Management of Wound Care Patients by Championing Policy Changes

Martha R Kelso, Chief Executive Officer Wound Care Plus, LLC

Martha Kelso is the Chief Executive Officer of Wound Care Plus, LLC, the largest mobile wound care provider in the Midwest. With over 20 years of experience in advanced wound care, Kelso is a visionary and entrepreneur in the field of mobile medicine. Ms. Kelso and her team have a relentless passion for education as a vehicle to elevate the art and science of wound healing. They have educated thousands of health care professionals and caregivers, not just on the practicalities of wound care, but also on federal regulations and national guidelines. Ms. Kelso is a published author, clinical editor for peer reviewed publications and a member of several national advisory boards. She is frequently called upon as a legal expert witness and has been a speaker at hundreds of educational events. Ms. Kelso is widely recognized as being a pioneer in the advanced wound care arena who works tirelessly to shape the future landscape of healthcare. Martha Kelso is a consultant for 3M.

Operating a mobile wound care group across multiple places of service (POS) and various care settings is not for the faint of heart. The challenges in extended care are varied and complicated. Understanding the challenges can be rewarding and essential to providing appropriate and adequate care to the patients we serve regardless of the place in the healthcare continuum in which one chooses to practice.

The procedures and treatments healthcare providers are allowed to perform, along with reimbursement for that treatment, will vary depending on the site of care. Procedure coverage is not universal across care settings and procedures may be precluded based on the care setting. Additionally, insurance companies may restrict the type of wound healing modalities they are willing to cover, along with the frequency of coverage and length of time for the coverage. Furthermore, modalities may only be covered for certain wound types versus all wound types. Knowing the limitations and boundaries based on the patient's care setting, type of wound and level of reimbursement coverage is imperative when formulating an appropriate treatment plan.

By using this intimate knowledge of how and when to deploy the appropriate treatment tools to manage chronically stalled wounds, the wound care clinician is often a resource and champion for the patients and community being served. This knowledge and advocacy for the patient can mean the difference between amputation versus limb salvage. It can also mean the difference between treating a chronic maintenance wound, versus advancing a wound to complete closure. To your patient, your knowledge and command of the treatment algorithm means everything.

KNOW YOUR DENIAL REASONS

One of the key strategic metrics that a mobile wound care group may commonly review is the denial report. For example, if a practice receives this denial: "the procedure code/ type of bill is inconsistent with the place of service", then the clinician may be performing a procedure that the payor will not allow or, perhaps, currently cover in the place of service in which it was performed. Most likely, this is one of two problems. Either that procedure is precluded from being performed in the care setting in which it was performed, or the wrong place of service code has been reported with that procedure code. These can be easy fixes, but they can also be permanent problems. The only way to know for sure is to review the payor's current policies or reach out to the payor directly.

One such denial example would be performing muscle or bone debridement in extended care settings. In most Medicare Administrative Contractor (MACS) areas, Medicare has stated that muscle or bone debridement must be performed at an ambulatory surgery center (ASC), outpatient wound center, or inpatient acute hospital/operating room. This is a complex procedure that could cause significant negative outcomes if something should go wrong. Additionally, a muscle or bone debridement may require anesthesia or other treatment approaches that only hospitals would have access to compared with extended care settings, like assisted living facilities or nursing homes. The result is that performing muscle or bone debridement would be inappropriate in an extended care setting with little chance of reimbursement being successfully achieved.

Various nuances regarding procedures across sites of care should be noted, and in most cases, implemented in to practice. However, sometimes being aware of these variances and notifying the carrier if denials for certain procedures does not make sense can result in a policy change, particularly if the carrier was not aware that the procedure codes were denying based on place of service and this was not the carrier's intent.

COMMUNICATE WITH PAYORS

In our practice, we noticed that muscle and bone debridement was denied for the inpatient rehabilitation facility (IRF) site of care for one of the MACS in which we currently operate. In examining other claims for the same care setting for Medicare beneficiaries, it became obvious that this had been going on for a few months (or longer). The team of aging specialists reviewed local and national coverage determinations put forth by Medicare to determine if guidance or language from this payor could help explain the issue. No publicly available information in the Medicare coverage database explained the rationale for this denial, so an email was sent directly to Medicare asking for clarification or for the code to be covered in this care setting. In about a week, a policy development coordinator from Medicare responded with a favorable decision indicating that muscle and bone debridement would now be reimbursed in an IRF care setting.

As a healthcare professional, it is my belief that it is our collective duty to be good stewards of healthcare for our patients by petitioning payors to allow certain procedures in specific care settings to allow wounds to heal in an optimal fashion. Although it is a role I fell in to quite by accident, it is something I enjoy getting involved with and have made many significant policy changes, particularly during the pandemic that allowed our patients better

access to quality care and advanced modalities, which had previously been denied.

Although payors may reject our requests, it is our ability to advocate for patients with perseverance that often brings about the most satisfying change in the healthcare system. Our group has made more than 20 requests and approximately 85% of our requests have been granted. We celebrate each success with joy and enthusiasm, as does the wound client that needs those modalities to heal.

SPEAK UP AND SPEAK OUT

On occasion, however, petitioning payors for change can result in situations where the concerns being raised may not be uniformly shared across other practices, which can result in coverage refusal. By bringing awareness to other healthcare providers about an issue, the collective effort to speak up for change becomes stronger and can result in practice changes that, ultimately, benefit patients.

In the attempt to petition for one such change, the Medical Director of a state-operated Medicaid plan responded to a request stating they had not received "enough" requests from providers requesting a change. Any stimulus for change would require more providers submitting their request in order to be considered. As you can imagine, we are reaching out to other groups in that state to submit requests in writing to allow the "stimulus" for change so the Medicaid recipients can have access to this advanced modality.

MANUFACTURERS NEED OUR HELP

Healthcare providers often rely on manufacturers to help secure coverage or assist with policy changes that impact reimbursement of services and access to care. Although manufacturers play an important role in the overall process of expanded coverage and access, payors often rely on the provider's perspective in considering policy changes.

Of course, it is important to appreciate that the suggestion is not that payors should cover all products all the time. However, our experience demonstrates that expanded coverage and access for new modalities, products and in varied care settings demands proactive communication with payors. Payors should hear from clinicians about the real-world evidence that is generated and the suboptimal outcomes that patients are achieving in the current environment. An important takeaway from our group's experience is that legislators and policy makers need to hear from the community clinicians who are on the front lines of patient care in order to truly understand the scope of the problem and the impact that small changes to policy can make in the lives of patients.

On occasion, Medical Directors make the decisions on what should be allowed and why. Medical Directors like to hear from medical people with real world experience treating insured patients with wounds. A petition should include a medical synopsis of an unnamed patient case example with photos to help illustrate why the change needs considered. When using experience coupled with necessity to help shape policy, medicine and wound healing can prevail.