PHYSICIAN BILLING INFORMATION FOR HYDROGELS

For a hydrogel to be eligible for reimbursement the Form 1500 must have:
1. HCPCS code A6248
2. “A” 1-9 modifier usage
3. POS = 12

PROCESS:

1. Complete a surgical procedure that creates a break in the skin (e.g. punch biopsy, wart removal, etc.)
   OR
   Debride an existing wound using autolytic, enzymatic, mechanical, or sharp debridement

2. Apply the hydrogel to the wound base. Note: Any dressings or hydrogel placed on the wound while the patient is in the office are considered part of the surgical or debridement procedure and are not billable.

3. Provide the patient with the remaining tube of hydrogel so the patient can continue to use it in their home. Medicare covers dressings used in the patient's home if they are used on wounds as a result of “Surgical Procedures” or “Debridement.”

4. Submit an appropriate ICD9 code and complete the HCFA 1500 form using CPT/HCPCS code A6248 plus an “A” modifier 1-9 for the number of wounds treated, and POS=12. Include date of service, charges and Units 3 for 3oz tube See attachment for additional information.

OTHER IMPORTANT INFORMATION

- Some hydrogels such as SilvrSTAT™ can be used as an autolytic debridement agent. Thus a 30 day supply (3 oz tube) for a patient's home use will meet the billing criteria.
- The maximum billable amount of a hydrogel for home use is 3 ozs. per wound, per 30 days.
- The maximum allowed reimbursement for hydrogels using the A6248 code is approximately $17.44-$21 per oz. or $52.32-$60 for 3 ounces. Please check with CMS for the exact reimbursement allowed in each state.
- Therefore, when you purchase a 3 ounce tube of a hydrogel such as SilvrSTAT for $35.18, the practice would net $17.14 for each tube given to the patient for use at home.
- And on a case of 12 tubes at a cost of $422.16, the practice would profit $205.68
HCPCS CODING GUIDANCE FOR HYDROGEL DRESSINGS

The Centers for Medicare & Medicaid Services (CMS) have assigned the following Medicare billing code: **A6248 Hydrogel Dressing, wound filler, gel, per fluid ounce.**

**COVERAGE AND PAYMENT RULES:**

For any item to be covered by Medicare, it must (1) be eligible for a defined Medicare benefit category, (2) be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member, and (3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for “reasonable and necessary” are defined by the following indications and limitations of coverage and/or medical necessity.

Surgical dressings are covered when either of the following criteria is met:

1. They are required for the treatment of a wound caused by, or treated by, a surgical procedure
   
   **OR**

2. They are required after debridement of a wound.

Surgical dressings include both primary dressings (i.e., therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin) or secondary dressings (i.e., materials that serve a therapeutic or protective function and that are needed to secure a primary dressing).

The surgical procedure or debridement must be performed by a physician or other healthcare professional to the extent permissible under State law. Debridement of a wound may be any type of debridement (examples given are not all-inclusive): surgical (e.g., sharp instrument or laser), mechanical (e.g., irrigation or wet-to-dry dressings), chemical (e.g., topical application of enzymes), or autolytic (e.g., application of occlusive dressings to an open wound). Dressings used for mechanical debridement, to cover chemical debriding agents, or to cover wounds to allow for autolytic debridement are covered although the agents themselves are non-covered.

Surgical dressings are covered for as long as they are medically necessary.

Examples of situations in which dressings are non-covered under the Surgical Dressings benefit are:

a. Drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure; or
b. A Stage I pressure ulcer; or
c. A first degree burn; or
d. Wounds caused by trauma which do not require surgical closure or debridement - e.g., skin tear or abrasion; or
e. A venipuncture or arterial puncture site (e.g., blood sample) other than the site of an indwelling catheter or needle.
IMPORTANT NOTE: Surgical dressing codes billed without modifiers A1-A9 (see Coding Guidelines) are non-covered under the Surgical Dressings benefit.

