EBOOK

FINAL LCDs FOR SKIN SUBSTITUTES (CELLULAR TISSUE PRODUCTS)

Frequently Asked Questions & Summary

by Caroline Fife, MD

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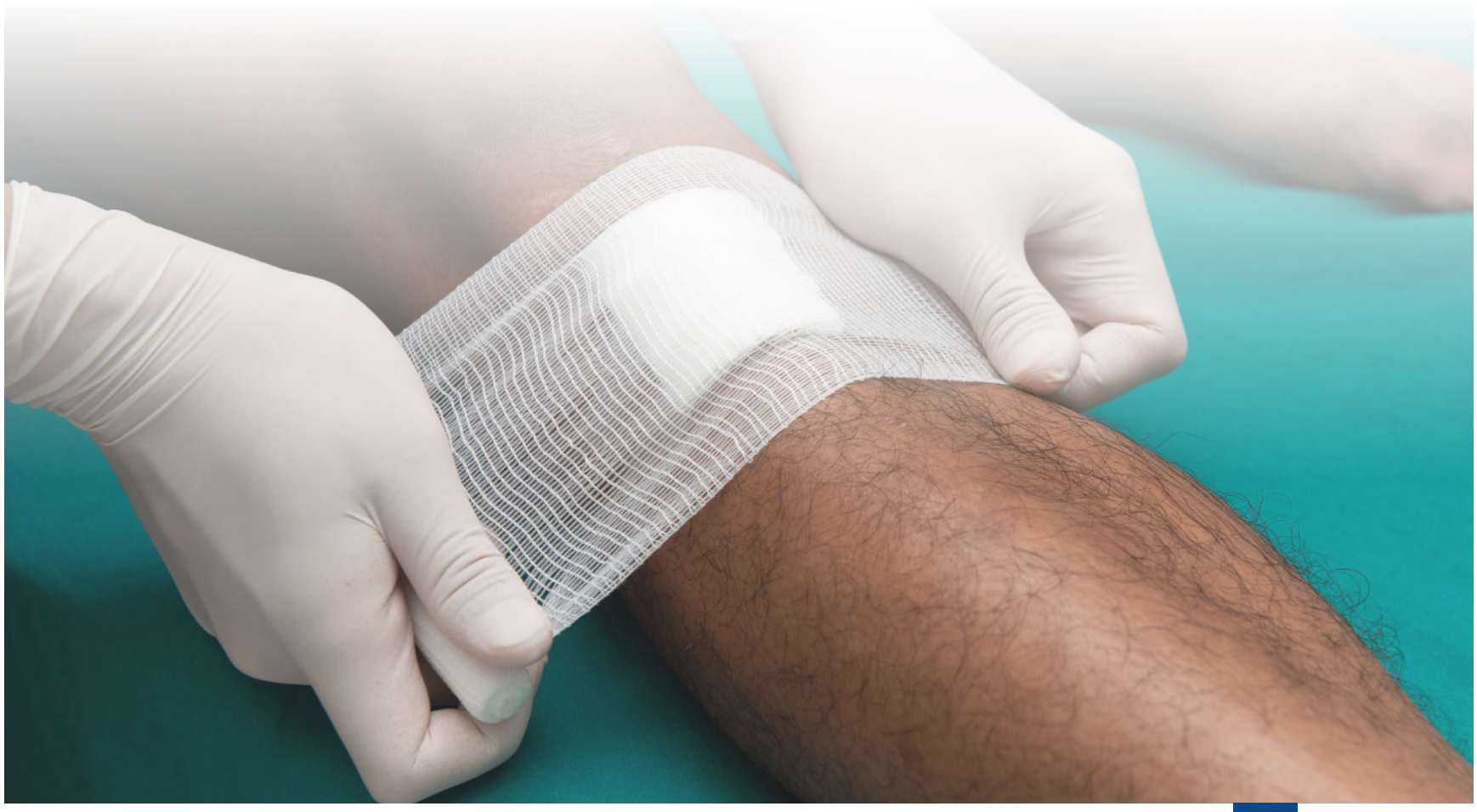

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The full text to the LCD can be found by clicking here or visiting https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39756&ver=7

INTRODUCTION

Medicare coverage polices (both "local" and "national") can be daunting to understand and even more difficult to meet – particularly when the policies contain detailed clinical and documentation requirements.
We can help.

