROTIC TISSUE ____% OF WOUND
___GRANULATION TISSUE ____% OF WOUND
___FIBROTIC TISSUE ____% OF WOUND
___KERATOTIC TISSUE ____% OF WOUND
___UNDERMINING ___DRY
___TUNNELING
___EXUDATE ___PUS
___ERYTHEMOTOUS BASE
___PSORIATIC
___SUB EPIDERMAL BLEEDING
___VENOUS WEEPING
___CHRONIC/NON HEALING
___ LEG ULCERATION
___NEED FOR MOISTURE

ULCERATION TYPE
___Pre-Ulceration/Keratoderma; ___Venous; ___Arterial; ___Diabetic/Neuropathic; ___Pressure; ___Rheumatoid/Deformity; ___Post Surgical; ___Post Chemical Burn
Skin Condition: ____Normal ____Thin ____Atrophic ____Stasis Wound/Venous ___Ischemic
Wound Staging:
____Pre-Ulcerative/Keratoderma; Wagner Grade 0
____Superficial ulcer without subcutaneous tissue involvement; Wagner Grade 1
____Full Thickness skin to subcutaneous tissue/fascia: NPAUP Stage III: Wagner Grade 2
____Full Thickness skin through fascia/muscle: NPUAP Stage IV; Wagner Grade 3
____Full Thickness skin to Bone: NPUAP Stage IV; Wagner Grade 4
Treatment:
____The wound cleaned, flushed, irrigated and prepared for debridement/dressing. The wound was debrided sharply manually with ___#15 blade ___ curette ___tissue nipper down the level of the tissue at the base of the wound that may include muscle, tendon, bone, or any necrotic tissue (see wound grade). The debridement was performed to reduce risk of infection and improve wound healing.
Anesthesia Used: YES NO (Patient Neuropathic)
Type of tissue removed from the wound: ___Necrotic ___Fibrinous ___Granular ___Tissue Biopsy Performed
Evaluation of possible infection: ___ Culture and Sensitivity ___X-Ray ___Blood Work
___Oral antibiotics prescribed: _____
Impression: ___Healed ___ Improved ___ Initial Assessment ___Unchanged ___Worsening
____Treatment plan was given to the patient verbally.
____The patient and their family were educated thoroughly regarding the wound care regimen. All materials and supplies were dispensed per the patient needs. Home instructions were reviewed and all questions answered in detail.
Topical Wound Care Plan: Unna Boot Hydrogel Foam Dressings Helix 3 – CP Helix 3 – CM
Products Dispensed: _____ (Please see attached prescription and Patient Acknowledgement of Receipt.)
Goal of Current Therapy: ___Complete Resolution ___Infection Control ___Palliative Care
Prognosis: ___Good ___Fair ___Poor
Footgear Recommendations: ___AFO ___Non-Pneumatic AFO with Molded Inlay ___Diabetic Therapeutic Shoes and Insoles
Follow-Up for Wound Care: _____day(s); _____week(s) ___Picture Taken

Physician Signature: _____

Appendix B

Foot and Ankle Center

Patient's Name:_____ Date:_____

WOUND DRESSING PRESCRIPTION

Product:

___ Polymem (A6212) ___ Amerigel/Hydrogel/Solosite Gauze (A6231) ___ Helix 3 – CP (A6010)
___ Promogran (A6021) ___ Prisma (A6021) ___ Adaptic (A6222)
___ Fibracol (A6021) ___ Helix 3 – CM (A6010) ___
other_____

Number: _____ Grams_____g Size:___ X ___

Apply to Wound Site (Location: See Office note):_____

Dressing To Be Changed ___Twice a day____Daily ___When Dressing 75% saturated ___3 x Week ___Weekly Other:_____ over the next month.

Anticipated Length of Need: ___1 month ___2 months ____ 3 months ____> 3 months ___until healed

Goal of Treatment: To achieve complete healing of the wound site (s) and then to prevent reoccurrence through the use of shoes, insoles, bracing, education or through any other means necessary.
Diagnosis:

NON-PRESSURE CHRONIC ULCERATIONS			
Right Calf		Left Calf	
Limited to breakdown of skin	L97.211	Limited to breakdown of skin	L97.221
With fat layer exposed	L97.212	With fat layer exposed	L97.222
With necrosis of muscle	L97.213	With necrosis of muscle	L97.223
With necrosis of bone	L97.214	With necrosis of bone	L97.224
Right Heel/Midfoot		**Left Heel/Midfoot**	
Limited to breakdown of skin	L97.411	Limited to breakdown of skin	L97.421
With fat layer exposed	L97.412	With fat layer exposed	L97.422
With necrosis of muscle	L97.413	With necrosis of muscle	L97.423
With necrosis of bone	L97.414	With necrosis of bone	L97.424
Right Ankle		Left Ankle	
Limited to breakdown of skin	L97.311	Limited to breakdown of skin	L97.321
With fat layer exposed	L97.312	With fat layer exposed	L97.322
With necrosis of muscle	L97.313	With necrosis of muscle	L97.323
With necrosis of bone	L97.314	With necrosis of bone	L97.324
Right (Other Part Of Foot)		**Left (Other Part Of Foot)**	
Limited to breakdown of skin	L97.511	Limited to breakdown of skin	L97.521
With fat layer exposed	L97.512	With fat layer exposed	L97.522
With necrosis of muscle	L97.513	With necrosis of muscle	L97.523
With necrosis of bone	L97.514	With necrosis of bone	L97.524
Right (Other Part Of Lower Leg)		**Left (Other Part Of Lower Leg)**	
Limited to breakdown of skin	L97.811	Limited to breakdown of skin	L97.821
With fat layer exposed	L97.812	With fat layer exposed	L97.822
With necrosis of muscle	L97.813	With necrosis of muscle	L97.823
With necrosis of bone	L97.814	With necrosis of bone	L97.824

Pressure Ulcer - Right Ankle	
Stage 1	L89.511
Stage 2	L89.512
Stage 3	L89.513
Stage 4	L89.514
Pressure Ulcer - Left Ankle	
Stage 1	L89.521
Stage 2	L89.522
Stage 3	L89.523
Stage 4	L89.524
Pressure Ulcer - Right Heel	
Stage 1	L89.611
Stage 2	L89.612
Stage 3	L89.613
Stage 4	L89.614
Pressure Ulcer - Left Heel	
Stage 1	L89.621
Stage 2	L89.622
Stage 3	L89.623
Stage 4	L89.624
Pressure Ulcer - Other Site	
Stage 1	L89.891
Stage 2	L89.892
Stage 3	L89.893
Stage 4	L89.894

WOUND PROPERTIES:
___ Wound is Full Thickness
___ Wound is Draining/Exudatative
___ Wound is Dry and Needs Hydration
___ Wound needs antimicrobial Dressing (Silver)
___ List of 30 Standards and Complaint Resolution Form Dispensed To Patient.
___ Patient/Family Educated Regarding How to Apply and Use at Home

Physician/Nurse Practitioner Signature _____ Date ___/____/____

Proof of Delivery (POD)

Foot and Ankle Centers

Delivery Address: 929 North Main Street

Name: _____ DOB: _____ Date: _____

Quantity	Prescribed Item and description	Code
	Prisma Collagen dressing, sterile, pad size 16 sq in or less, each	A6021
	Helix Matrix Collagen dressing, sterile, pad size 16 sq in or less, each	A6021
	Fibrocol Collagen dressing, sterile, pad size 16 sq in or less, each	A6021
	Amerigel Hydrogel/Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, each dressing	A6231
	Foam Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	A6212
	Helix CP Collagen based wound filler, dry form, per gram of collagen	A6010
	Gauze 2x2 Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6216
	Gauze 4x4 Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	A6216
	Kling Rolls Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	A6443
	Tongue Depressors (Sterile) to be dispensed with powder dressings	---------

Brand Name: _____ Serial/Lot Number: _____

Of Wounds ____

Foot and Ankle Center Supply Warranty Information

By signing below, I am certifying that I have received the above designated item and that the item is satisfactory and not substandard in any way. All devices eventually wear out through normal wear and tear. The products you have received have a 1 month manufacturer's warranty against defects in materials and workmanship, assuming normal wear and tear (see product manual if applicable.) We will repair or replace, free of charge devices that are under warranty. For issues of initial fit, please return within 7 days to our office so that we can address concerns of the initial fit of the device. Due to the medical nature of most of these devices, they cannot be returned, unless defective and under warranty.

√ I have received a copy of the privacy policy, on this visit or on a previous visit as noted in my medical record.

√ I received Use, Care and Maintenance Instructions, including Warranty Information.

√ I received the Patient Rights and Responsibilities handout, Feedback Complaint Policy and the DMEPOS Supplier Standards.

√ I received a copy of the Quality Improvement Program Survey.

√ I received my DMEPOS items.

By signing below, I acknowledge and understand all of the above.

_____ Date: _____ Witness: _____

Patient/Guardian Signature

_____

Printed Name