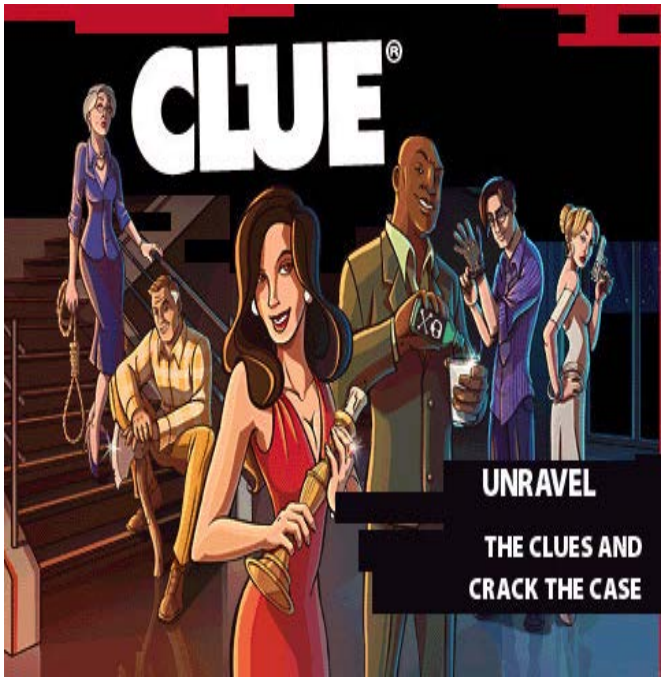
"Who Killed Our Wound Center?"

Toni Turner, RCP,CHT,CWS

InRich ADVISORS

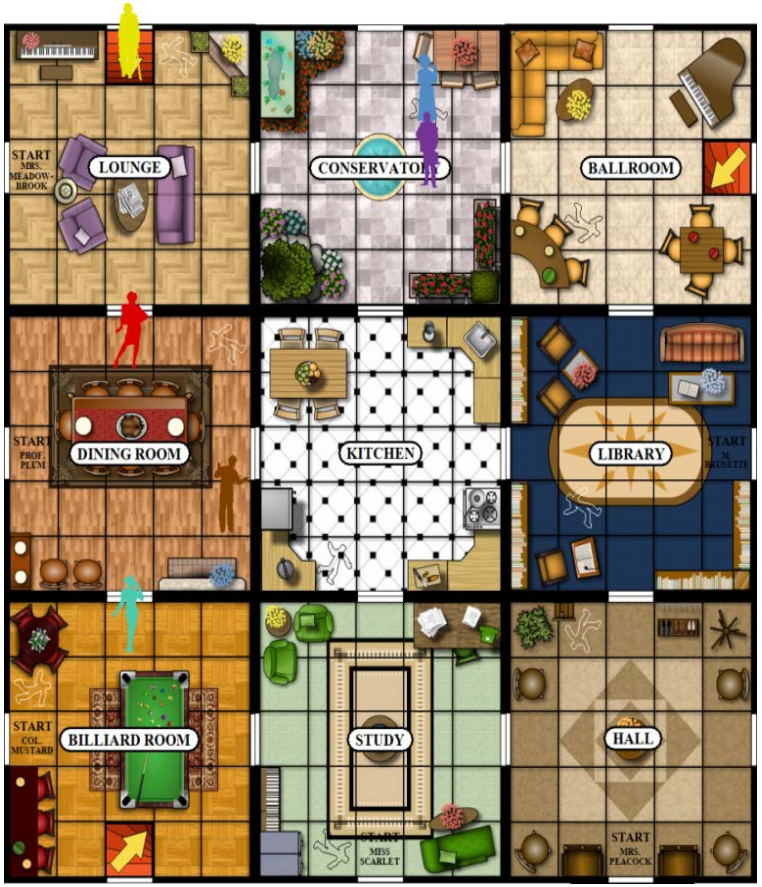
Who Killed Our Wound Center?

- You run a busy clinic providing advanced wound care procedures, services and modalities.
- Your waiting room is full, your clinicians can barely keep up, but your hospital administrator says that you are sinking faster than the Titanic from a financial standpoint.
- How is that possible…we seem so busy?
- It's time to find out who is killing your wound center by playing "Wound Center Clue"



Where did the fatality occur?:

- Registration
  - Wrong information entered
- Exam room
  - Inaccurate charge ticket filled out
- Front Office
  - Wrong charges keyed
- Coding room
  - Wrong revenue code/modifier
- Billing room
  - Bill Cycle
- Third party submission
  - Edits outdated in scrubber



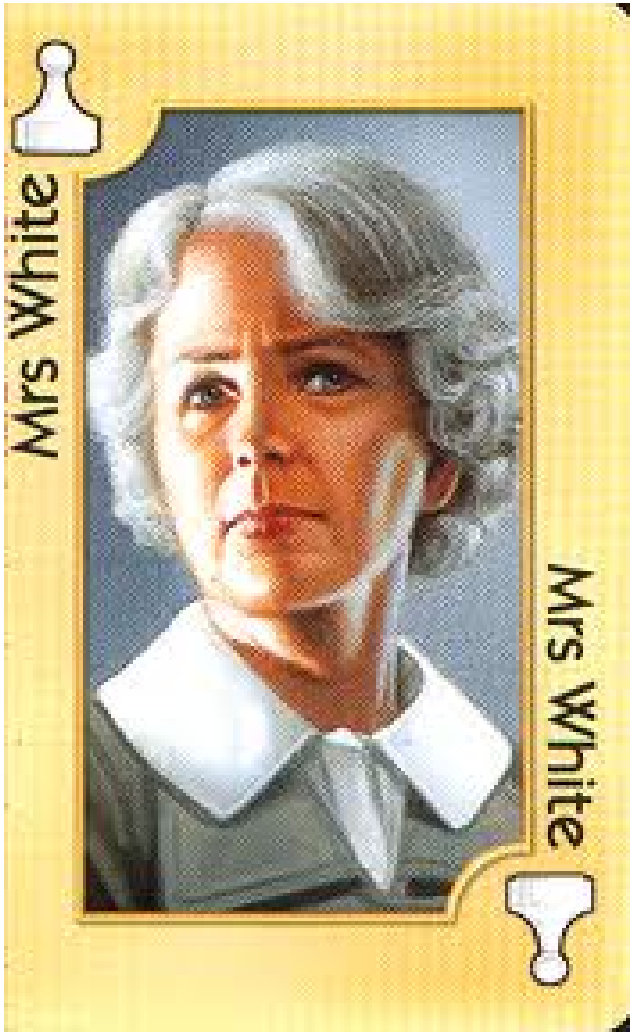
The Suspects:

