Why Haven't You Started Dispensing Surgical Dressings?

Using these products can offer better patient outcomes and generate revenue for your practice.

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Physicians and surgeons everywhere are looking for ways to improve their patient care, but in times of decreasing reimbursements there is also the constant need to look at your costs and overhead. So when implementing programs to expand offerings to your patients, you also need these programs to help offset these rising costs and inflation. Some physicians have turned to selling products in-house for cash but along with that comes inventory management, returns, sales tax, etc., and sometimes only nominal profit margins. And sometimes pushing products can relegate the physician to become more of a salesperson than a doctor, selling devices that offer a profit of $20 or less.

One of the best ways to improve a practice's revenue is by finding services that are billable to insurances. Surgical dressings dispensed in your office can be rewarding in many ways, from streamlined patient care, better patient outcomes, and a revenue-generating service that can make dealing with wounds more fulfilling for practitioners.

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In 2023 Medicare data, primary surgical dressings were reimbursed by Medicare to a tune of:

A6010 Collagen $62,311,180

A6021 Collagen dressing < 16 sq in—$49,686,194

A6196 Alginate $39,441,988

A6212 Foam dressings, ≤ 16 sq in—$15,158,945

And this list is far from comprehensive, but it highlights the staggering amount of money paid out for these dressings.

Surgical dressings dispensed in your office can be rewarding in many ways, from streamlined patient care, better patient outcomes, and a revenue generating service that can make wound care more fulfilling for practitioners. Even for patients with co-pays and deductibles on these supplies, they often in the long run would *save* money on bandaging supplies when provided by their doctor, as opposed to purchasing supplies OTC for a prolonged period.

AND a surgical dressing dispensing program is not something that is only limited to wound care doctors. Foot and ankle surgeons should be aware that surgical wounds (or post-operative wounds) are a covered wound type for the surgical dressing

Continued on page 72

THE *PM* FORUM

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Surgical Dressings *(from page 71)*

benefit for most of their patients.

There is a growing trend where Payers generally prefer to pay for in-office wound care, due to lower costs for patients and generally less billed to insurers.

When implementing an additional surgical dressing program, benefits include:

- Dressing prescription ≤ can often be filled the same day
- Immediate access for the patient to start using the next day
- Less risk of delivery is-

Continued on page 73

FIGURE 1

Type of Dressing	Minimal Exudate	Moderate Exudate	Heavy Exudate	Usual Dressing Change
Alginate	Not Covered	Full Thickness		once daily
Collagen	Full Thickness		Not Covered	up to 7 days
Composite	Not Covered	Any		up to 3 times week
Contact Layer	Any			1 time week
Foam	Not Covered	Full Thickness		up to 3 times week
Gauze Impregnated	Any			once daily
Gauze Non-Impregnated (no border)	Any			3 times day
Gauze Non-Impregnated (border)	Any			once daily
Hydrocolloid (cover/filler)	Any		Not Covered	up to 3 times week
Hydrogel (no border)	Full Thickness	Not Covered		once daily
Hydrogel (border)	Full Thickness	Not Covered		up to 3 times week
Hydrogel Filler	Full Thickness	Not Covered		3 units per wound/per 30 days
Specialty Absorbative (no border)	Not Covered	Full Thickness		once daily
Specialty Absorbative (border)	Not Covered	Full Thickness		every other day
Transparent Film	Partial Thickness or Closed	Not Covered		up to 3 times week
Wound Filler	Any			once daily
Wound Pouch	Any			up to 3 times week
Zinc Paste Impregnated Bandage	Any			1 time week

Surgical Dressings *(from page 72)*

sues causing more delays in patients receiving their wound care supplies.

Studies from multiple health professional organizations show that across the board, patient compliance with treatment regimens goes up significantly when patients leave the physician's office with supplies in hand.

However, along with anything that gets paid for by insurances, there are audits and paperwork requirements. Surgical dressing documentation isn't a small matter, requiring focused attention to detail and coding regulations. It is advisable for any office, new or otherwise, to implement a simple but robust self-auditing program and documentation review. A Targeted Probe and Educate (TPE) Review from October 2024—December 2024 shows that, based on dollars, the overall claim potential improper payment rate is 40%. Improper rate, of course, isn't the same as not meeting medical necessity; it can often mean that the documentation requirements were not met.

