
# Wound Management and DME

When correctly done and billed properly this is a win-win for patients and practices.

**BY PAUL KESSELMAN, DPM**

Many wound care professionals claim that wound care compliance is improved when patients leave their offices with the required surgical dressings. Providing patients with surgical dressings may also provide additional profitability to your practice.

Unfortunately, recently announced post-payment audits have created a climate of fear so that much of that profitability may be fleeting, as recoupments by a variety of Medicare and third-party auditors are setting new records. This month's DME for DPMs will review some of the Surgical Dressing LCD requirements and ways to improve your chances of surviving a surgical dressing audit.

The DME MAC recently announced that the results of post-payment audits for certain foam (A6212) alginates (A6196) and collagen (A6010) dressings revealed a post-payment audit failure rate that was greater than expected. The recently released 2020 Comprehensive Error Rate Testing (CERT) report ranked surgical dressings as number three in DMEPOS errors at approximately 67%. This error rate is estimated to project an improper payment just shy of $195M. The errors cited by both the DME MAC and CERT are often due to insufficient documentation, no documentation, and lack of medical necessity.

In an attempt to reduce these errors, the following, based on the Surgical Dressings LCD, provides a list of "Top Ten" reasons for failing a surgical dressing audit. Corrective actions necessary to avoid such errors are also provided.

***1) Location and number of wounds: The medical record must provide the location and number of wounds at each location.*** This is equally important if there is only one vs. several wounds. The number and location of every wound should be charted during each patient encounter. This is especially important when ordering and billing for surgical dressings.

***2) Size and depth of the wound. It is important to document the length, width, and depth of the wound.*** Order a dressing which most closely matches the wound size. Allowance of a small border is appropriate. Ordering a size which results in significant waste when a similar smaller size dressing is available can result in an overpayment and recoupment demand.

The depth of the wound should be classified according to its deepest depth and should include the depth to which it was either debrided and the actual depth of the wound (e.g., partial, full, fat, etc.). By providing both depths (they may be the same), your chart will reflect the requirements of both the surgical dressing LCD and that of the debridement of wounds LCD.

***3) Exudate: One can qualitatively state whether there is no, minimal, moderate, or high exudate.*** This may be based on how much the dressing absorbs and/or how often it may require changing. Observing the wound itself and the wound margins (e.g., macerated, dry, necrotic, and xerotic) can often provide some information on the "amount" of wound exudate.

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The surgical dressing LCD matches the appropriate dressing classification to the qualitative estimate of exudate. One example is not to order a foam dressing for a necrotic xerotic wound with minimal to no exudate. In this example, a hydrogel may be more appropriate.

***4) Status of the Dressing: State whether the dressing you order is primary or secondary.*** It may seem intuitive to you that the dressings you order to place on wounds are primary and those that hold that dressing opposed to the surface are secondary. However, Medicare does not view it that way. It is therefore important that your medical records document which dressing is primary (applied to the wound), and which is secondary. Medicare's rationale is that some dressings may be used as

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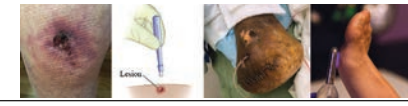

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both a primary or secondary dressing (e.g., sterile gauze).

***5) Frequency of dressing change and quantity of dressings: State how often the dressing is to be changed and how many pads, ccs, inches, etc. are to be used with each dressing change.*** Each class of dressing allows for a specific number of dressing changes and the quantity to be applied in a specific time period (day/week). Some insurances allow daily dressing changes, others three times a week, etc. The units (number) of primary or secondary dressings allowed to be applied per dressing change also vary by the dressing's classification and whether it is primary or secondary. The dressing being primary or secondary may also limit the quantity of dressings to be reimbursed.

***6) Expected duration of need: Most notes do not provide an estimated time of healing.*** It is the expectation that as the wound heals, there will be fewer dressing changes, and thus less quantity of both the primary and secondary dressings. If the wound is not progressing and a change in dressing change frequency or a change in the name or type of dressing is needed, your note must document the medical necessity. Medicare (and most third-party payers) allow for a 90-day allowance on the first order. However, because of expected frequency changes or the possibility one may need to change the type of dressing, it is much wiser to provide only a shorter 30-day order with two refills. At no more than a monthly interval, the wound should be assessed for the issues mentioned within this top ten list. Most commercial DME suppliers will not provide a 90-day supply. They will provide only a 30-day supply due to the Medicare policy.

***7) Date of Expected Need: Don't presume that the auditor assumes it starts on the date corresponding to the DOS of debridement.*** Most prescribers and suppliers wrongly assume that the Medicare auditor will assign the date of initial need for the surgical dressing as the date the order is located in the chart. Compliance with the Surgical LCD requires you to actually document the date the patient will require their first dressing application.