1. Miss White in the Business Office with the ***Chargemaster***
2. Professor Plum the clinician with his ***Super bill***
3. Miss Scarlet in Clinic Front Office with the ***Charge Entry Process***
4. Col. Mustard in Utilization Management with ***Coding***
5. Mrs. Peacock, A/R Management with the ***Billing Cycle***

Mrs. White who hardcodes the CHARGEMASTER

The Chargemaster:

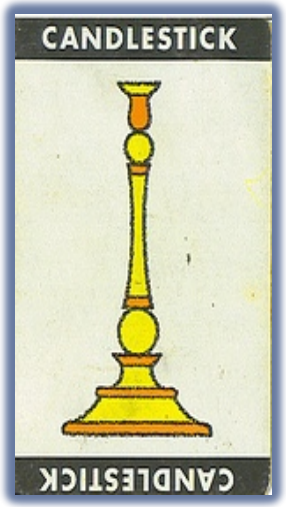
- Includes a core group of data elements that correspond to all of the services, procedures and supplies that may be used in each service line of your facility.



CHARGE DESCRIPTION MASTER (Quiet but…deadly)

In addition to the list of services, the CDM electronic file includes the following:

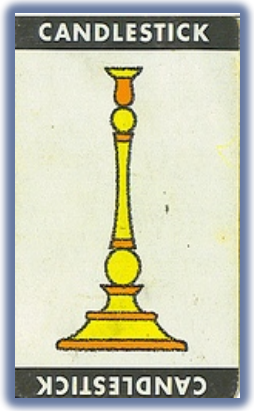
- unique reference identifier
- the procedure or service description
- the appropriate HCPCS/CPT code (if available)
- the UB-04 **revenue code** number
- unit of service and/or multiplier
- corresponding charge dollar amount

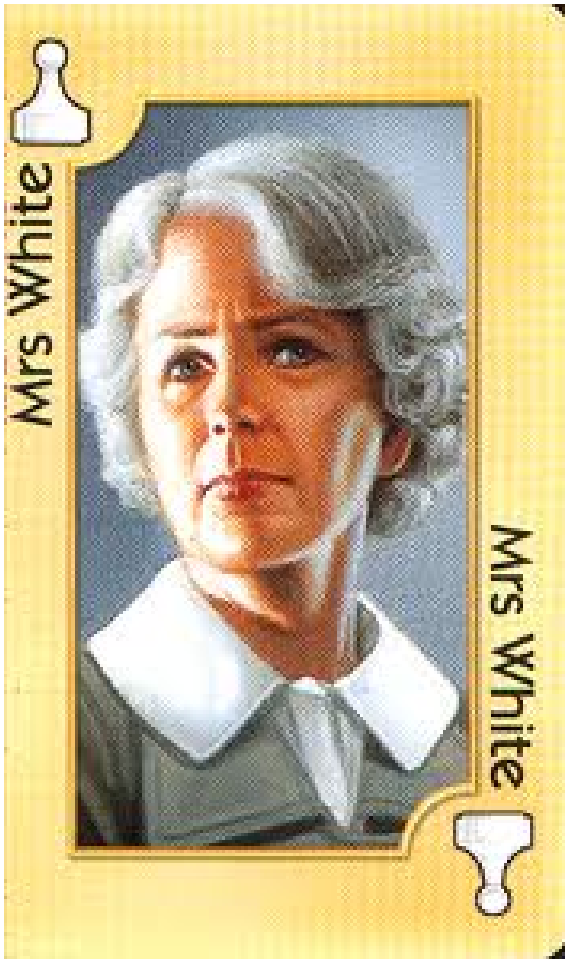


CDM Number	CDM Service Description	HCPCS/ CPT	UB04 Rev Code	UOS	Charge Amount
4500100	ED VISIT LEVEL I	99281	450	1	$200.00

Can the CHARGEMASTER kill?

- A poorly constructed chargemaster can cause inaccurate claims to be submitted which may result in denials and delays in payment.





Chargemaster Homicide?

CDM#	Description	QTY	Charge	Rev	CPC/CPT
140400523	PUNCTURE ASPIRATION OF ABSCE	1	170.50	0361	10160
140400524	I&D POST-OP WOUND	1	2,910.50	0361	10180
140400525	PARING BENIGN LESION ONE	1	285.75	0361	11055
140400526	PARING BENIGN LESION 2 to 4	1	574.50	0361	11056
140400527	PARING BENIGN LESION>4	1	845.75	0361	11057
140400528	BIOPSY SKIN ONE LESION	1	161.75	0361	11100
140400529	BIOPSY SKIN EACH ADDL	1	161.75	0361	11101
140400530	SEL DEBRID W/O ANES <=20 SQCM	1	256.50	0420	97597
140400531	SELECT DEBRID W/O ANES>20SQC	1	256.50	0420	97598
140400532	NONSELECTIVE DEBRID W/O ANES	1	129.50	0420	97602
140400533	WOUND VAC 50 SQ CM OR LESS	1	140.50	0420	97605
140400534	WOUND VAC>50 SQ CM	1	181.75	0420	97606
140400535	DEBRID SKIN PARTIAL THICK L1	1	218.25	0361	11040
140400536	DEBRIDE FULL THICKNESS	1	519.75	0361	11041
140400537	DEBRID SKIN SUBCU &TISSUE L3	1	735.00	0361	11042
140400538	DEBRID SKIN SUBCU TISS&MUSC L	1	870.25	0361	11043
140400539	DEBRID SKIN SUBCU MUSC BONE I	1	1,081.75	0361	11044
140400540	APPLY TOTAL CONTACT CAST	1	364.00	0361	29445
140400541	APPLY UNNA BOOT PASTE	1	208.00	0420	29580
140400542	APPLY UNNA BOOT PASTE	1	352.50	0420	2958050
140400543	TRIM NONDYSTROPHIC NAILS	1	128.75	0361	11719
140400544	DEBRIDE NAIL 1 to 5	1	186.50	0361	11720
140400545	DEBRIDE NAILS>5	1	186.50	0361	11721
140400546	AVULSION OF NAIL PLATE 1	1	264.50	0361	11730
140400547	AVULSION OF NAIL PLATES>1	1	183.50	0361	11732

Revenue Codes are harmless…right?