Patient compliance with treatment regimens goes up significantly when patients leave the physician's office with supplies in hand.

A tip: If CGS is your carrier, for added reassurance to the practitioner looking to start a dispensing program, or for the provider who wants to have their current program's documentation reviewed: they provide a free and excellent pre-payment audit of your documentation that can help reduce risk of recoupments on future audits on your claim. This is a PRE-payment review, and takes around 10-14 business days. And using this service while starting out (or wanting a review of your current documentation) is a fantastic way to make sure you're being compliant in your documentation (to access scan the QR code at right).

Key Definitions

Per CMS:

"Primary dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin."

"Secondary dressing materials that serve a therapeutic or protective function and that are needed to secure a primary dressing are also covered. Items such as adhesive tape, roll gauze, bandages, and disposable compression material are examples of secondary dressings."

The Program and Qualified Wounds

Surgical dressings, a separate Medicare Part B benefit category in accordance with section1861(s)(5) of the Social Security Act, are defined in program instructions in Chapter 15, Section 100 of the Medicare Benefit Policy Manual (CMS Pub. 100-02).

Surgical dressings are covered when:

1) The necessity for a qualifying wound is met; and

2) The requirements are met for any product to be classified as a surgical dressing for purposes of coverage under this benefit.

Surgical dressings are limited to primary and secondary dressings required for the treatment of a wound:

1) Caused or treated by a *surgical procedure* that has been performed by a physician or other health care professional to the extent permissible under State law.

2) For which surgical dressings are required *after debridement* of a wound, as long as the debridement was reasonable and necessary and was performed by a health care professional acting within the scope of their legal authority when performing this function. Debridement may be of any type (surgical, mechanical, chemical, autolytic, etc.).

Providers should refer to their carrier's LCD for a more detailed explanation of bandage types and program limitations and should tailor their dispensing program to the physician's preferred bandaging types.

Non-Covered Wounds

Examples (not all-inclusive) of clinical situations in which dressings are noncovered under the Surgical Dressings benefit are:

- Drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure; or,
- A Stage 1 pressure ulcer; or,
- A first-degree burn; or,
- Wounds caused by trauma which do not require surgical closure or debridement—e.g., skin tear or abrasion; or,
- A venipuncture or arterial puncture site (e.g., blood sample) other than the site of an indwelling catheter or needle.

Quick Reference Guide

Figure 1 on page 72 is Noridian's quick reference guide on dressing types, exudate required, wound thickness, and the usual dressing changes. Providers should refer to their carrier's LCD for a more detailed explanation of bandage types and program limitations and should tailor their dispensing program to the physician's preferred bandaging types. (To access, scan the QR code at right.)

Continued on page 74

Surgical Dressings *(from page 73)*

Three Top Mistakes in Not Maximizing a Surgical Dressing Program

1) Some supplies are not billable to Medicare, but that does not mean other insurers won't pay for them. This refers to (but is not limited to) such products as sterile gauze used to clean the wound but that is not part of the bandage, as well as wound cleanser supplies.

2) Not dispensing multiple kits for multiple wounds. Patients with bilateral wounds or wounds on different anatomic sites of the same extremity will require a separate kit to appropriately dress.

The maximum quantity of each surgical dressing type that may be dispensed per wound is for 30 days.

3) Not ordering a primary dressing. If a primary dressing is appropriate it should be ordered—there are few situations where a wound would only need a secondary dressing like gauze and tape. These secondary dressing reimbursements are often nominal, and wouldn't be worth the staff time to dispense and bill in-house if they were the only things dispensed.

Top Denial Reasons

This list is not to be considered comprehensive of all the requirements for dispensing and billing surgical dressings, but rather to serve as a quick review of the top denial reasons by insurances.

1) Insufficient documentation. Medical record documentation does not contain current clinical information that supports the reasonableness of and the necessity for the type and quantity of surgical dressings provided. Examples: wounds not being diagnosed as full thickness, non-surgical wounds, and not having debridement documentation.

2) Dispensing for more than 30 days. The maximum quantity of each surgical dressing type that may be dispensed per wound is for 30 days. The MACs require that the documentation demonstrates that the medical necessity of dispensed surgical dressings be updated monthly IF the patient is using the product(s) for more than one month. The monthly (or weekly) required evaluation should include: wound type(s), wound(s) location, wound(s) size, wound(s) drainage quantity, and any other relevant wound status information.

