Defining appropriate CAMPs administration: a response to the Medicare wastage guidance

The recent change in the Centre for Medicare and Medicaid Services (CMS) physician fee schedule (PFS) to reclassify cellular, acellular and matrix-like products (CAMPs) as an incident-to-supply has created confusion about the appropriate use, administration and documentation of this technology. There is particular uncertainty about how to interpret the terms 'wastage', 'administered' and 'discarded' in relation to CAMPs usage and the implications for reimbursement. CMS regards incident-to-supply items as an integral, but incidental part, of a clinician's service.

The consternation relates to the following answers by CMS in its frequently asked questions section for the JW modifier and JZ modifier policy:[1]

- 'As long as the discarded amount is accurately documented, CMS does not dictate how it is calculated.'
- 'Under Medicare Part B, the JW and JZ modifiers are only used when billing for drugs and biologicals, which are separately payable. The JW and JZ modifiers are not appropriate for billing incident-to supplies, even if such incident to supplies are payable separately.'
- 'In addition, discarded amounts of incident-to supplies are not payable by Medicare.'
- 'Non-BLA skin substitutes are no longer payable under Medicare Part B as a drug or biological as of January 1, 2026, and only the administered portion is payable.'
- 'If a provider or supplier administers a portion of a non-BLA skin substitute from the package or container and a portion is discarded, the provider or supplier may only bill for the units administered. It is not appropriate to bill Medicare for such discarded units under any circumstance.'

However, the clinical reality is that hard-to-heal wounds that have not responded to standard of care have a diverse three-dimensional topography. The traditional two-dimensional length × width measurement fails to capture the true three-dimensional area and topography of most wounds. In practice, a larger sized CAMP product might be needed than the initial length × width measurement indicated. Hence, the uncertainty about how to define 'wastage' and anxiety about the risk of clawbacks.

Clinicians need to regain confidence to continue using CAMPs to promote healing in recalcitrant wounds. Doing so will require greater clarity on how to demonstrate medical necessity, ensure appropriate CAMP size selection, and avoid excessive product utilization. To advance this work, the *Journal of Wound Care (JWC)* convened an expert panel in February 2026, sponsored by BioLab Holdings (US), Kerecis (US), and Swift Medical (Canada), to develop guidance on these issues. The panel's objectives were to define CAMPs administration, help shield clinicians from payer clawbacks, and promote consistent documentation in line with Medicare policy.

The panel recommendations will be published in a *JWC* Position Document later this year. In the meantime, the panel co-chairs are delighted to release the key panel recommendations.

Definitions

- **Waste**: this term originates from drug and biologic policies and so does not align statutorily with incident to supplies. Its use in relation to CAMPs is a misnomer]
- **Therapeutic treatment area (TTA)**: given the inadequacy of 'wound surface area' to describe the wound topography and therefore the amount of CAMP needed for effective treatment, the panel proposes that, instead, the 'therapeutic treatment area' should be determined to calculate product size required
  - The panel defined the TTA as the total amount of CAMP needed to adequately treat the wound: the internal wound area plus the fixation edge.
  - **Requirement**: the CAMP must be applied in accordance with its instructions for use (IFU). Its use must be justified as based on medical necessity. This must be specified in the patient's record: thorough and consistent document is required
- **Administered product**: the portion of CAMP that is applied to the TTA, based on clinical assessment, medical necessity and in line with the product's IFU
- **Discarded product**: the remaining, unused portion of product that is not applied to the patient
- **Over-utilization/under-utilization**: defines inappropriate use, such as of an oversized CAMP without justification and/or avoidable excess, or of a CAMP that does not cover the entire wound bed, thereby compromising healing.

