Healing wounds requires adequate circulation, no infection, offloading, and regular debridement (Figure 1). But after all that, dressings are useful to protect and maintain the wound environment to facilitate healing. It would be too presumptuous to assume that the wound dressing independently achieves healing. But dressings serve several important purposes. The main functions of a dressing are to absorb exudate, prevent infection, splint the wound area, and for psychological comfort.

The decision about which dressing to use is complicated by the setting (hospital, clinic, skill nursing facility, home care, or home) due to the formulary, the payer, and the ability for a patient or caregiver to independently apply the dressing. Physicians may also find the decision process daunting since there are more than 1,000 products on the market used for wound dressings.

The process, however, can be made simpler by considering dressings in categories, as generics, instead of brand names. Figure 2 is a table of common dressing categories and a list of brands in each. In a hospital, skilled nursing facility, or on home care, formularies might be fairly restricted. Therefore, prescribing a brand-name dressing that is not on formulary causes delay before a suitable substitute is used. Physicians do not often mind if a pharmacist substitutes a generic for a brand name antibiotic, and the same should be true of dressings. In reality, dressings in the same category, silver alginate for example, would require thousands of patients in a randomized controlled trial of human subjects to prove any.
albeit small, clinical difference. In order to avoid delays in faxes back and forth between facilities and physicians to approve a substitute, physicians should use generic categories in their prescriptions, especially for home DME use.

The use of dressings is considered part of the global care of a patient as a hospital inpatient, or in an outpatient clinic, skilled facility (except Medicare Part B patients), physician’s office, and with home care. Dressings cannot be billed separately for collection. The good news is that most categories contain equivalent dressings; these entities can streamline their formularies to create cost-effective options for use with one dressing from each category. Prescribers who allow generic substitutions will find that confusion and delays are kept to a minimum.

In the case of dressings for home use (not home care), where a patient or caregiver applies the dressing, due to reimbursement issues, dressing prescriptions must follow these steps. A dressing prescription has 3 basic parts, which are necessary for third-party payers; the diagnosis, the medical necessity information, and the prescription.

Dressing Prescription
A dressing prescription should include the diagnosis. Documentation of the wound diagnosis and etiology by ICD-10 code helps to determine eligibility for third party payers, including the government payers Medicare and Medicaid.

Certain medical necessity information is also required. Payers require the size of the wound with each prescription. This helps determine the appropriate size of the dressing. Payers will also want to know the amount of drainage as: none, mild, moderate, heavy. Certain dressings, like foams, are restricted to wounds with moderate or heavy drainage. Conversely, collagens are not reimbursed for wounds with heavy drainage.

Finally, the actual prescription for the dressing is needed. Wound dressings can have three layers (primary, secondary, and tertiary) and adjuncts (like tape and saline). Primary dressings are in contact with the wound bed. These are typically non-adherent dressings, collagens, or alginates. A primary dressing might also cover a graft, like a skin graft or a biologic. A secondary dressing is used to absorb exudate and support the primary dressing. This can be simple gauze, or a foam if there is moderate or heavy drainage. A tertiary dressing is usually a type of wrap, like thin or thick roll gauze, a conforming bandage, a cohesive bandage, or a multilayer compression dressing.

In some cases, a dressing can serve as more than one layer. For example, a bordered foam dressing can cover a collagen and be a secondary and tertiary layer, or it can be used alone and be all three layers.

Many dressings, like collagens, alginates, and foams, can have silver added to aid in killing bacteria.

A dressing prescription has 3 basic parts, which are necessary for third-party payers: the diagnosis, the medical necessity information, and the prescription.
Wound Dressings (from page 92)

Gauze is used, the tape can solely contact the dressing, leaving the skin unaffected. In these cases, plastic or cloth tape can be used. If tape is to be used on the skin to border a dressing, a gentle option is needed. Paper tape is a good, inexpensive one. Soft fabric tapes and silicone tapes are very gentle, but more costly. Silicone is now common as a contact layer under foam and is used to affix the foam border to the skin.