As the leading wound care software innovator with a reputation of exceeding regulatory and payer expectations, Intellicure works hard to understand and interpret coverage policies that impact practicing wound care clinicians.

In an unprecedented move, on November 14, 2024, all regional Medicare Administrative Carriers (MACs) released identical, final Local Coverage Determinations (LCDs) pertaining to the use of "skin substitutes" for diabetic foot ulcers (DFUs) and venous leg ulcers (VLUs). All Medicare regions will be implementing the same coverage policies when these LCDs become effective on February 12, 2025. The policies standardize highly specific and detailed requirements around the use of Cellular and/or Tissue based products (CTPs), also known as skin substitutes, for DFUs and VLUs. We recommend you read the LCD(s) yourself, but to help you prepare for these changes, we have summarized the most important details in this document.

Intellicure's wound care EHR and wound care documentation apps, including its SMART apps for Epic and Cerner, are built to ensure that clinicians meet regulatory requirements in a way that still allows efficient documentation. Clinicians who correctly use our tools are more likely to submit correct claims and less likely to lose payments in a Medicare audit.

Click here or visit Intellicure.com/demo to schedule a live demonstration of Intellicure.

Response to Comments on LCD

Intellicure builds regulatory changes, such as this LCD, into its charting software, ensuring clinicians remain compliant while optimizing their reimbursement potential.

About the Author

Caroline Fife, MD, FAAFP, CWS completed a Family Medicine residency at the University of Texas, Southwestern in Dallas followed by a two-year Fellowship in Undersea and Hyperbaric Medicine at Duke University. Until 2013 she was a Professor of Medicine at the University of Texas Health Science Center, Houston where she initiated the Memorial Hermann Center for Wound Healing in 1990, and the Memorial Hermann Center for Lymphedema Therapy in 1998. Since 2013, she has been a Professor of Geriatrics at Baylor College of Medicine in Houston. She is also the co-founder and Chief Medical Officer of Intellicure, LLC, a Texas-based health information technology company which since 2000, has provided a specialty-specific electronic medical record system to wound and hyperbaric centers across the US. She is the Executive Director of the U.S. Wound Registry, a non-profit organization recognized by CMS as a qualified clinical data registry which has developed a suite of CMS approved wound care-relevant quality measures to enable practitioners to meet the requirements of Medicare's Quality Payment Program.

Past and present board activities include the Alliance of Wound Care Stakeholders, the American Academy of Wound Management, the Association for the Advancement of Wound Care, the American Professional Wound Care Association, the Chronic Limb Ischemia (CLI) Global Society, and the ADA Amputation Prevention Alliance (APA). She is the clinical editor of Today's Wound Clinic and has authored more than 100 peer reviewed articles and book chapters as well as editing 3 textbooks. Her research contributions include the development of real time lymphatic imaging with Dr. Eva Sevick using near infrared technology, and more recently, the use of real-world data for comparative effectiveness studies to understand what works best for patients with chronic wounds and ulcers.

Dr. Fife authors wound care content for several outlets, especially her popular wound care blog CarolineFifeMD.com. She often speaks at the world's largest wound care conferences, including the Symposium for the Advancement of Wound Care and the Advancements in Wound Care conference.

FREQUENTLY ASKED QUESTIONS ABOUT THE FINAL LCDs FOR CTPs

When will the changes take place?

The effective date for these policies is Feb. 12, 2025.

What types of wounds does the policy cover?

Diabetic Foot Ulcers (DFUs) and Venous Leg Ulcers (VLUs).

What will happen about the use of CTPs/skin subs in other wound types?

For other wound types (e.g. pressure ulcers or other chronic ulcers or wounds, etc.) the use of CTPs “must meet the reasonable and necessary threshold for coverage and products must be used in accordance with their intended use as approved/regulated by the FDA.”

What DFUs are covered for CTPs/skin subs?