A	B	C	D	E
2008 Revenue center ID	Description (applicable to CY 2008 claims)	Used in 2010 OPPS NPRM (2008 claims)	Primary cost center source for CCR	Primary cost center name
0360	Operating Room Services	Y	3700	**Operating Room**
0361	Operating Room Services: Minor surgery	Y	3700	**Operating Room**
0510	Clinic	Y	6000	**Clinic**
0760	Treatment/Observation Room	Y	6000	**Clinic**
0761	Treatment/Observation Room: Treatment room	Y	6000	**Clinic**

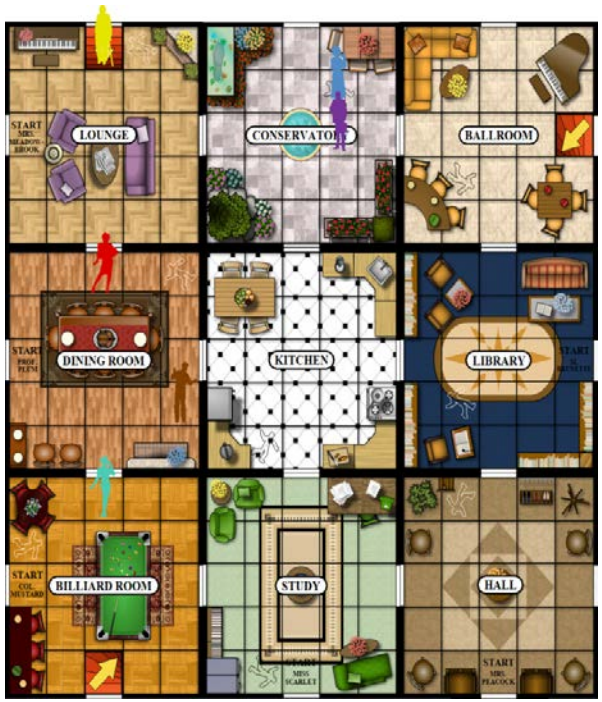


Exhibit "A", Deadly Chargemaster

CDM#	Description	QTY	Charge	Rev	CPC/CPT
140400523	PUNCTURE ASPIRATION OF ABSCE	1			10160
140400524	I&D POST-OP WOUND	1			10180
140400525	PARING N ONE	1			11055
140400526	PARING N 2 to 4	1	574.50	0361	11056
140400527	PARING N>4	1	845.75	0361	11057
140400528	BIOPSY ON	1	161.75	0361	11100
140400529	BIOPSY DL	1	161.75	0361	11101
140400530	SEL DEBRID W/O ANES <=20 SQCM	1	256.50	0420	[illegible]
140400531	SELECT DEBRID W/O ANES>20SQC	1	256.50	0420	[illegible]8
140400532	NONSELECTIVE DEBRID W/O ANES	1	129.50	0420	[illegible]2
140400533	WOUND VAC 50 SQ CM OR LESS	1	140.50	0420	[illegible]5
140400534	WOUND VAC>50 SQ CM	1	181.75	0420	97606
140400535	DEBRID SKIN PARTIAL THICK L1	1	218.25	0361	11040
140400536	DEBRIDE FULL THICKNESS	1	519.75	0361	11041
140400537	DEBRID SKIN SUBCU & TISSUE L3	1	735.00	0361	11042
140400538	DEBRID SKIN SUBCU TISS&MU	1	1,102.50	0361	11043
140400539	DEBRID SKIN SUBCU MUSC BO	1	1,470.00	0361	11044
140400540	APPLY TOTAL CONTACT CAST	1	208.00	0420	29445
140400541	APPLY UNNA BOOT PASTE	1	208.00	0420	29580
140400542	APPLY UNNA BOOT PASTE	1	352.50	0420	2958050
140400543	TRIM NONDYSTROPHIC NAILS	1	128.75	0361	1171[illegible]
140400544	DEBRIDE NAIL 1 to 5	1	186.50	0361	1172[illegible]
140400545	DEBRIDE NAILS>5	1	186.50	0361	11721
140400546	AVULSION OF NAIL PLATE 1	1	264.50	0361	11730
140400547	AVULSION OF NAIL PLATES>1	1	183.50	0361	11732

Outdated descriptions.

Wrong Revenue Codes

Deleted Codes

Duplicate short descriptions but related to different service.

CHARGE DESCRIPTION MASTER

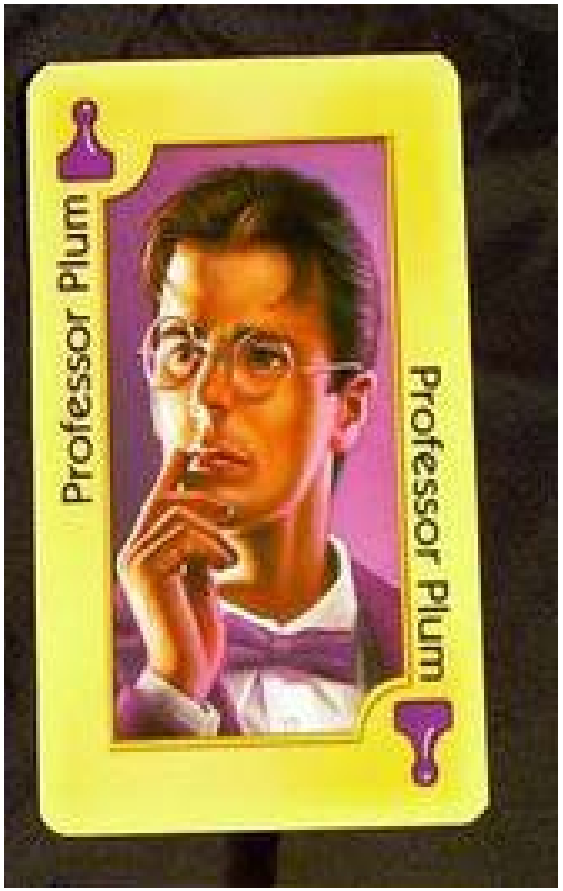
- The CDM is one of the most complex master files within any hospital facility and is subject to continuous updates.
- Proper maintenance is essential to ensure proper charging for services and supplies within financial and regulatory parameters.
- Poor maintenance of the CDM can put the hospital at financial risk and may introduce risk of regulatory non-compliance.