The frequency of dressing change is sometimes confused by manufacturer recommendations. There is little science behind how often a dressing should be changed. Instead, it should be changed as often as it needs to be changed based on drainage and local wound conditions. The frequency of dressing changes may vary frequently as some patients’ wounds fluctuate in the amount of drainage depending on their activity and limb dependency. If a dressing is ordered to

Continued on page 96

<table>
<thead>
<tr>
<th>WOUND TYPE</th>
<th>No or Mild Drainage</th>
<th>Moderate Drainage</th>
<th>Heavy Drainage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Foot Ulcer</td>
<td>Primary: Collagen (1) Secondary: Gauze</td>
<td>Primary: Collagen (1) Secondary: Foam (1,3)</td>
<td>Primary: Alginate (1) Secondary: Foam (1,3)</td>
</tr>
<tr>
<td></td>
<td>Tertiary: Roll gauze (2)</td>
<td>Tertiary: Roll gauze (2)</td>
<td>Tertiary: Roll gauze (2)</td>
</tr>
<tr>
<td>Venous Leg Ulcer</td>
<td>Primary: Nonadherent (4) Secondary: Gauze</td>
<td>Primary: Alginate (1) Secondary: Foam (1,3)</td>
<td>Primary: Alginate (1) Secondary: Foam (1,3)</td>
</tr>
<tr>
<td></td>
<td>Tertiary: Roll gauze (2)</td>
<td>Tertiary: Multilayer compression</td>
<td>Tertiary: ABD and multilayer compression</td>
</tr>
<tr>
<td>Graft or Biologic Covering</td>
<td>Primary: Nonadherent (4) Secondary: Gauze</td>
<td>Primary: Nonadherent (4) Secondary: Foam (1,3)</td>
<td>Primary: Nonadherent (4) Secondary: Foam (1,3)</td>
</tr>
<tr>
<td></td>
<td>Tertiary: Roll gauze (2)</td>
<td>Tertiary: Roll gauze (2)</td>
<td>Tertiary: ABD and roll gauze (2)</td>
</tr>
<tr>
<td></td>
<td>Tertiary: X</td>
<td>Tertiary: Roll gauze (2)</td>
<td>Tertiary: ABD and roll gauze (2)</td>
</tr>
</tbody>
</table>

1. Also supplied impregnated with silver
2. Supplied thin (Kling), thick (Kerlix), or cohesive bandage (Coban)
3. Foams are also supplied as a nonadherent and bordered
4. Nonadherents can be silicone or petroleum-based

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Figure 3
Many products only have in vitro/benchtop studies that should not be relied upon due to inherent bias.

Wound Dressings (from page 94)

be changed every other day, and it is dry upon each dressing change, it can be extended to every three days or two times a week. Conversely, dressings that are soaked with drainage should be changed more frequently, as often as necessary to avoid maceration and infection. This might result in multiple dressing changes per day, despite the fact that payers will typically only reimburse for enough supplies to change a dressing once daily.

Examples of dressing combinations that are frequently used for various ulcers by etiology and amount of drainage can be seen in Figure 3. Clinicians are inundated with product options nearly daily, with company representatives visiting the office and promoting dressings that have little or no clinical studies of efficacy. Many products only have in vitro/benchtop studies that should not be relied upon due to inherent bias. Many times, physicians delegate this decision of which dressing to use to a nurse or staff member. But physicians who prescribe dressings by category can help to organize their knowledge of dressings, make better choices for patients, and limit frustrations by avoiding numerous callbacks asking for permission to substitute on formulary. Ultimately, patients benefit by their doctor having a larger role in their care and making the choice of appropriate dressing.

References


Dr. Rogers is a fellowship-trained podiatrist in wound care and diabetic limb salvage. He is board certified by the American Board of Podiatric Medicine and holds a Certificate of Added Qualification in Wound Care and Amputation Prevention. He is the medical director of Advanced Tissue, LLC, a company supplying dressings at home for patients.