Chronic non-infected DFUs that have failed to achieve at least 50% ulcer area reduction with documented standard of care (SOC) treatment for a minimum of 4 weeks, with documented compliance.

What VLUs are covered?

Chronic non-infected VLUs that have failed to respond to documented standard of care (SOC) treatment for a minimum of 4 weeks with documented compliance.

(continued on next page ...)

FAQS CONTINUED

What is the definition of Standard of Care (SOC) for a DFU?

*(*see additional SOC details in separate section)*

▸ Comprehensive patient assessment:

- ■ History and exam
- ■ Vascular assessment
- ■ Diagnostic tests indicated as part of the implemented treatment plan
- ■ An “implemented treatment plan”
- ■ “Assessment of” Type 1 or Type 2 diabetes management history
- ■ “Attention to” certain comorbidities
  - ▪ e.g., vascular disease, neuropathy, osteomyelitis
- ■ “Review of”
  - ▪ Current blood glucose levels/ hemoglobin A1c (HbA1c)
  - ▪ Diet and nutritional status
  - ▪ Activity level
- ■ Physical exam that includes assessment of skin, ulcer, and vascular perfusion
- ■ Assessment of off-loading device or use of appropriate footwear.

What is the definition of Standard of Care (SOC) for a VLU?

*(*see additional SOC details in separate section)*

▸ The use of a firm strength compression garment (>20 mmHg) or multi-layered compressive dressings (“an essential component of SOC”).

▸ Comprehensive patient assessment:

- ■ History and exam
- ■ Vascular assessment
- ■ Diagnostic tests indicated as part of the implemented treatment plan
- ■ An “implemented treatment plan”
- ■ Assessment of clinical history including:
  - ▪ Prior ulcers
  - ▪ Higher body mass index
  - ▪ History of pulmonary embolism or superficial/deep venous thrombosis
  - ▪ Higher number of pregnancies
  - ▪ Physical inactivity
- ■ Physical exam such as:
  - ▪ Edema
  - ▪ Skin changes
  - ▪ Vascular competence
- ■ Evaluation of superficial or deep venous reflux, perforator incompetence, and chronic (or acute) venous thrombosis.

FAQS CONTINUED

What is the evidence of an "implemented treatment plan" for DFUs or VLUs?

▸ Debridement "as appropriate" to a clean granular base

▸ Documented offloading of a DFU

▸ [Documented] sustained compression dressings for a VLU

▸ Infection control with removal of foreign body or nidus of infection

▸ Management of exudate with maintenance of a moist environment (moist saline gauze, other classic dressings, bioactive dressing, etc.).

▸ Documentation of smoking history, and counseling on the effect of smoking on wound healing.

▸ Treatment for smoking cessation and outcome of counselling, if applicable.

What documentation is required to demonstrate "response to SOC" and treatment with CTPs?

▸ Measurements of the initial ulcer (pre-SOC ulcer measurements)

▸ Weekly ulcer measurements and post-completion SOC ulcer measurements following (at least) 4 weeks of SOC

▸ Failure to heal or stalled response despite SOC measures must have preceded the application for a minimum of 4 weeks SOC treatment

▸ Ulcer measurements at initial placement of the skin substitute graft/CTP

▸ Ulcer measurement before each subsequent placement of the skin substitute graft/CTP

▸ Documentation that SOC treatment was continued for the course of therapy with CTP/skin sub.

▸ Documentation of continuous compression therapy for VLUs for the episode of care

▸ Documentation of the interventions that failed during prior ulcer evaluation and management

