DME and Wound Care

Here's a Q&A on commonly occurring issues.

BY PAUL KESSELMAN, DPM

The science of wound care dressings has dramatically advanced from the previous standard of moist saline dressings in the 1970s to the recent evolution of cellular tissue products using embryonic tissue. Incorporating the most rapidly advancing technology is often demanded by our patients. It is difficult to keep up with the scientific applications of all the new products available in today's rapidly expanding marketplace. The reimbursement for these products is equally complex. Presented in a question and answer format, this article will answer some of the questions most often posed regarding reimbursement of wound care services.

Surgical Dressings

Q: *Are surgical dressings covered by podiatrists when dispensed out of their office?*

A: One may reflexively react, of course. However, the answer actually is not that obvious. It is often "maybe" or "no". It is dependent on many factors, with the most important initial question based on the patient's insurance policy.

Medicare Fee for Service (FFS)

Medicare's surgical dressing policy is either the second or most complex Local Carrier Decision (LCD) affecting podiatrists. Claims for Surgical Dressings, like AFOs, therapeutic shoes, etc., are to be submitted to your DME MAC. Your Regional DME MAC has stringent guidelines on coverage for surgical dressings, with carve-outs for coverage based on Consolidated Billing and product type.

Foremost is whether or not the patient is under Home Health (HH) or SNF Consolidated Care. If either of these are the case (the patient is receiving home care services paid for by Medicare or resides in a SNF), think twice prior to in-office dispensing of any wound care products. Patients under HH Consolidated Care may also be covered by the Home Health Agency (HHA) for wound care.

If your patient is receiving home health services, ask them or their aide if Medicare is paying for any of their custodial care. If so, it is likely the patient is covered by Part A Medicare for their home health care and thus, the HHA may be required to provide the patient with surgical dressings. This HH Consolidated billing exclusion is similar to patients residing in a SNF if they are less than 120 days from a hospital discharge.

Under a similar consolidation to the HH exclusion, patients are covered under a Medicare Part A SNF Consolidated Billing up to 120 days post-hospital discharge.

In either case, the consolidation of billing tells you Medicare is paying either the HHA or the SNF a one-lump payment for many of these services provided to the beneficiary. Because surgical dressings are part of both consolidation programs, your practice needs to take extra measures to ensure your patients are not enrolled in either of these programs. Otherwise, you may find yourself facing a significant economic loss on the provision of these products.

Q: *Are all surgical dressings treated equally in reimbursement?*

A: There are many classifications of surgical dressings (e.g., foam, alginate, hydrocolloid, etc.) and many caveats regarding product coverage. Each dressing type has a variety of policy restrictions. For example, foam or hydrogel dressings may only be applied to full thickness wounds a few times a week. At a recent meeting a speaker incorrectly stated that a surgical dressing could be reimbursed on post-matrixectomy or after verrucae resections. According to numerous well-known pathologists to the podiatric profession, both of these post-op wound types are ablative procedures and not full thickness wounds. Thus, while foam, hydrogel dressings, and collagen dressings may enhance the healing process, they nevertheless are not covered by Medicare for these types of superficial wounds. Furthermore, patients undergoing these types of procedures are typically healthy and not in need of these types of advanced surgical dressings.

Making this matter more com-

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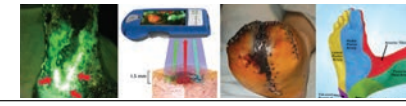

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plicated is that each dressing has a variety of HCPCS codes and associated fees, usually based on size or volume. The fee schedules can be found on the appropriate DME MAC fee schedule. As with all DME, the MAC to be billed is based on the patient's legal state address (and sometimes zip code) and claims should be submitted to the appropriate DME MAC.

Q: *Can I be reimbursed for surgical dressings applied in my office?*

A: Surgical dressings applied in the office are considered a component of the surgical or evaluation/management CPT billed to Medicare. Only those surgical dressings used by the patient in their home have the potential to be considered for payment by FFS Medicare. The amount you may dispense is usually for a 30-day period with frequencies of application based on the product type. The date of service (if using direct patient dispensing) is the date you actually provided the surgical dressings to the patient. However, one may choose to ship surgical dressings either from your office or from a vendor. See below for more information should you choose to select this method.

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Non-Medicare, Medicaid, and Third Party Payers

Q: *My patient is on a private insurance or non-FFS Medicare plan. What are their benefits for surgical dressings?*

A: Most non-FFS Medicare carriers share the same basic coverage terms as does FFS Medicare regarding surgical dressings.