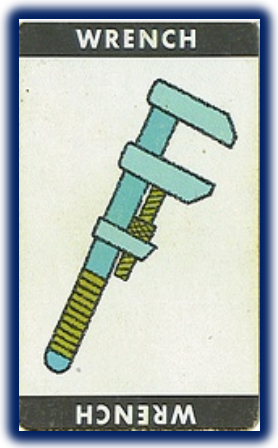
Because the Healthcare Common Procedure Coding System (HCPCS) codes and APCs are updated regularly, hospitals should pay particular attention to the task of updating the CDM to ensure the assignment of correct codes to outpatient claims. This should include timely updates, proper use of modifiers, and correct associations between procedure codes and revenue codes.

- OIG Compliance Guidance for Hospitals

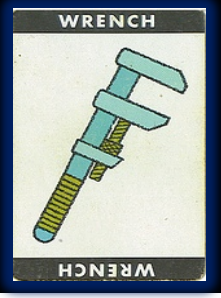
How about that Superbill Professor Plum ?

- A Superbill or Charge Ticket is a mechanism for communicating the services and/or procedure information from the clinical provider to the coder or data-entry staff.





Superbill …a heavy blow!



Provider: ☐ Hesse (032000) ☐ Black (013600) ☐ Dixon (020600) ☐ West (008900) ☐ Nurse

WOUNDCARE/HYPERBARIC CHAMBER FEE SCHEDULE – PROVIDER

Qty	CODE	MVCode	HYPERBARIC MEDICINE	Global
	99183	610035	Physician Supervised HBO	
			OFFICE NEW	
	99201	6199201	New Pt. Visit, level 1 - Brief	
	99202	6199202	New Pt. Visit, level 2 – Limited	
	99203			
	99204			
	99205			
			OFFICE ESTABLISH	
	99211	6199211	Est. Pt. Visit, level 1- Brief	
	99212	6199212	Est. Pt. Visit, level 2- Limited	
	99213	6199213	Est. Pt. Visit, level 3- Intermediate	
	99214	6199214	Est. Pt. Visit, level 4- Extended	
	99215	6199215	Est. Pt. Visit, level 5- Complex	
			INPATIENT WOUND CONSULTA	
	99251	6299251	Consult - Minor 20MIN	
	99252	6299252	Consult - Low 40 MIN	
	99523	6299253	Consult - Moderate 55 MIN	
	99254	6299254	Consult - High 80 MIN	
	99255	6299255	Consult - High110 MIN	
			DEBRIDEMENT PROCEDURES	
	11100	611102	Biopsy of Skin Lesion (Single)	
	11101	611103	Each separate / Additional Lesion	
	11042	611106	Debridement of Skin (SubQ) 1st 20 cm	
	11045	6110450	Debridement-Skin (SubQ) ea. add 20 cm	
	11043	61110	Debrid Skin SQ-Tiss-Muscle 1st 20 cm	10 Day
	11046	6110460	Debrid skin-SQ-Tiss-Muscle add 20cm	10 Day
	11044	611111	Debrid skin SQ Tiss Mus Bone 1st 20cm	10 Day
	11047	6110470	Debrid skin SQ Tiss Mus Bone add 20cm	10 Day
	97597	611107	Mist/Removal of devitalized tissue from wounds selective debridement (sharps, scissors, scalpel & forceps) < 20 sq. centimeters	
	97598	611108	Mist/Removal of tissue from wounds selective debridement (sharps, scissors, scalpel & forceps) >20 sq. centimeters	
	97602	6197602	Removal of devitalized tissue from wounds, nonselective debridement (wet to moist dressings, enzymatic, abrasion, including topical applications, wound assessment and instructions)	N/a
	10060	611112	Incision & Drainage of Abscess	10 Day
	10061	611113	Incision/Drainage-Abscess-Complex	10 Day

Qty	CODE	MV Code	VAC PROCEDURES	Global
	97605	6197605	VAC <50 cm per session	
	97606	6197606	VAC >50 cm per session	
			E SUBSCRIBE	
	G8553	11008553	E-Subscribe	n/a
			STUDIES	
	93922	40093922	Ankle Brachial Index- Limited (single)	n/a
	93923	40093923	TCOM / ABI inclusive - Multi Level	n/a
			PARRING OR CUTTING	
	11055	6111055	Paring or Cutting of Callous, Single H 61.30 P 19.68	
	11056	6111056	Paring or Cutting of Callous, 2 to 4 61.30 27.91	
	11057	6111057	Paring or Cutting of Callous, 5+ 61.30 36.14	
			PROCEDURES	
			…pligraf first 25 cm or less	10 Day
			…pligraf each add 25 cm	10 Day
			…rcutaneous, toe; single tendon	90
	G0440	600440	Application Dermagraft first 25 cm or less	
	G0441	600441	Application Dermagraft each additional 25 cm	
			Dermagraft-Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar [including subcutaneous tissues], or incisional	
	17250	6117250	Chemical Cauterization	
			BURN TREATMENT	
	16035		Eschar otomy; initial incision	
	16036		Additional incision (in addition to primary)	
	16000	40016000	Initial Treatment, first degree burn, when no more than local treatment is required	
	16020	40016020	Dressing and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% TBSA)	
	16025	16025	Dressing and/or debridement of partial-thickness burns, initial or subsequent; medium (e.g., whole face or whole extremity, or 5% to 10% TBSA)	
	16030	40016030	Dressing and/or debridement of partial-thickness burns, initial or subsequent; large (e.g., more than one extremity,	

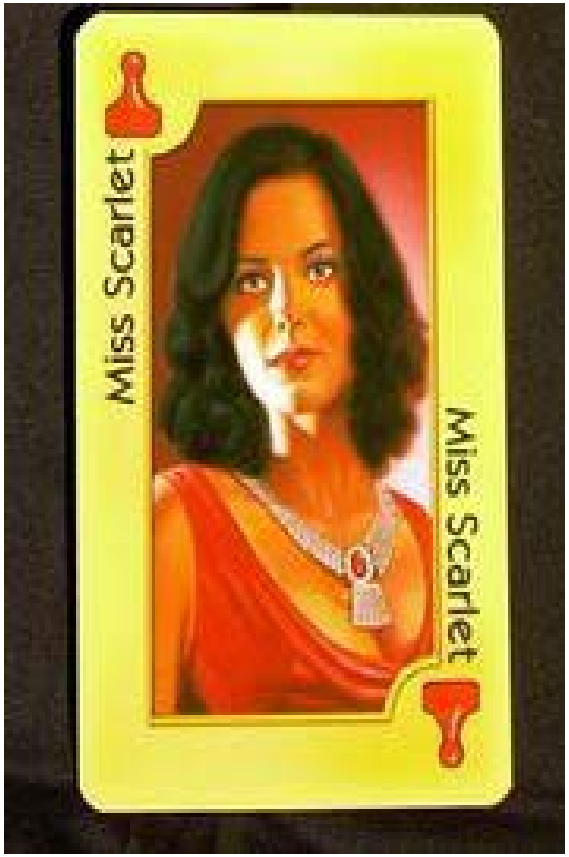
1. Not kept up to date.