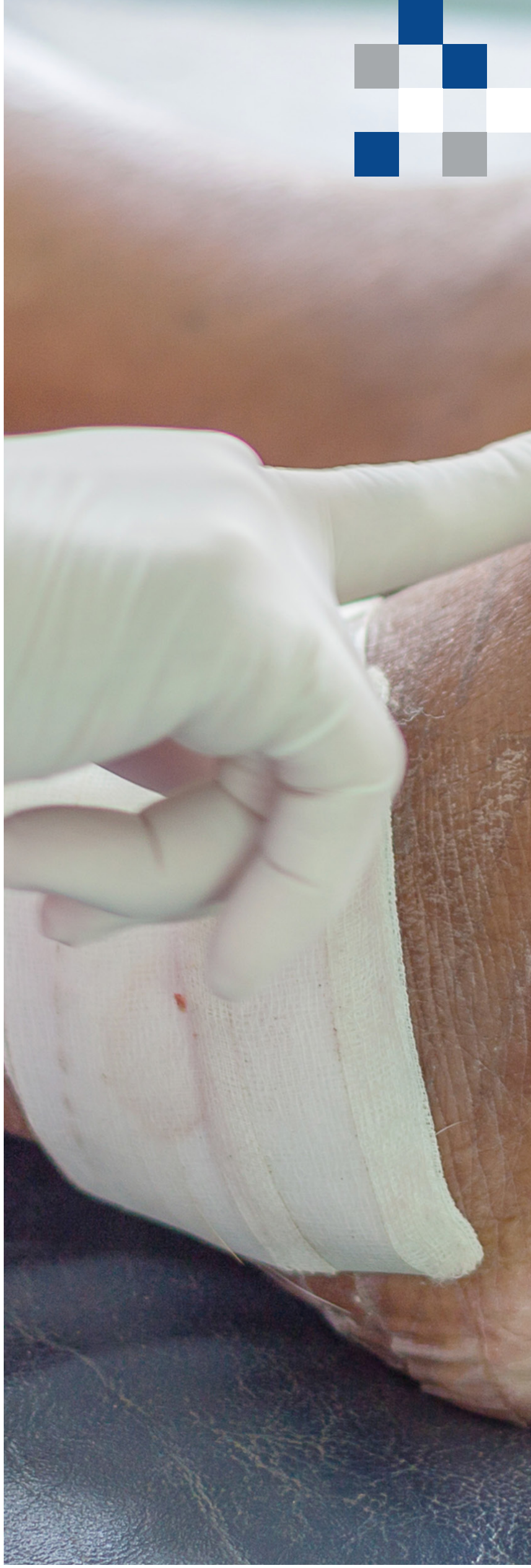
▸ An updated medication history

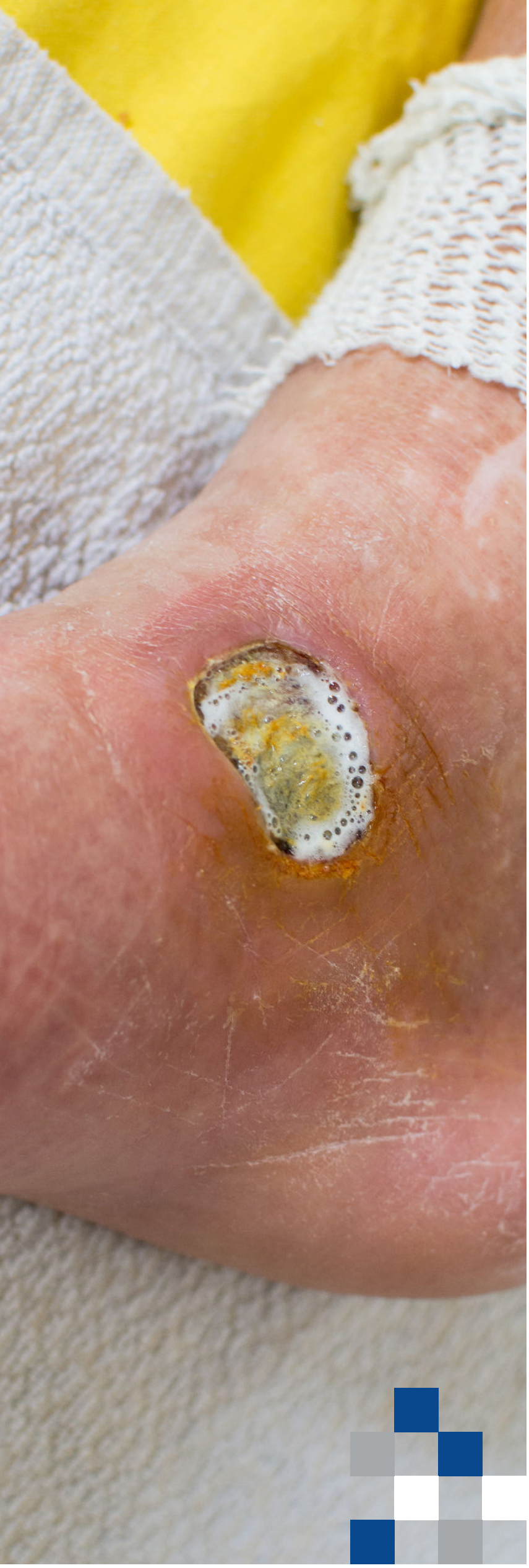
▸ A review of pertinent medical problems diagnosed since the previous ulcer evaluation