The rules for both public and private payers are widely variable. Some require wound care providers to have been credentialed equivalent to a commercial DME vendor. If dispensing DME (and specifically surgical dressings) is not in your contract, you may not be reimbursed for dispensing surgical dressings by non-FFS Medicare carriers.

An additional consideration for both FFS Medicare and non-FFS Medicare carriers is the fee schedule for many surgical dressings. Reimbursement is often below your wholesale cost. In these situations, it is best to prescribe these items and refer the patients to their insurance carrier to determine which commercial DME vendor can provide surgical dressings to their covered beneficiaries.

Q: *My patient's Medicare HMO refuses to pay for surgical dressings provided on the same date of service as any office treatment. What can/should I do?*

A: This seems to be common with some Medicare Advantage plans. Despite appealing to the carrier and providing them with written proof of delivery that the surgical dressings are to be used for home use, several carriers have been intransigent about resolving this matter. Since the same date of service of product dispensing and office service is the only objectionable issue, the solution seems to reside in shipping the surgical dressings to the patient using a courier service (either directly from your office or from your vendor). Alternatively, and acknowledging the hardship this may present, one can ask the patient or their family to return the next day for the supplies.

Many vendors offer direct shipping from their facility to your patients. Because of sheer volume, the vendor can often provide the delivery service at a lower cost than if you shipped the products directly from your office.

If you choose the shipping method of providing DMEPOS to your patient, be sure the courier obtains a written receipt upon delivery and sends it to your office.

Either way, the additional shipping costs may negate any profit you may have received from the carrier. If you choose the shipping method of providing DMEPOS to your patient, be sure the courier obtains a written receipt upon delivery and sends it to your office (either via email, fax, etc.). This becomes your written proof of delivery. The date of service using a courier service can be the day of shipment or date of delivery to the patient. You may choose to provide surgical dressings to Medicare patients with shipping methods as well.

As with all private payers, one should contact the payer well in advance of dispensing any DMEPOS and inquire regarding your practice's ability to dispense, prior authorization issues, fee schedules, and any policy restrictions.

Cellular Tissue Products

These live or freeze-dried products were not in existence until about 20 years ago when the introductory products were referred to as Human Skin Equivalents. Presently referred to as cellular tissue products (CTP), there are a rapidly expanding number of products on the market. Shipping, handling, and storing are complicated and often dictated by the day of the week and the shelf life of the product. Some are fresh and others frozen or freeze dried.

Pricing is variable and many of

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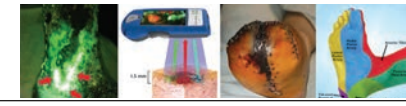

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these products are very expensive, resulting in most insurance carriers (including FFS Medicare) having strict reimbursement policies. Most private payers and Medicare Part C plans require pre-authorization. Products have their own "Q" HCPCS code and are billed in units (e.g., cms.). Unlike surgical dressings, CTPs are billed in the same fashion as medical/surgical services.

FFS Medicare

Q: *Does FFS Medicare have an LCD for all CTPs?*

A: This is variable and MAC-dependent. While some MACs presently have an LCD for CTPs, others do not. Historically, some MACs had an LCD for CTPs, then redesigned them to provide only a framework within the policy for the clinical restrictions for using all CTPs. Additionally, the LCD had attached Policy Article(s) (PA) with specific indications and coverage limitations for each CTP. This allowed many MACs to add policy articles for new products without the painstaking requirements surrounding the addition of new CTPs to the LCD. Unfortunately, many MACs have recently pulled the LCD (and accompanying PA) on CTP altogether, removing some sense of security provided by the existence of an LCD (and attached PA).

If your MAC recently pulled its CTP LCD, one may consider still using that as your framework for coverage parameters. Alternatively, one could use the CTP LCD and PA from an adjacent MAC. FFS Medicare does not have prior authorization requirements for CTP.

Q: *My MAC doesn't list the Q code pricing in their fee schedule. Where can I find resources for the fee schedule for CTP?*

A: Similar to injectable "J" HCPCS codes, the Q codes are listed by CMS in the Average Sale Price (ASP) for Part B drugs. These are updated on a quarterly basis and may be found at: https://www.cms.gov/medicare/medicare-fee-for-service-part-b-drugs/mcrpartbdrugavgsalesprice/index.Html

Q: *I don't understand the pricing rules for product coding; these seem to be confusing. Is there some way to make this easier to understand?*

A: The rules for use of these codes and prices (for in-office application only) can be perplexing, but can be made simple if one follows these simple rules:

MAC requires wastage to be tracked, making it imperative to order a CTP size that is as close as possible to the wound size.