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Key recommendations and statements

Overall guidance

- Appropriate CAMP administration relies on accurate wound assessment of the wound's three-dimensional topography and clinical judgment, not just mathematical formulas
- Manufacturers should be encouraged to produce a wider variety of CAMP sizes that are more appropriate for typical wound dimensions to help reduce the amount discarded
- The most efficient sized CAMP available at the time should be used, taking into account any practice constraints and the patient's personal, religious, and societal preferences
- Although audit defence is critical, the primary focus must be to ensure medical necessity and provide optimal patient care
- Clinicians and industry need to stop using the term 'waste' as, under the new incident-to-rules, it is not a statutory concept. The narrative should focus instead on the area onto which the CAMP is administered
- The reality is that wounds are three-dimensional. A two-dimensional length × width measurement drastically underestimates the required CAMP size for a deep wound, potentially leading to inappropriate under-utilization claims by auditors
- A CAMP needs an edge to be secured properly. The typical overlap is 0.5–1.0cm, but some flexibility is required, depending on the wound characteristics, tissue quality, wound location and fixation method (for example, negative pressure wound therapy (NPWT) can push the CAMP into crevices)
- Auditors often insist that CAMPs must be surgically anchored. Fixation methods such as adhesive strips, contact layers and NPWT bolstering can be used, provided they comply with the IFU
- These recommendations cannot cover every clinical scenario. Clinicians should use free-text documentation to justify unusual situations, such as use of a larger CAMP because it was the most efficient size available, the most clinically appropriate option, or the only size available on the formulary/mobile kit. Measurements must be taken post-debridement.

Achieving accurate measurements

- The two-dimensional length × width measurement is an oversimplification for wounds with depth, tunnelling, or irregular contours
- CMS does not require a single method for measuring the wound size, but consistency and accuracy are required. Options include:
  - Drape/tracing method, three-dimensional imaging that can capture the TTA, planimetry, or manual measurements that adjust length and width to account for depth.
  - Tunnelling and undermining: appropriate wound bed preparation must be performed. Rather than laying or stuffing a sheet graft into an undermined area (which is often considered off-label), the recommendation is to undertake surgical site preparation. This could involve excising the undermined tissue so the CAMP can make direct contact with the healthy wound bed. A clinician might remove most of the undermined tissue (75%), but leave the wound intact, depending on tissue quality and patient tolerance
- Avoid packing traditional sheet grafts into lengthy tunnels. The CAMP should not be rolled up, layered, or packed into significantly undermined spaces; this can violate some product IFUs and could trigger a CMS denial.

Clinical application and fixation

- The primary recommendation is to follow the manufacturer's instructions for use regarding application and fixation
- Define the medically necessary overlap required to secure the graft
  - The guidance typically ranges from 0.5–1.0cm beyond the wound edges, depending on the wound type and fixation method. (Important to review the IFU and literature)
- Appropriate anchoring is based on clinician discretion and wound characteristics (unless the IFU dictates otherwise) and can include:
  - Adhesive strips
  - Sutures or staples
  - NPWT or bolsters
  - Tacky non-adherent dressings
- Acceptable practice is to use a single large CAMP to cover multiple distinct wounds or multiple smaller grafts, emphasising the need for clear documentation and proper coding modifiers.

Establishing medical necessity and documentation

- Clinicians must document why a specific product, size, and application method were chosen. Medical necessity should outline what negative outcomes might occur if the wound is not properly treated (e.g., sepsis, amputation, prolonged non-healing)
- The importance of proper wound bed preparation, debridement, and comorbidity management
- There is no such thing as cookie-cutter wound care. For massive wounds, staged procedures, or when the ideal product size is unavailable, such as in a mobile or restricted formulary setting, clinicians must provide clear, free-form text justifications in the chart
- Document wound progression towards healing (reduction in size, improved granulation, decreased pain/exudate) to justify continued applications or the need to change graft type or treatment methodology. JWC

Reference

1 Centre for Medicare and Medicaid Services. Medicare Programme. Discarded drugs and biologicals: JW modifier and JZ modifier policy: frequently asked questions. 2026. https://tinyurl.com/v8s3cus4 (accessed 5 March 2026)