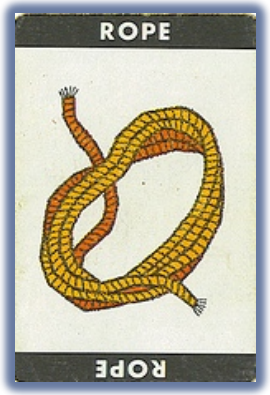
2. Untrained Clinicians.

3. Documentation doesn't support clinician selections.

Miss Scarlet at Clinic Front Desk with the Charge Entry Process

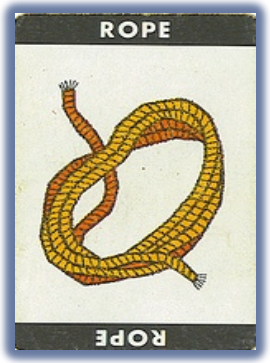
- Keys daily charges of clinical services and procedures performed into hospital information system via superbill or charge ticket.





The Charge Entry Process can HANG you!

- Front office staff has limited access to communicate change of principal diagnosis in a single encounter to coders.
- Typically have been trained on the "how to" of data entry but not on the difference between each abbreviated descriptor which can be very similar for a series of CPT/HCPC codes.



Could it be Colonel Mustard……the Coder?

- The medical coder **assigns** alpha-numeric **codes** that are specific to the patient's symptoms and diagnosis and identify each procedure and other service performed.
- Hospitals and medical **providers submit the coded data created by Coders** to insurance companies—or to the government in the case of Medicare and Medicaid recipients **for reimbursement** of expenses.
- **Coding accuracy is highly important to healthcare organizations, and has an impact on revenues and describing health outcomes.**

Inpatient vs. Outpatient Coding

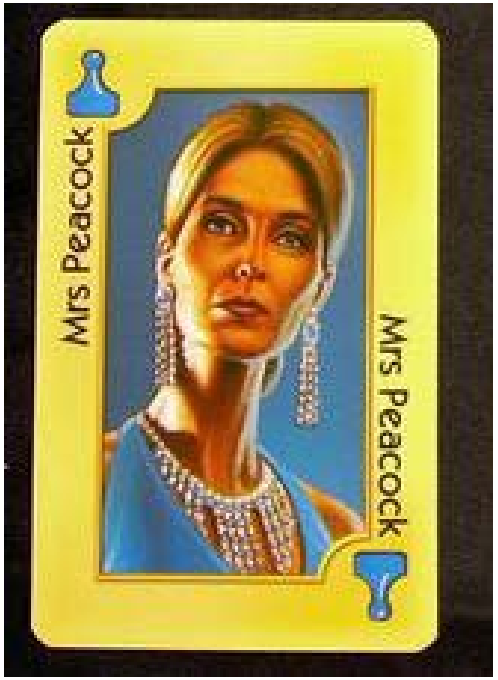
- IP codes for ***stays***
- Diagnosis ***condition*** coding

- OP codes for ***encounters***
- Diagnosis ***problem*** coding

- A common problem that arises in the outpatient arena involves the assignment of codes for **primary and secondary diagnosis.**
- Commonly done procedures in the Outpatient Wound Clinic require **dual diagnosis** on claim to qualify for payment.
- Many of the **guidelines related to the use of the ICD-9-CM** coding system are the same as those ***for inpatient visits***, so the outpatient coder must also review the National and **Local Coverage Decision Policies** that apply to their settings.

Mrs. Peacock, A/R Management with the *Billing Cycle*

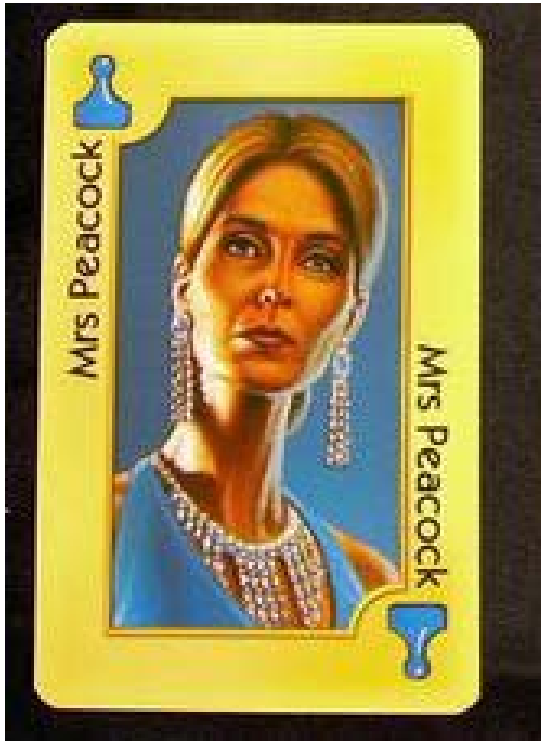
- Performs all billing functions related to submission of claims and collections.
- Determines billing cycle (daily or monthly).



How can the Billing Cycle Kill an innocent OP Wound Clinic?

- Repetitive billing woes!

Services repeated over a span of time and billed monthly with designated revenue codes are defined as repetitive services.



