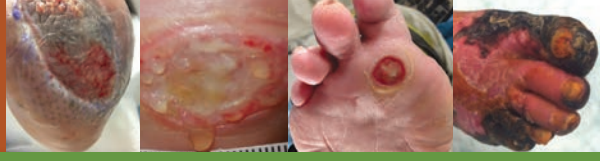

The Ins and Outs of Billing for Wound Care Products

You need to know the potential pitfalls of providing some of these dressings.

BY PAUL KESSELMAN, DPM

One of the most difficult classes of DME products to profitably provide to your patients are surgical dressings. There are many pitfalls along the way. including coding and chart documentation, to say nothing about potentially taking a loss depending on costs vs. reimbursements. Recent pre-payment probes have denied approximately 100% of claims for alginate dressing. This would steer most reasonable providers far away from providing these services to their patients. A draft policy proposed last summer (and yet to be adopted) would severely restrict coverage on multi-ingredient products. This month's edition will answer some frequently asked questions regarding the potential pitfalls of providing these products to your patients.

Question 1: *Are all patients for all wounds covered if they have a wound/ulcer, etc. that I treat in my office?*

Answer: Medicare patients are covered for surgical dressings subject to several limitations, including but not limited to wound depth.

Partial thickness wounds (e.g. warts, ingrown nails) do not qualify for surgical dressings as most classes of surgical dressings require the wound to be at a minimum of full thickness (involving at least the entire dermis). There are then a myriad of questions one must answer in order to determine which type(s) of surgical dressing are potentially covered (see below).

Surgical dressings used during the treatment of patients in your office are not covered as they are included in the service (e/m or surgical) to those patients. Those that are dispensed from your office to be used by patients in their homes are considered DMEPOS ("A" codes) and paid by the DME MAC. This is in contrast to bioengineered skin substitutes (e.g., Apligraf, etc.) which are considered drugs and payable by your local Part B carrier, as these are not considered DME.

Non-Medicare carriers also have a significant number of rules about who and who cannot provide surgical dressings. The most accurate statement one can make about non-Medicare carriers is that they often restrict coverage to and contract with large commercial DME mail order carriers. Therefore, it is best to check with the carrier directly to determine whether or not you can obtain reimbursement for surgical dressings to be used in the patient's home.

Due to the significant potential and difficult differences in prediction for reimbursement by non-Medicare carriers, the remainder of this Q&A applies to Medicare DME.

Question 2: *Where can I find the fee schedule for surgical dressings, and are these issued yearly like the physician fee schedule?*

Answer: The surgical dressing fee schedule is part of your DME MAC reimbursement schedule. Many DMEPOS receive minor quarterly adjustments (up and down). One can either charge significantly higher than the annually released schedule or check the DME MAC quarterly.

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Question 3: *Are there general guidelines to determine which dressings to apply to specific types of wounds?*

Answer: Medicare would expect that wounds that are highly exudative to be treated with highly absorptive products (alginates, foams, etc.). Conversely, dry wounds would be expected to be treated with hydrogels.

Question 4: *Is there a maximum number of dressings I can provide?*

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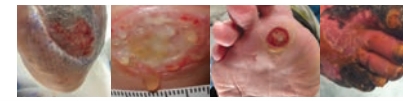

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Answer: This is actually a multi-part question.

A) The DME MAC allows for a 30-day supply of surgical dressings to be applied to each wound;

B) The reimbursement policy expects the prescriber to anticipate the number of dressings the patient would be required to use over the prescribed 30-day period; that is, more frequent changes initially, with fewer as the wound progresses.

C) Different classes of surgical dressings allow for different change frequencies. For example, hydrogels may allow for daily dressing changes (maximum monthly allowance = 30 days), whereas alginate dressings permit only three times/week changes (maximum = 12 dressings/month).

D) One may not expect Medicare to cover dressing classifications with opposite properties applied to the same wound (refer to Question 3). In other words, it would be rare to require using a highly absorptive product (e.g. Alginate) with a gel-based product (e.g. hydrogel) on the same wound.

Question 5: *Can I provide more than one product to a specific wound?*

Answer: Yes, Medicare will allow a single primary dressing (that which comes directly in contact with the wound) and a single secondary dressing (one which secures the primary dressing or assists in the function of the primary dressing). However, a third dressing for the same wound would not be reimbursed. For example, one could apply a liquid hydrogel dressing (A6248) to a necrotic wound and secure it with sterile non-border gauze pad < 16 sq cm (A6216). However, securing it with a conforming gauze dressing (A6445) would not be covered.

Exceptions to the rule apply—for example, when a primary dressing with an adhesive border is applied to the wound, a secondary dressing cover would not be allowed.

