



A Simplified “How to” on Prescribing Wound Dressings for Home Use

The choice of the proper dressing can facilitate faster healing.

BY LEE C. ROGERS, DPM

Healing wounds requires adequate circulation, no infection, offloading, and regular debridement (Figure 1).¹ But after all that, dressings are useful to protect and maintain the wound environment to facilitate healing. It would be too presumptuous to assume that the wound dressing independently achieves healing. But dressings serve several important purposes. The main functions of a dressing are to absorb exudate, prevent infection, splint the wound area, and for psychological comfort.

The decision about which dressing to use is complicated by the setting (hospital, clinic, skilled nursing facility, home care, or home) due to the formulary, the payer, and the ability for a patient or caregiver to independently apply the dressing. Physicians may also find the decision process daunting since there are more than 1,000 products on the market used for wound dressings.

The process, however, can be made simpler by considering dressings in categories, as generics, instead of brand names. Figure 2 is a table of common dressing categories and a list of brands in each. In a hospital, skilled nursing facility, or on home care, formularies might be fairly restricted. Therefore, prescribing a brand-name dressing that is not on formulary causes delay before a suitable substitute is used. Physicians do not often mind if a pharmacist substi-

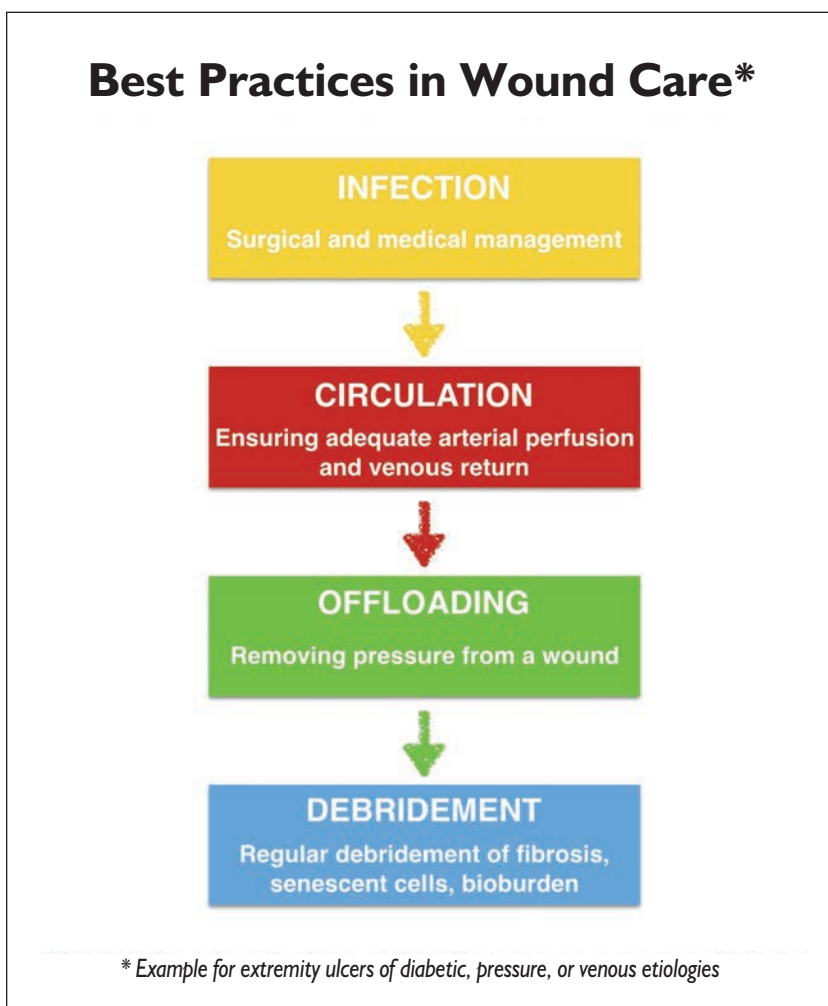


Figure 1

tutes a generic for a brand name antibiotic, and the same should be true of dressings. In reality, dressings in the same category, silver alginate for

example, would require thousands of patients in a randomized controlled trial of human subjects to prove any,

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albeit small, clinical difference. In order to avoid delays in faxes back and forth between facilities and physicians should approve a substitute, physicians should use generic categories in their prescriptions, especially for home DME use.

The use of dressings is considered part of the global care of a patient as a hospital inpatient, or in an outpatient clinic, skilled facility (except Medicare Part B patients), physician's office, and with home care. Dressings cannot be billed separately for collection. The good news is that most categories contain equivalent dressings; these entities can streamline their formularies to create cost-effective options for use with one dressing from each category. Prescribers who allow generic substitutions will find that confusion and delays are kept to a minimum.

In the case of dressings for home use (not home care), where a patient or caregiver applies the dressing, due to reimbursement issues, dressing prescriptions must follow these steps. A dressing prescription has 3 basic parts, which are necessary for third-party payers; the diagnosis, the medical necessity information, and the prescription.

Dressing Prescription

A dressing prescription should include the diagnosis. Documentation of the wound diagnosis and etiology

Dressing Category	Uses	Brand Names
Nonadherent	Covers grafts or biologics, prevents adherence/pain with dressing changes (made from multiple materials)	Adaptic, Adaptic Touch, Inadine, Mepitel, Telfa, Versatel
Hydrogel	Moistens wound bed	Curafil, Intrasite, Normigel, Silvasorb, Solocite
Collagen	Acts as a substrate for negative wound healing factors - MMPs and elastase	Endoform, Promogran, Promogran Prisma, Puracol
Alginate	Highly absorbant primary dressings	AlgiSite, Maxorb, Melgisorb, Silvercel, Tegaderm Alginate,
Foam	Highly absorbant secondary dressing	Allevyn, Hydrofera Blue, Mepilex, Optifoam, Tegaderm Foam
Hydrocolloid	Provide moist wound environment, occlusive	Duoderm, Exuderm, Tegaderm Hydrocolloid
Roll Gauze/Cohesive Bandage	Affixes primary and secondary dressings to the extremity, absorbs exudate	Kling, Kerlix, Coban

Figure 2

Many dressings, like collagens, alginates, and foams, can have silver added to aid in killing bacteria.

none, mild, moderate, heavy. Certain dressings, like foams, are restricted to wounds with moderate or heavy drainage. Conversely, collagens are not reimbursed for wounds with heavy drainage.