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 also to indicate the number of wounds on which that dressing is being used. The modifier number must correspond to the number of wounds on which the dressing is being used, not the total number of wounds treated. For example, if the patient has four (4) wounds but a particular dressing is only used on two (2) of them, the A2 modifier must be used with that HCPCS code.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Dressing for one wound</td>
</tr>
<tr>
<td>A2</td>
<td>Dressing for two wounds</td>
</tr>
<tr>
<td>A3</td>
<td>Dressing for three wounds</td>
</tr>
<tr>
<td>A4</td>
<td>Dressing for four wounds</td>
</tr>
<tr>
<td>A5</td>
<td>Dressing for five wounds</td>
</tr>
<tr>
<td>A6</td>
<td>Dressing for six wounds</td>
</tr>
<tr>
<td>A7</td>
<td>Dressing for seven wounds</td>
</tr>
<tr>
<td>A8</td>
<td>Dressing for eight wounds</td>
</tr>
<tr>
<td>A9</td>
<td>Dressing for nine wounds</td>
</tr>
<tr>
<td>AW</td>
<td>Item furnished in conjunction with a surgical dressing</td>
</tr>
<tr>
<td>EY</td>
<td>No physician or other licensed health care provider order for this item or service</td>
</tr>
<tr>
<td>GY</td>
<td>Item or service statutorily non-covered or does not meet the definition of any Medicare benefit</td>
</tr>
<tr>
<td>LT</td>
<td>Left side</td>
</tr>
<tr>
<td>RT</td>
<td>Right side</td>
</tr>
</tbody>
</table>

If dressing changes are sent home with the patient, claims for these dressings may be submitted to the DMERC. In this situation, use the place of service corresponding to the patient's residence (POS=12); Place of Service Office (POS=11) must not be used.

Surgical dressings must be tailored to the specific needs of an individual patient. When surgical dressings are provided in kits, only those components of the kit that meet the definition of a surgical dressing, that are ordered by the physician, and that are medically necessary are covered.

The following are some specific coverage guidelines for a hydrogel dressing when the product itself is necessary in the individual patient. The medical necessity for more frequent change of dressing must be documented in the patient's medical record and submitted with the claim to the DMERC (see Documentation section).

Hydrogel dressings are covered when used on full thickness wounds with minimal or no exudate (e.g., stage III or IV ulcers). Hydrogel dressings are not usually medically necessary for stage II ulcers. Documentation must substantiate the medical necessity for use of hydrogel dressings for stage II ulcers (e.g., location of ulcer is sacro-coccygeal area). Usual dressing change for hydrogel wound covers without adhesive border or hydrogel wound fillers is up to once per day.

The quantity of hydrogel filler used for each wound must not exceed the amount needed to line the surface of the wound. Additional amounts used to fill a cavity are not medically necessary. Documentation must substantiate the medical necessity for code A6248 billed in excess of 3 units (fluid ounces) per wound in 30 days.

Use of more than one type of hydrogel dressing (filler, cover, or impregnated gauze) on the same wound at the same time is not medically necessary.
SPECIFICS FOR COMPLETING HCFA 1500 FORM

1. Box “11” must have “NONE.”
2. Box “17” must have your name or the referring physician’s name.
3. Box “17a” must have the UPN# of the physician in Box 17.
4. Box ”21” requires a diagnosis code. While coding is patient specific, the following are examples of ICD-9 codes associated with hydrogels. ICD-9 893.0 (Open wound), ICD-9 681.11 (Onychia and paranychia of toe), ICD-9 703.0 (Ingrown nail) with ICD-9 681.11 as a secondary diagnosis or ICD-9 707.10 (ulcer, chronic, lower limb).
5. Box “24A” is the date of service the patient receives the product for home use.
6. Box “24B” Place of Service is ALWAYS home, noted as “12.”
8. Box “24D” “MODIFIER” record the number of wounds; A1 for one wound, A2 for two wounds, A3 for three wounds, etc. If this modifier is not filled in, then it will result in a denial.
9. Box “24F” total amount of “$ CHARGES.”
   If you are dispensing 3 ounces (units) of a hydrogel for one wound (A1), for a thirty day period, then your total charges would be $52.32.
   For Example - (Retail Price) X (# of tubes dispensed) = ($ Charges [Box 24])
   $17.44 X 3 units = $52.32
10. Box “24G” documents the number of units (ounces) of hydrogel dispensed to the patient.
11. Box “31” must have the date and physician signature.