1) Choose the size which most closely approximates the size of the wound. You may have to order something slightly larger than the wound size. If there are three sizes available, and the intermediate size is closest but slightly larger than the wound size, that is the size to order.

2) MAC requires wastage to be tracked, making it imperative to order a CTP size that is as close as possible to the wound size. One should then calculate the amount of the product actually applied to the wound adding 6% to the ASP in order to calculate the fee billed to the FFS MAC. The wastage should be calculated (Total – Amount Applied) = Wastage. The ASP for the Q code +6% should then be calculated for the wastage.

3) The Q code should be amended by the modifier JC for the product applied. The Q code for the wastage should be amended with the JW modifier. As an example, QXXXX with a per mm price of $1.00 and applying a 30 sq. mm product but purchasing 44 sq. mm, a claim would appear as follows:

QXXXX	JC	30 units	$30
QXXXX	JW	14 units	$14

FFS Medicare requires that for a specific DOS, the application codes (152XX) and the Q product code be billed on the same claim.

Non-FFS Medicare

Q: *Where can I find the policy restrictions for specific products?*

A: Federal and State regulations often require this information to be easily available on the plan's website. Because your patient's policy may be more or less restrictive than the policy listed on the plan's website, it is imperative that one call the plan for further information regarding a specific patient's benefits. It is essential to obtain both prior authorization and pre-determination of benefits for your patient, prior to proceeding with the CTP application in your office.

Q: *Where can I find the fee schedule for a specific product?*

A: Contact the plan for more information, despite the fact that most pay a percentage of the Medicare fee schedule. However, if the plan is paying a significant percentage less than Medicare does, it may be uneconomical for you to apply certain CTPs in your office. Information on requirements for the use of application and wastage modifiers should be obtained while obtaining pre-determination of benefits.

General Questions:

Q: *I want to save money and reduce wastage. Can I order one large package of a product and divide this for use between two patients on whom I would be applying this on the same date of service?*

A: There are two very good reasons never to consider doing this:

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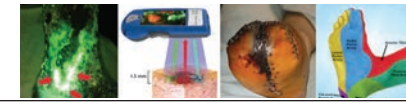

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1) FDA regulations restrict the use of each product ordered to one patient. Therefore, it would be a violation of FDA regulations to do so and could result in licensure revocation.

Providing both surgical dressings and CTPs in your office may be financially rewarding and also cost-effective for patients.

2) The potential of cross-contamination between patients increases the potential for significant professional liability and litigation could follow.

Q: *The product I wish to apply doesn't appear in the ASP. What do I do?*

A: There are many CTPs which currently do not have an HCPCS code, but all are listed in the *Redbook of Drugs,* which is available online at: http://www.micromedexsolutions.com/micromedex2/4.34.0/WebHelp/RED_BOOK/Introduction_to_REDB_BOOK_Online.htm

If you are planning on using a non- Q HCPCS CTP, it is imperative that you contact the FFS MAC or other carrier in order to determine how best to communicate the data required for payment. Recently some FFS and other insurance carriers have also begun requiring more information which must be placed into the equivalent electronic narrative field. You may also require the assistance of your EHR vendor in order to successfully resolve these matters.

Q: *The ambulatory surgery center has refused to order a product for me due to cost considerations. Do I have any recourse?*

A: There is a complex set of rules which apply only to facilities which categorize CPTs as high or low cost. These rules only apply for facility application and do not apply when the same products are used in your office. This becomes very problematic when the cost for CTPs are not bypassed and incorporated into the lump sum facility fee. That is, the cost of the CTP is included in the facility fee for the free-standing ambulatory surgery centers (or hospital out-patient department) whereas it is paid separately for patients while they are in-patients in the hospital or are in your office. Because of cost considerations, this often makes it financially impossible for a free-standing surgery center to afford providing a CTP. In this scenario, the provider has several options:

Inquire as to which CTP is lower cost and on formulary; perform the procedure as "in-patient" or if the patient is medically stable, perform the procedure in your office. If you choose to perform the procedure in your office, the complex rules of high vs. low cost do not apply and you are paid fee for service as noted in the previously listed set of rules at the beginning of this section.

Providing both surgical dressings and CTPs in your office may be financially rewarding and also cost-effective for patients. Patients potentially can avoid large facility deductibles and co-payments. Simultaneously, this saves money and avoids long delays in obtaining care in more familiar surroundings.

Due to the high costs associated with both surgical dressings and CTPs, it is essential for the astute provider to have an up-to-date comprehensive understanding of each patient's plan and policy. **PM**

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.