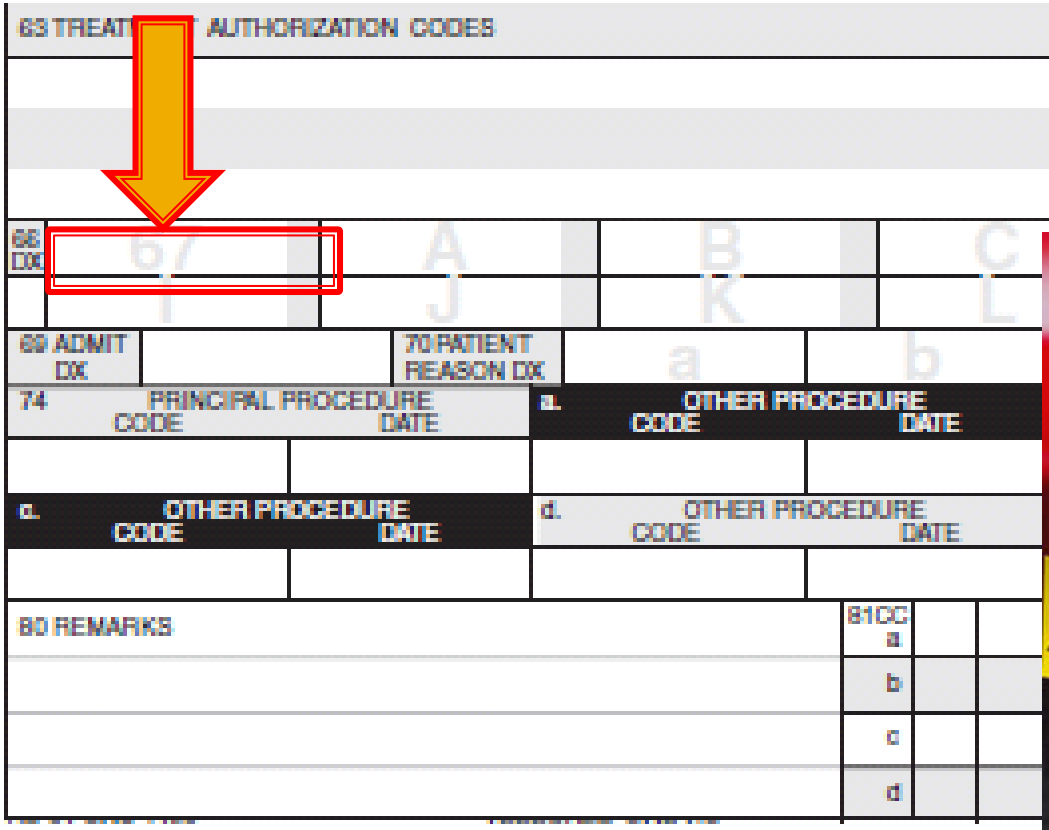
Revenue Codes which *can* be billed repetitively

Revenue Code	Type of Service
0290–0299	Durable Medical Equipment (DME) rental
0410, 0412 and 0419	Resp
0420–0429	Physi
0430–0439	Occu
0440–0449	Spee
0550–0559	Skille
0820–0859	Kidney dialysis treatments
0482 and 0943	Cardiac rehabilitation services
0948	Pulmonary rehabilitation services

In the case of hyperbaric oxygen therapy (HBOT), Medicare requires the hospital use the revenue code 0413 for the provision of hyperbaric services. **Note that this revenue code is NOT on the list of services which can be billed as repetitive.**

The plot thickens….

- Repetitive billing = single claim submission
- Single UB04 claim = single primary code field



Get a clue!

- Patient may receive multiple procedures or services throughout the month that require dual diagnosis yet with different diagnosis codes to be reported as primary!

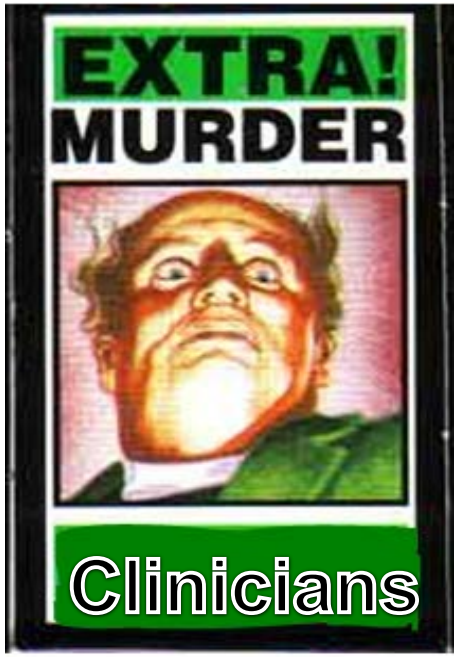
Dueling Diagnosis?!

- Claims for **HBO for the treatment of diabetic wounds** of the lower extremities require documentation of **dual diagnoses**. An ICD-9-CM code from either the **250.70–250.73 or 250.80–250.83 range (representing a diabetes-related problem)** and one of the following ICD-9-CM codes: ***707.10, 707.11, 707.12, 707.13, 707.14, 707.15, or 707.19 (representing a lower extremity wound)*** must be reported.

- Claims for **skin substitutes (Apligraf –Dermagraft)** **Dual diagnosis** requirement for coding neuropathic diabetic ulcers. **Code the ulcer as the primary diagnosis. Code diabetes with neurologic manifestations as the secondary diag**

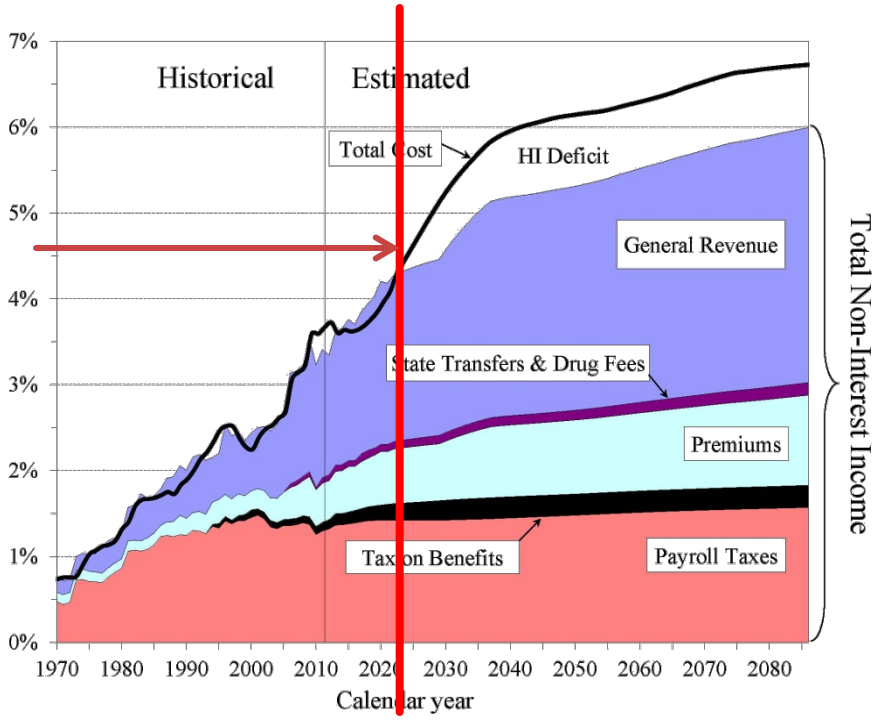
Or could the villain actually be *in* the Clinic??