▸ An explanation of the planned skin replacement with choice of skin substitute graft/CTP product

▸ **For VLUs**, documentation that the patient is under the care of a qualified provider for the treatment of the systemic disease process(es) etiologic for the condition (e.g., venous insufficiency)

▸ **For DFUs**, documentation that the patient is under the care of a qualified provider for the treatment of the systemic disease process(es) etiologic for the condition (e.g., diabetes, neuropathy)





FAQS CONTINUED

What risks and complications must be documented?

▸ A review of the procedure risks and complications is required

▸ The following “potential harms” are listed in the LCD(s) although the inclusion of these is not described as mandatory:

- “The risk of human based products includes infections being transmitted from the donor tissue to the recipient. Most products undergo stringent processing to reduce this risk, but bacterial and viral transmission risk remains.”
- Allergies and hypersensitivity to products may occur
- The effect on the wound basement membrane is not fully understood
- “Concerns have been raised regarding specific constituent molecules within the matrix which have the potential to elicit adverse responses in host tissues.”
- The long-term risk of CTPs/skin subs “remains unclear”

What products can I use for DFUs?

▸ Only those on the attached list for DFUs.

▸ Note that no liquid or gel preparations are considered “grafts,” because their fluidity does not allow graft placement and stabilization of the product on the wound

What products can I use for VLUs?

▸ Only those on the attached list for VLUs.

▸ Note that no liquid or gel preparations are considered “grafts,” because their fluidity does not allow graft placement and stabilization of the product on the wound

What is the maximum number of applications allowed?

Up to 8 applications over 16 weeks are allowed, if meeting medical necessity, documentation of wound closure, and many other specific requirements.

What happens after the 4th application of a CTP/ skin sub?

▸ For application numbers 5, 6, 7 and 8, the KX-modifier must be added as an attestation of medical necessity for use over 4 applications.

▸ Use of more than 4 applications, “require an attestation from the provider showing that the requirements specified in the LCD have been met and the additional applications are medically necessary. In absence of this attestation, denial of the additional applications will occur.”

▸ These additional applications require documentation that includes progression of wound closure under the current treatment plan.

FAQS CONTINUED

Are any applications allowed beyond 8?

No.

What size of CTP/skin sub is allowed?

▸ Use “the most appropriate size product available at the time of treatment”

▸ “Excessive wastage should be avoided by utilization of size appropriate packaging of the product consistent with wound size.”

Is folding the product allowed?

No. “The graft must be applied in a single layer without overlay of product or adjacent skin in compliance with the correct label application techniques for the skin substitute graft/CTP.”

Can a larger size product be used if it is folded or applied in some manner other than “flat”?

No, Products must be applied in a single layer without overlay.

Can CTPs/skin subs be placed over muscle, tendon or bone?

Yes, but ONLY if the “label indications” allow use over muscle, tendon or bone.

When are repeat applications [meaning, any application after the first one] NOT covered?

▸ Repeat applications are not considered “reasonable and necessary” if a previous application was “unsuccessful,” which is defined as: **“an increase in depth, size, no measurable change from baseline, no significant improvement such as granulation, epithelialization or progress toward closure.”**

▸ Repeat applications are not covered in patients with “inadequate control of underlying conditions or exacerbating factors, or other contraindications (e.g., active infection, progressive necrosis, active Charcot arthropathy of the ulcer extremity, active vasculitis, ischemia).”

What specific DFUs and VLUs are not covered?