3) Dressing Type does not match level of exudate. In addition to these general requirements for coverage of all surgical dressings, each surgical dressing type has its own individual coverage requirements. Make sure your documentation matches the level of exudate. For example, collagen dressings are for mild to moderately exudative

Continued on page 75

Surgical Dressings *(from page 74)*

wounds, alginates and foams are for moderately to highly exudative wounds.

4) Size of the wound does not match the dispensed products. Larger wound dressings pay more, but the size of the wound must meet the medical necessity of the dressing dispensed. For example:. using a 6x7in collagen matrix on a 2x2in wound, when there is a 2x2in collagen matrix available, could result in a take-back or denial.

5) Frequency doesn't add up. If you dispense 30 units of collagen particles for a month's supply, but your documentation states for the patient to change the bandage every other day, then the patient should have received 15 units of collagen particles.

6) Differentiating Primary vs. Secondary Dressings. It's clear primary dressings pay more. The majority of the time you can't dispense two primary dressings (e.g., collagen particles and a foam) for a single wound. Proper documentation should differentiate which of the dressings are primary, and which of the dressings are secondary bandaging to avoid denials.

Medicare statutorily does not cover some common items dispensed with surgical dressing kits. However, some private payers WILL pay for these items.

Modifiers Review

- Modifiers A1-A9 have been established to indicate that a particular item is being used as a primary or secondary dressing on a surgical or debrided wound and to indicate number of wounds on which that dressing is being used. Modifier number must correspond to the number of wounds on which dressing is being used, not total number of wounds treated. For example, if patient has four (4) wounds but a particular dressing is only used on two (2) of them, the A2 modifier must be used with the applicable HCPCS code.
- Modifiers A1-A9 are not used with HCPCS A6531 and A6532.
- Tape HCPCS A4450 and A4452 are used with surgical dressings and must be billed with AW modifier (in addition to appropriate A1-A9 modifier).
- RT and/or LT modifiers must be used with HCPCS A6531, A6532, and A6545 for gradient compression stockings and wraps.
- Suppliers must bill each item on two separate claim lines using the RT and LT modifiers and 1 UOS on each claim line.

Continued on page 76

Surgical Dressings *(from page 75)*

- KX modifier not for Medicare Claims, but some insurers may require
- If the patient is under hospice, if the condition being treated by surgical dressings is unrelated to the patient's hospice diagnosis, you will need to apply the GW modifier to all the billed items.

Non-Covered Items for Medicare

Medicare statutorily does not cover some common items dispensed with surgical dressing kits. However, some private payers WILL pay for these items, so it is recommended to learn your payer mix and bill it when appropriate, rather than leave money on the table.

- A6260—Wound cleanser, any type, any size
- Solutions used to moisten gauze (e.g. saline)
- A6402*—Sterile gauze, non-impregnated

*If it is incorporated into the bandage is a covered benefit, but is non-covered when only used to clean the wound.

- A6250 Skin Sealants or barriers
- A6205 Silicone gel sheetslow)
- Topical antibiotics/Topical antiseptics
- Elastic stockings, support hose, foot coverings, surgical leggings, gauntlets.

Summary

A surgical dressing program can be a challenging but rewarding compliment to any podiatric practice. Patients will benefit from receiving their care and supplies directly from the team that understands their treatment plan best. If you're already writing the orders and following up, keeping it in-house just makes sense—clinically and financially. PM

Helpful Links

To access each website below, please scan the adjacent QR codes.

Noridian Surgical Dressing

CGS Surgical Dressing

Medicare LCD L33831 Surgical Dressings

Medicare Policy Article A54563 for Surgical Dressings

Standard Documentation Requirements for All Claims Submitted to DME MACs

If it's not documented, it didn't happen! As well as the documentation requirements listed in the above LCD and Articles, there's an additional policy Article A55426 for ALL the DME MACs that needs to be reviewed.

Medicare (CGS) Provided Documentation Checklist

CGS puts out a comprehensive checklist for you to review your documentation; we highly recommend periodically reviewing your documentation with this checklist because it is what is used when audited.

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Note: *This article was written with the assistance of Dr. Paul Kesselman.*

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