



Pulling up the Pants Leg



You don't want to miss managing your diabetic patients' venous leg ulcers

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Practice Management Pearls is a regular feature that focuses on practice management issues presented by successful DPMs who are members of the American Academy of Podiatric Practice Management.

One of the paradoxical things in podiatric practices across the country is the propensity for doctors to miss pathology that is right in front of them, hiding right under their patients' pants legs in the form of venous insufficiency or venous-related leg ulcers. Missing this phenomenally common pathology not only costs your patients dearly, it will also result in tens of thousands of dollars of lost revenue in your practice over the course of a year. Considering the reimbursements associated with wound debridement to the excellent compensation with dispensing wound care products or compression garments (both of which are considered wound care products covered by Medicare), treating and managing venous leg ulcers pays well. But your patients will be the biggest winners when you start looking for and assessing this debilitating condition.

Leg and foot ulcers in diabetic patients have three common underlying causes: venous insufficiency, peripheral neuropathy, or peripheral arterial occlusive disease. With this in mind, as experts in wound care and the management of diabetic ulcers, we often walk in to our diabetic patients' rooms and fail to even bother pulling up their pants legs to evaluate the presence of edema or ulceration. It goes without saying that careful examination of vascular and neuropathic status is im-

portant for the proper assessment and management of venous leg ulcers.

When speaking of any lower extremity ulceration, the best treatment is prevention. Management of edema should be instituted before the development of ulceration. Mechanical therapy is the gold standard for treatment of venous insufficiency. Elevation of the legs above the level of the heart for 30 minutes three or four times daily may reduce edema and improve the cutaneous microcirculation. Elevation of the legs while sleeping at night can also reduce leg swelling; howev-

setting of venous ulceration. Multi-layered compression bandages are also effective at reducing edema initially in the event of a large or deeper venous ulcer, but patients must be told that compression garments will be required for the long term.

Compression should generally not be used in the setting of peripheral arterial disease or uncompensated congestive heart failure. Although compression therapy is the key to venous ulcer treatment, some patients require adjunctive therapy to attain ulcer healing. In addition, some pa-

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er, compression stockings are the gold standard method of edema management, particularly in the active patient.

Compression Garments

Compression garments are also the mainstay of treatment once a venous ulcer develops and in the cases of those with an active venous ulcer, compression garments that achieve 30-40 mm HG are covered by most insurances.

Compression stocking use in compliant patients increases the ulcer-healing rate and can significantly reduce the rate of recurrence.¹ Compression therapy is believed to exert its positive effect on venous ulcers by increasing fibrinolysis, reducing venous hypertension, and improving the cutaneous microcirculation. Stockings exerting a pressure of 30 to 40 mm Hg are typically used in the

patients have venous ulcers combined with arterial occlusive disease, making excessive compression therapy a hazardous intervention.

Chronic venous insufficiency affects up to 50% of the adult population, and it is estimated that 1% of individuals will suffer from venous leg ulceration during their lifetime.^{2,3} Correctly applied compression therapy is the cornerstone of treatment and has been demonstrated to improve healing rates in patients with existing venous leg ulcers (VLUs) and to reduce ulcer recurrence.^{4,5} Compression therapy is often used sub-optimally in practice because of a lack of knowledge of what products are available for patients who are unable to put on traditional hose or stockings. Suboptimal care also results from the physician's inability or awareness to stock and

Continued on page 86



Pants Leg (from page 85)

carry compression garments in their offices for immediate treatment and management.

In our office and retail center, we carry the following brands of compression garments for a variety of different venous conditions and leg sizes. For those who are able

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to pull on traditional compression socks, we stock both 20-30 and 30-40mm Hg grade Medi, Jobst, and Juzo. We also carry and sell donning devices that can significantly help patients don compression hose. For those who have an active wound on their leg(s), 30-40mm Hg garments are billed with the modifier AW with the code A6531.

For the wide majority of our diabetic (and non-diabetic) patients with venous leg ulcers, traditional compression socks are not indicated, requiring instead a Velcro style garment like the new AmerX Extremity-Ease garment

(with zipper and short stretch Velcro bungee cords), or the Farrow Compression garment. These types of garments make donning compression hose MUCH easier, and they also are covered by the presence of an active wound (AW) with the code A6545.

When billing for any compression garment (traditional or Velcro wrap), the documentation of a venous stasis ulcer is mandatory. Additionally, the prescribed garment must achieve a minimum of 30-40mm HG. When a gradient compression wrap is used for an open venous stasis ulcer, the A6545 code must be billed with the AW modifier. If there is no open ulcer, the AW modifier must not be used. Claims for code A6545 without an AW modifier will be denied as statutorily non-covered.

The right (RT) and left (LT) modifiers must also be used with this code.

When the same code for bilateral items (left and right) is billed on the same date of service, bill both items on the same claim line using LTRT modifiers and the quantity of the dressings being dispensed. Claims filed without RT and/or LT modifiers will be denied as incorrect coding. While the posted fee schedule for A6545 is \$92.23 for all states, coverage is limited to one compression garment per leg every six months.

While the LCD for the utilization of these devices requires the presence of a venous ulcer, the author will oftentimes start with an Unna Boot with local wound care to address the initial needs of the venous ulcer, then transition to a Velcro graduated compression garment to help facilitate final healing.

Bottom Line

Compression therapy undoubtedly improves outcomes for patients with current and healed venous leg ulcers. Stocking your office with these products and understanding how compression therapy works will help prevent venous ulcers and the disability associated with infection and potential limb loss. Start pulling up your patients' pants and start being proactive in the prevention and maintenance of venous leg disease. **PM**

References

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