▸ Infected wounds

▸ Ischemic wounds

▸ Necrotic wounds

▸ Patients with active vasculitis

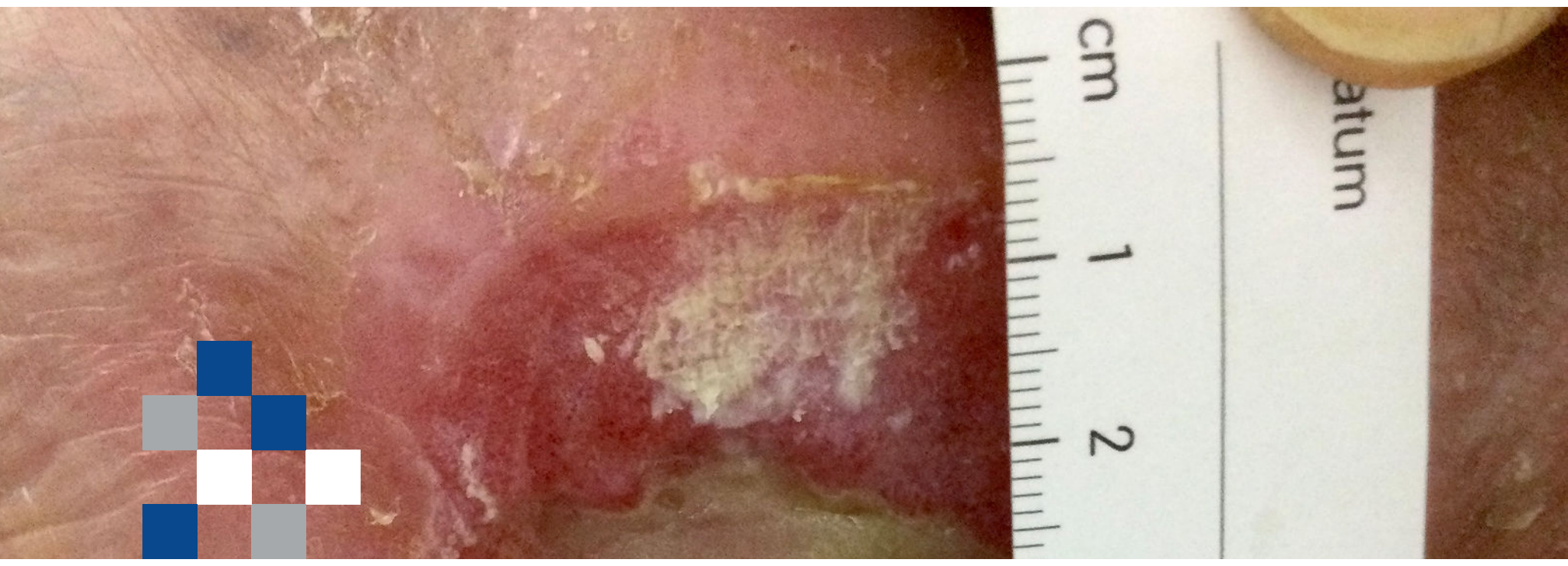
▸ Patients with active Charcot arthropathy of the ulcer extremity

▸ Patients with “inadequate control of underlying conditions or exacerbating factors”

Can a debridement be charged separately when a product is applied?

No, a debridement cannot be separately charged with routine or repeat skin sub placement.

“Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session procedures should never be reported with skin substitute grafts/CTPs ...“



FAQS CONTINUED

Is there a list of products that are covered?

Yes, there is a specific list of covered products for DFUs and VLUs included at the end this eBook.

What if a product is not on the "covered" list:

If a product is not on the covered list, Medicare does not cover its use in DFUs or VLUs.

Will Medicare cover products not on the covered list for wound types other than DFUs and VLUs?

Unknown.

Are ABIs required in all patients?

ABIs are not specifically required but some type of vascular assessment is required (see below).

Is documenting pulses sufficient to demonstrate adequate perfusion?

Probably not, at least among diabetics. "Palpation of pulses … is not a reliable indicator of sufficient perfusion in diabetes."

How to I document application on multiple wounds?