- ***Death by Documentation!!***



Impending Medicare Bankruptcy

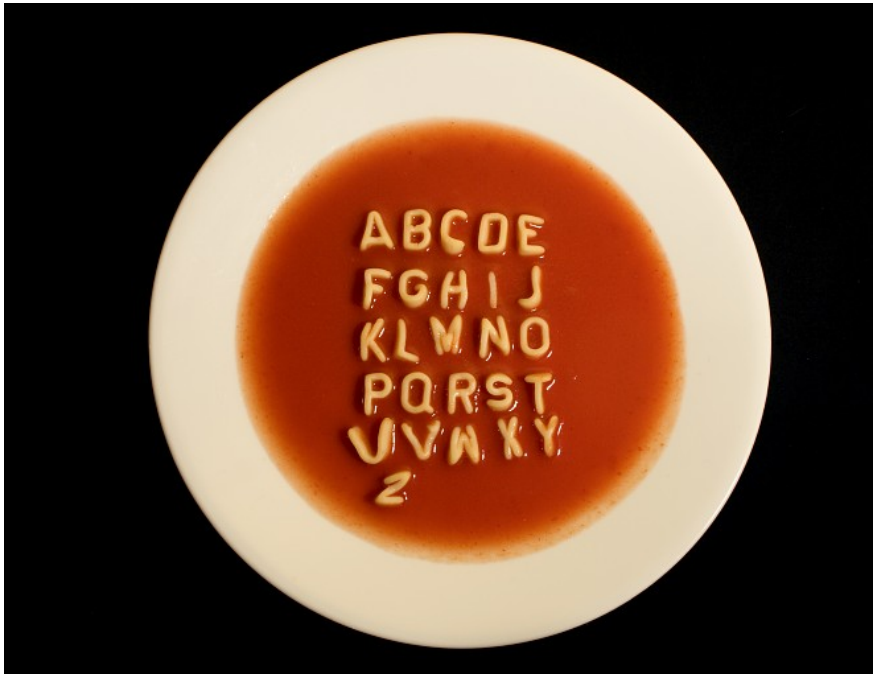
- Medicare will go bankrupt in either 2024 or 2016, depending on how you calculate the effect of Obamacare (2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds).
- Improper payments are a significant contributor to this problem.
  - >30% of Medicare payments are "improper"



Medicare Cost and Non-Interest Income by Source as a Percentage of GDP

Coming for the Money . . . alphabet soup of auditing agencies!

- RACs, ZPICs, CERTs, SIUs, etc.
- Not a matter of if…it's a matter of when!



RAC Auditors

- RAC: Recovery Audit Contractors
- Mission: reduce Medicare improper payments (over or underpayments)
- Work on commission
  - Receive 9% - 12.5% of everything they *collect*
  - Can go back as far as 36 months
- Use proprietary software programs to identify potential payment errors (e.g. duplicate payments, fiscal intermediaries' mistakes, medical necessity and coding)

The original “rack” auditor (which might have been easier)

How do the RACs Find the Money?

- Look for statistical anomalies
- It is imperative that you know not only whether you can justify your billed level of service, **but whether the distribution of your charges falls in an acceptable range from a statistical standpoint**
  - From March 2005-March 2008, the RACs corrected more than $1.03 billion in Medicare improper payments.

Reasons for Recoupment for "Improper Payments" by the RAC

1. Services that did not meet Medicare's ***medical necessity*** criteria (e.g. therapy sessions that were excessive).
2. Services coded incorrectly (e.g. principal diagnosis on the claim did not match principal diagnosis on the medical records).
3. Failure to support claims with ***proper medical documentation*** (e.g. medical records did not describe adequately the procedures reported on the claim).
4. Submittal of claims to Medicare that should have been submitted to another insurer.
5. Other reasons (e.g. submitting duplicate claims or using outdated fee schedules).

Documentation is KEY to hanging on to your $$!

- The medical record itself should read like a story telling about the patient and how you cared for that patient.
- A good medical record gives the reader, ***perhaps even years down the road,*** an understanding of the thought process that went into the decision-making and ultimately the treatment of the patient.

Documentation and the Absent Minded Professor

- "I'm a good doctor, I just don't like the paperwork"

"The OIG finds that excuse neither charming nor persuasive"!

Chief Medical Officer OIG/HHS

How to Establish Medical Necessity for HBOT: Option # 1

- 707.X related to Diabetes (280)
- Start HBOT 2.0 ATA x 30 treatments

That was easy. What is wrong with that?

How to Establish Medical Necessity for HBOT: Option #2

Paste this into your EHR (EHRs are GREAT for this purpose, saves typing!):
"Hyperbaric oxygen therapy is the administration of oxygen at greater than sea level pressure. It has been shown to increase tissue PO2 and enhance vascularity among patients with ischemic diabetic foot ulcers. Pooled data from 3 trials with 118 patients showed a reduction in the risk of major amputation when adjunctive HBOT was used, compared to the alternative therapy (RR: 0.31; 95%-CI 0.13 to 0.71). Both BCBS and the ADA have concluded that there is sufficient evidence to support the use of adjunctive HBOT in the treatment of adequately perfused chronic non-healing wounds of the lower extremity."
This patient has a Wagner III Diabetic foot ulcer and needs HBOT.

Thank goodness for EHRs! What's wrong with that?

Indication vs. Medical Necessity

Documenting diagnosis (ICD-9) alone is not enough to reveal the big picture!

You need to Connect the Dots!

- Review the facts—describe the patient's history in light of the specific coverage policy requirements.
- **Tell the story** (Connect the dots)
  - Detail how ***THIS PARTICULAR PATIENT*** meets the coverage indication by having failed 30 days of care **including** revascularization, infection control, nutrition control, off-loading, etc**.**

How to Establish Medical Necessity for HBOT: Option #3

- **Gather the evidence, and MAKE THE CASE**
  - Support the ICD-9 code you provided with further documentation if necessary (e.g. MRI), exam findings.