Question 6: *Is the HCPCS code for each dressing sufficient for my claim form?*

Answer: Each product is described by its corresponding HCPCS code. The HCPCS code then is required to be amended with an "A + Number" modifier to indicate the number of wounds treated. For example, one would bill a foam dressing with an adhesive border of less than 16 sq.in. to be described as: A6212-A1, with the last digit indicating that one wound is being treated, A2 indicating two wounds are being treated, etc.

Question 7: *Who is the prescribing entity for the surgical dressing, and where do I put this on a claim form?*

Answer: This depends on the nature of the physician/patient relationship. In most cases for podiatrists dispensing DME out of their offices, the DPM providing the wound care would also be the prescribing entity. Therefore, your name would be placed in Box 17 on the CMS 1500 form (or its electronic equivalent) as well as your Type I NPI to be placed in Box 17B (or its electronic equivalent). You are also required to use one of the "D" modifiers to indicate that you are: DN-Referring Provider; DK-Ordering Provider; or DQ-Supervising Provider. In the case of DME, your best choice is one of the first two options.

Due to Surety Bonding and Facility Accreditation, you should not be filling DME prescriptions from outside your group unless you (or your group) has gone through the arduous process of obtaining these requirements.

Question 8: *How do I choose which surgical dressings to use?*

Answer: This is likely one the biggest tasks you face in wound care. One response is based on the science of the wound, and then the corresponding dressing you wish to apply. Training experiences, a patient's allergies, and other medication history may also play a role. Finally the choice of dressing should be related to medical necessity and outcomes.

This brief article is no substitute for staying updated on new advances in wound care technology. This can be accomplished by taking courses offered by a myriad of organizations (e.g. APWH, etc.), attending M&M conferences at your local hospital, or subscribing to a vast array of wound publications. Text books abound on this subject as well. One regularly updating website to consider frequently is: www.woundsource.com

Medicare only covers venous compression stockings as a benefit when the beneficiary is being actively treated for an open venous leg ulcer.

The other response is based on cost and reimbursement for the thousands of products available. Developing a profit/loss spread sheet based on the costs and reimbursements for those products you may be interested in providing is a tool to consider to develop for your practice. Any such tool will require frequent updating.

One may also wish to take into consideration the co-payments patients may be burdened with should they not have secondary coverage.

Question 9: *Are any surgical dressings for Medicare recipients required to be approved by PDAC?*

Answer: Yes, for some time collagen dressings for Medicare DME claims have required PDAC approval. One should refer to the PDAC website (www.dmepdac.com) to determine whether there are product advisories on product classifications and whether or not specific products have a current validation letter.

Question 10: *Are venous compression stockings covered?*

Answer: Medicare only covers venous compression stockings as a benefit when the beneficiary is being actively treated for an open venous

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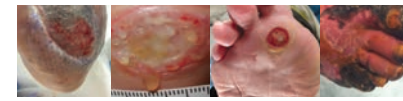

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leg ulcer. Under these circumstances, the venous compression dressings are considered a secondary dressing to enhance compression and the properties of the primary (contact) dressing. One would need to document the active treatment of an open wound in the chart as there is no way to document this on the claim. Long-term treatment of venous compression stockings for Chronic Venous Insufficiency (CVI) is not covered by Medicare.

Question 11: *Where can I find more information on surgical dressing reimbursement?*

Answer: Each DME MAC has both a Local Carrier Decision (LCD) and Policy Article (PA) posted on their website. These documents are quite lengthy but should become part of any wound care suppliers library. The LCD and PA are currently being reviewed by the DME MAC and will likely be undergoing some revisions as a draft policy very shortly.

Summary

The vast array of surgical dressings is astounding and confusing even to the most experienced of wound care providers. Payment and billing strategies must take into account a wide variety of issues including pricing, reimbursement policies, and wound science. This is by no means an easy task. However, large DME suppliers have found a way for this to be quite profitable. With value payment methods set to take effect shortly, using every method to heal wounds effectively should be incorporated into the wound care provider's playbook. This is true regardless of whether you are simply prescribing or are prescribing and supplying. Providers certainly must be selective in the choices they make for surgical dressings and the time it takes to properly document the need for same to mitigate the financial risks associated with the provision of these products. **PM**

Author's Note: *The use of any proprietary name surgical dressings in this article has been avoided in order to avoid the appearance of endorsing any product. I have recently worked as a consultant to AMERX and previously for Dermasciences.*

Dr. Kesselman is in private practice in NY. He is certified by the ABPS and is a founder of the Academy of Physicians in Wound Healing. He is also a member of the Medicare Provider Communications Advisory Committee for several Regional DME MACs (DMERCs). He is a noted expert on durable medical equipment (DME) for the podiatric profession, and an expert panelist for Codingline.com. He is a medical advisor and consultant to many medical manufacturers.