***8) Who is performing the surgical dressing changes? If the patient is not performing the dressing changes, state who and why.*** Third party payers want to be assured their money is being spent wisely. If the patient (or caregiver) is not reliable to perform dressing changes, it may be wiser to refer the patient to a Home Health Agency.

**Compliance with the Surgical LCD requires you to actually document the date the patient will require their first dressing application.**

***9) Presence of Infection: Certain dressings are incompatible with certain types of infection.*** This is important not only from the specific surgical dressing perspective, but to document medical necessity for the frequency of dressing changes.

***10) Type of Debridement: This was left for last but certainly is not the least important requirement. In fact, it may be the most important criterion required by the Surgical Dressing LCD.*** Some type of debridement is often required by your Part B LCD covering wound care CPT codes. Debridement of some type is also a requirement of the surgical dressing LCD. Wounds which qualify for surgical dressing must have undergone some type of debridement including autolytic, mechanical (e.g., whirlpool), sharp, chemical or enzymatic, ultrasound, or wet-to-dry. The date of debridement may be different than the date of medical necessity for a surgical dressing. Thus, the date of debridement must also be included in the medical record on the date one establishes the need for surgical dressings. The date of debridement must also be relevant to the date when surgical dressings are required.

Other less frequent reasons why practices fail surgical dressings audits include:

***Lack of use of the appropriate HCPCS code for the surgical dressing dispensed or incorrect use or absence of a modifier.***

The Surgical Dressings LCD requires the use of an A# modifier system to follow the HCPCS code for each surgical dressing, with the (#) indicating the number of wounds being treated by the surgical dressings. Often the number of wounds is not tabulated correctly. Upon audit, the claims examiner may determine that the quantity of dressings may not match the number of wounds and thus deny the claim.

***Dressings with multiple ingredients or specific ingredients may not be covered.*** It is important to know the list of multiple ingredient dressings, as some ingredients (if the majority component) are not covered.

Medicare considers dressings made primarily (by weight) of honey, silver, charcoal, copper, and iodine (other than iodoform packing) to be ineffective and non-covered. If the multi-component dressing is made primarily of any of the above components, then the dressing is considered non-reimbursable.

***PDAC approval for certain types of collagen dressings.*** Certain collagen dressings (A6021-A6024) must be PDAC approved. A listing of approved dressings may be found at: https://www4.palmettogba.com/pdac_dmecs/

***Failure to adhere to NSC requirements.*** A practice may also fail any DMEPOS audit for failure to obtain the following:

*1) Payment Authorization:* DME is different than medical/surgical services. Patients should be asked to complete an authorization for payment each time DME is dispensed.

*2) Written Proof of Delivery (WPOD)*: Should be obtained after each delivery.

*3) Supplier Standards, Complaint Protocol:* Should be provided

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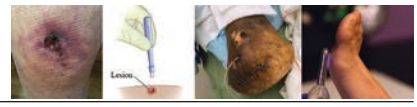

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at each encounter where a WPOD is obtained.

*4) Your signature and date:* These should be legible or electronic. They cannot be stamped.

***Non-FFS Medicare (Medicare Advantage, Medicaid and Medicaid Advantage and other third party payers).***

These carriers often have a wide variety of rules and regulations which may be quite different than FFS Medicare. Carve outs and separate enrollment as a supplier and inclusion of the surgical dressings as part of the debridement (when performed on the same date) are often problematic. Reimbursements are often so low as to make profitability elusive, and limited to only very large commercial entities which have a direct purchasing relationship with the manufacturer.

This article in not intended to provide a comprehensive review of a very lengthy and complex surgical dressings LCD, LCA and supplementary instructions article (SIA). These are all available in the policy section of each DME MAC home page. The reader is encouraged to frequently reference their DME MAC for this information.

Surgical dressings are expensive to purchase and have a slim profit margin. Many patients require surgical dressings for a protracted period of time. This creates the potential for enormous profit for an active wound care practice. Many commercial DME suppliers which provide large quantities of surgical dressings are quite successful because of their attention to detail and ability to purchase directly from the manufacturer.

Recoupment resulting from a failed audit can have devastating economic consequences to a practice. Studying the CERT audit news (https://cgsmedicare.com/jc/pubs/news/2021/04/cope21348.html) or the full CERT audit report (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Improper-Payment-Measurement-Programs/CERT) as well as avoiding the errors listed herein, will assist the reader in properly documenting the medical necessity for surgical dressings. **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.