▸ All wound [surface] areas within the same anatomic site, as described by the skin application code descriptors, should be added.

▸ If the skin substitute graft is applied to wounds on a different anatomic site, they should bill the corresponding application code for the anatomical site for each date of service (DOS).

▸ Do not code modifier 59 on skin substitute, graft application, or skin substitute product codes. Skin substitute graft application codes are appropriately coded based upon total surface area of anatomical locations and not by number of ulcers.

▸ Modifier -50 and modifiers -LT and -RT are not appropriately appended to skin substitute codes. Coding for skin substitute graft application is based upon total surface area of the ulcers; therefore, Modifiers -50, -LT, and -RT are not required for proper claim adjudication.

ADDITIONAL STANDARD OF CARE RECOMMENDATIONS (SOC)

FOR DFUs

Vascular evaluation:

▸ "Vascular evaluation is vital for all patients with DFU to demonstrate adequate perfusion for wound healing."

▸ Palpation of pulses … is not a reliable indicator of sufficient perfusion in diabetes.

▸ An objective, non-invasive measure of perfusion/oxygenation to determine if there is adequate flow for wound healing is helpful in predicting ulcer healing and/or the need for vascular intervention.

SOC treatment schedule

(recommended by The Society for Vascular Surgery in collaboration with the American Podiatric Medical Association and the Society for Vascular Medicine)

▸ Weekly to monthly ulcer evaluations of ulcer size and healing progress

▸ Infection control

▸ Debridement of all devitalized tissue and surrounding callus material

▸ Dressings that maintain a moist ulcer environment, control of exudate, and avoiding maceration of adjacent intact skin.

▸ Adequate glycemic control

▸ Periodic assessments of appropriate footwear or off-loading devices.

FOR VLUs

Vascular evaluation:

▸ "Vascular evaluation is vital for all patients with VLU to demonstrate adequate perfusion for wound healing."

▸ Palpation of pulses . . . is not a reliable indicator of sufficient perfusion in diabetes. [Note that many patients with VLUs have diabetes. CF]

▸ An objective, non-invasive measure of perfusion/oxygenation to determine if there is adequate flow for wound healing is helpful in predicting ulcer healing and/or the need for vascular intervention.

Diagnostic tests:

▸ "Venous ulcers require a series of diagnostic testing to verify superficial or deep venous reflux, perforator incompetence, and chronic (or acute) venous thrombosis."

  ■ Venous duplex ultrasound is recommended and if the venous duplex ultrasound does not provide definitive diagnostic information, a venous plethysmography is recommended.

Compression:

▸ The use of the most supportive high-compression method is strongly recommended in the treatment of venous ulcers.

▸ High strength compression may be applied using techniques such as multilayered elastic compression, inelastic compression, Unna boots, compression stockings, and others.

▸ The extent of compression should be modified for patients with mixed venous/arterial disease.

ADDITIONAL DOCUMENTATION REQUIREMENTS FROM THE BILLING AND CODING INSTRUCTIONS

Click here to view the full text on the CMS website.

Documentation must include:

- Patient identification on every page (e.g., complete name, dates of service[s]).
- The legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
- Why the ulcer healing has stalled with standard ulcer care treatment of greater than 4 weeks
- What specific interventions that have failed
- An updated medication history
- A review of pertinent medical problems that may have arisen since the previous ulcer evaluation
- An explanation of the planned skin replacement therapy with choice of skin substitute graft or CTP product.
- The procedure risks and complications must also be reviewed and documented.
- Baseline wound characteristics (prior to beginning standard of care treatment) relative to size, location, stage, duration, and presence of infection, in addition to the type of standard of care treatment given and the response.
- It is expected that the response of the ulcer to treatment will be documented in the medical record at least once every 4 weeks.
- The ulcer description must also be documented pre- and post- treatment with the skin substitute grafts /CTP being used.
- The reason(s) for any repeat application should be specifically addressed in the medical record, including whether the current treatment plan has resulted in wound healing and expectation that the wound will continue to heal with this plan.
- Estimated time for extended treatment, number of additional applications anticipated and plan of care if healing is not achieved as planned.
- An assessment outlining the plan for skin replacement therapy
- The choice of skin substitute grafts/CTP for the 12-to-16-week period as well as any anticipated repeat applications within the 12-to-16-week period.
- Modifiable risk factors, such as diabetes optimization, are being addressed to improve likelihood of healing.
- For venous leg ulcers, it is expected that appropriate management and consultation, if indicated, be obtained for the diagnosis and stabilization of any venous related disease.
- An operative note must support the procedure (e.g., application of skin substitute grafts/CTPs to legs) for the relevant date of service (first application starts the 12-to 16-week episode of care) and include the reason for the procedure and a complete description of the procedure including product used (with identifying package label in the chart), and relevant findings.
- Graphic evidence of ulcer size, depth, and characteristics of the ulcer or photo documentation of the ulcer at baseline and follow-