You have to MAKE THE CASE FOR EACH PATIENT at EVERY ENCOUNTER!

Conflicting documentation as bad as no documentation!

Conflicting documentation between assessment and debridement details.

Plantar *Heel*

Wound Measurements	
Length: (cm)	2.4
Width: (cm)	2.4
Depth: (cm)	0.5
Hypergranulated:	No
Area: (sq cm) based on n*(L*W)/4	4.52
Volume: (cm^3) based on Area*D	2.26

Wound Margin:	Thickened and Rolled Under
	Percentage
Adherent Yellow Slough:	26-50%
Moist Yellow Slough:	None
Dry Black Eschar:	None
Moist Black Eschar:	None
Epithelialization:	26-50%
Granulation:	26-50%
Pink:	Yes

Debridement Details

Patient Name: [redacted]
Patient Number:
Patient Date of Birth: 1/8/1948
Patient Account Number:

Date: 2/17/2011
Clinician:
Physician / Extender: [redacted]

Debridement Performed for Assessment:	Wound #6 Right,Plantar Heel
Performed By:	Physician [redacted]
Debridement:	Excisional
Time-Out Taken:	Yes
Pain Control:	2% Lido
Level:	Skin/Sub/Tiss/Musc
Area (sq cm):	4.52
Tissue and other material debrided:	Necrotic/Eschar, Fibrin, Exudate, Other, Skin, Subcutaneous, Slough
Instrument:	Curette
Bleeding:	Moderate
Hemostasis Achieved:	Pressure
Procedural Pain:	4
Post Procedural Pain:	1
Response to Treatment:	Procedure was tolerated well

Notes

C&S SENT

Electronic Signature(s)

Signed By: [redacted]

Date:
02/17/2011 11:00:48 AM
02/17/2011 11:11:07 AM
02/17/2011 11:33:28 AM

No narrative of procedure.

Four months and 8 more *muscle* debridements billed later…

Wound Measurements

Length: (cm)	1.6
Width: (cm)	1.2
Depth: (cm)	1.3
Hypergranulated:	No
Area: (sq cm) based on n*(L*W)/4	1.508
Volume: (cm^3) based on Area*D	1.96

Wound Description

Wound Progress:	Improving
Wagner Scale:	Grade 2
Exudate Amount:	Moderate
Exudate Type:	Sero-sanguineous
Odor:	None
Pain:	0
Wound Margin:	Thickened

	Percentage
Adherent Yellow Slough:	1-25%
Moist Yellow Slough:	None
Dry Black Eschar:	None
Moist Black Eschar:	None
Granulation:	76-100%
Pale Grey:	Yes
Pink:	Yes

Debridement Details

Patient Name: [redacted]
Patient Number:
Patient Date of Birth:
Patient Account Number:

Date: 6/2/2011
Clinician:
Physician / Extender: [redacted]

Debridement Performed for Assessment:	Wound #6 Right,Plantar Heel
Performed By:	Physician [redacted]
Debridement:	Excisional
Time-Out Taken:	Yes
Pain Control:	2% Lido
Level:	Skin/Sub/Tiss/Musc
Area (sq cm):	1.51
Tissue and other material debrided:	Fibrin, Muscle, Exudate, Subcutaneous, Slough
Instrument:	Curette
Bleeding:	Moderate
Hemostasis Achieved:	Pressure
Procedural Pain:	0
Post Procedural Pain:	0
Response to Treatment:	Procedure was tolerated well

Electronic Signature(s)

Signed By: [redacted]

Date:
06/02/2011 11:42:04 AM

Entered By: [redacted] on 06/02/2011 11:24:20 AM

No narrative of procedure.

Payer Utilization Guidelines

- Exceeding quantity limitations set forth by payer policies can lead to denials and/or recoupment as not "reasonable and necessary".
- Recent In*Rich* audit: Patient reviewed had been in service for 12 months with a mastectomy wound having received 39 muscle debridement's on the same wound!

Quantity of data in Medical Record is GROWING.

- In order to meet payer requirements for documentation requirements, no longer possible for clinicians to rely on memory alone.
- Tracking Utilization caps
- Advanced Beneficiary of Notice (ABN)

NORIDIAN®
Administrative Services LLC

Medicare Administrative Contract (MAC) Jurisdiction F
Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
Medicare Part B

Local Coverage Determination (LCD) for Application of Bioengineered Skin Substitutes: Ulcers (of Lower Extremities) (L24273)

Documentations Requirements

The medical record must clearly show that the criteria listed in Indications and Limitation of Coverage and/or Medical Necessity section have been met. The ulcer must be measured at the beginning of conservative treatment, following cessation of conservative treatment and at the beginning of the skin substitute treatment. Clearly, if during treatment the ulcer shows obvious signs of worsening or lack of treatment response, continuing skin substitute treatment would be considered questionable absent documentation of a reasonable rationale for doing so, and other treatment modalities must be considered.

Studies have documented that, for Q4106, survival of the dermal substitute decreases significantly when the twenty-four (24) steps noted in the FDA labeling are not followed. **The documentation must show** that these twenty-four(24) steps were followed.

NAS will cover a maximum of eight (8) applications of Q4106 for the treatment of any given lesion. In addition, **the medical record must clearly document** that conservative pre-treatment wound management has been tried and failed to induce healing. Also, when used for billing of Dermagraft®, **the record must document** that the **twenty-four (24) steps** involved in the correct use of this product, as described in the clinical trials leading to FDA approval and included in the manufacturer's "Directions for Use" as of the date of development of this LCD have been followed. The provider must take notice of these specific instructions for use. They will not be listed in this policy.

The medical record must document that wound treatment by this method is accompanied by appropriate wound dressing during the healing period and by appropriate compressive therapy for foot ulcer(s) and appropriate steps to off-load wound pressure during follow-up. Adequate patient compliance **must be clearly ascertained and documented** during such treatment.

In Conclusion:

"Don't look where you fell, look where you slipped."

African Proverb

Be Proactive not Reactive!

- Self Audit regularly
- Initiate a compliance program customized to your service line.
- Involve physicians and staff
- Know your business better than any auditor!

Is your Hospital Without a clue?

Who is killing your clinic today?

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