Finally, the actual prescription for the dressing is needed. Wound dressings can have three layers (primary,

drainage. A tertiary dressing is usually a type of wrap, like thin or thick roll gauze, a conforming bandage, a cohesive bandage, or a multilayer compression dressing.

In some cases, a dressing can serve as more than one layer. For example, a bordered foam dressing can cover a collagen and be a secondary and tertiary layer, or it can be used alone and be all three layers.

Many dressings, like collagens, alginates, and foams, can have silver added to aid in killing bacteria. Grossly infected wounds should be treated with aggressive debridement, incision and drainage, removal of infected tissue combined with systemic antibiotics, but silver can help to reduce bioburden and prevent infection in some cases. Despite some uneducated concern, the risk of bacterial resistance to silver is low and the likelihood of cross-resistance to antibiotics is virtually non-existent.²

Often, adhesives are used to affix dressings to wounds. When a roll

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by ICD-10 code helps to determine eligibility for third party payers, including the government payers Medicare and Medicaid.

Certain medical necessity information is also required. Payers require the size of the wound with each prescription. This helps determine the appropriate size of the dressing. Payers will also want to know the amount of drainage as:

secondary, and tertiary) and adjuncts (like tape and saline). Primary dressings are in contact with the wound bed. These are typically non-adherents, collagens, or alginates. A primary dressing might also cover a graft, like a skin graft or a biologic. A secondary dressing is used to absorb exudate and support the primary dressing. This can be simple gauze, or a foam if there is moderate or heavy



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gauze is used, the tape can contact the dressing, leaving the skin unaffected. In these cases, plastic or cloth tape can be used. If tape is to be used on the skin to border a dressing, a gentle option is needed. Paper tape is a good, inexpensive one. Soft fabric tapes and silicone tapes are very gentle, but more costly. Silicone is now common as a contact layer under foam and is used to affix the foam border to the skin.

The frequency of dressing change is sometimes confused by manufacturer recommendations. There is little science behind how often a dressing should be changed. Instead, it should be changed as often as it needs to be changed based on drainage and local wound conditions. The fre-

quency of dressing changes may vary frequently as some patients' wounds fluctuate in the amount of drainage

depending on their activity and limb dependency. If a dressing is ordered to

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WOUND TYPE	No or Mild Drainage	Moderate Drainage	Heavy Drainage
Diabetic Foot Ulcer	Primary: Collagen (1) Secondary: Gauze Tertiary: Roll gauze (2)	Primary: Collagen (1) Secondary: Foam (1, 3) Tertiary: Roll gauze (2)	Primary: Alginate (1) Secondary: Foam (1, 3) Tertiary: Roll gauze (2)
Venous Leg Ulcer	Primary: Nonadherent (4) Secondary: Gauze Tertiary: Roll gauze (2)	Primary: Alginate (1) Secondary: Foam (1, 3) Tertiary: Multilayer compression	Primary: Alginate (1) Secondary: Foam (1, 3) Tertiary: ABD and multilayer compression
Graft or Biologic Covering	Primary: Nonadherent (4) Secondary: Gauze Tertiary: Roll gauze (2)	Primary: Nonadherent (4) Secondary: Foam (1, 3) Tertiary: Roll gauze (2)	X
Post-surgical	Primary: Hydrocolloid Secondary: X Tertiary: X	Primary: Nonadherent (4) Secondary: Foam (1, 3) Tertiary: Roll gauze (2)	Primary: Nonadherent (4) Secondary: Foam (1, 3) Tertiary: ABD and roll gauze (2)

1. Also supplied impregnated with silver
 2. Supplied thin (Kling), thick (Kerlix), or cohesive bandage (Coban)
 3. Foams are also supplied as a nonadherent and bordered
 4. Nonadherents can be silicone or petroleum-based

Figure 3



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be changed every other day, and it is dry upon each dressing change, it can be extended to every three days or two

age can be seen in Figure 3. Clinicians are inundated with product options nearly daily, with company representatives visiting the office and promoting dressings that have little or no clini-

formulary. Ultimately, patients benefit by their doctor having a larger role in their care and making the choice of appropriate dressing. **PM**

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times a week. Conversely, dressings that are soaked with drainage should be changed more frequently, as often as necessary to avoid maceration and infection. This might result in multiple dressing changes per day, despite the fact that payers will typically only reimburse for enough supplies to change a dressing once daily.

Examples of dressing combinations that are frequently used for various ulcers by etiology and amount of drain-

cal studies of efficacy. Many products only have in vitro/benchtop studies that should not be relied upon due to inherent bias. Many times, physicians delegate this decision of which dressing to use to a nurse or staff member. But physicians who prescribe dressings by category can help to organize their knowledge of dressings, make better choices for patients, and limit frustrations by avoiding numerous callbacks asking for permission to substitute on

References

¹ Rogers LC, Bevilacqua NJ. Organized programs to prevent lower-extremity amputations. *J Am Podiatr Med Assoc* 2010;100:101-104.

² Percival SL, et al. Bacterial resistance to silver in wound care. *J Hosp Infect* 2005;60:1-7.



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