CONTINUED

ADDITIONAL DOCUMENTATION REQUIREMENTS FROM THE BILLING AND CODING INSTRUCTIONS

up with measurements of wound including size and depth should be part of the medical record.

■ Any amount of wasted skin substitute grafts/CTP must be clearly documented in the procedure note with ALL the following information (at a minimum):

- Date, time, and location of ulcer(s) treated.
- Name of skin substitute grafts/CTP and package size.
- Approximate amount of product unit used.
- Approximate amount of product unit discarded.
- Reason for the wastage (including the reason for using a package size larger than was necessary for the size of the ulcer, if applicable).
- Manufacturer's serial/lot/batch or other unit identification number of grafts/CTP material. When the manufacturer does not supply unit identification, the record must document such. The amount billed as wastage cannot exceed the price of the package.

■ The HCPCS code of the applicable skin substitute grafts/CTP and the units billed must be consistent with the medical record regarding wound description and size.

■ Use of Modifier -KX for applications of >4

- Modifier -KX must be used as an attestation by the practitioner and/or provider of the service that documentation is on file verifying that the patient meets the requirements for additional applications of skin substitute grafts/CTP.
- Consistent with the LCD more than 4 applications of a skin substitute grafts/CTP in a 12–16-week period must be appended with a -KX modifier.
- Failure to apply the -KX modifier for applications greater then 4 will result in return of claim or claim denial. Aberrant use of the -KX modifier may trigger focused medical review.
- Documentation must support medical necessity for the use of additional applications or time and include:

▸ Explanation of why extended time or additional applications is medically necessary for the specific patient.

▸ That the current treatment plan has resulted in wound healing and expectation that the wound will continue to heal with this plan.

▸ Documentation should include estimated time for extended treatment, number of additional applications anticipated, and plan of care if healing is not achieved as planned.

▸ What modifiable risk factors, such as diabetes optimization, are being approached to improve likelihood of healing.

▸ For venous leg ulcers, it is expected that appropriate consultation and management be obtained for the diagnosis and stabilization of any venous related disease.

The following lists of covered and not-covered (next page) cellular tissue products (aka skin subs) are compiled from the Nov. 2024 LCDs and go into effect in Feb. 2025. Click here to view the full LCD.

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COVERED SKIN SUBS – DFUs ONLY

HCPCS	Product Description
A2019	KERECIS OMEGA3 MARIGEN SHIELD, PER SQUARE CENTIMETER
Q4105	INTEGRA DERMAL REGENERATION TEMPLATE (DRT) OR INTEGRA OMNIGRAFT DERMAL REGENERATION MATRIX, PER SQUARE CENTIMETER
Q4107	GRAFTJACKET, PER SQUARE CENTIMETER
Q4110	PRIMATRIX, PER SQUARE CENTIMETER
Q4121	THERASKIN, PER SQUARE CENTIMETER
Q4122	DERMACELL, DERMACELL AWM OR DERMACELL AWM POROUS, PER SQUARE CENTIMETER
Q4128	FLEX HD, OR ALLOPATCH HD, PER SQUARE CENTIMETER
Q4133	GRAFIX PRIME, GRAFIXPL PRIME, STRAVIX AND STRAVIXPL, PER SQUARE CENTIMETER
Q4158	KERECIS OMEGA3, PER SQUARE CENTIMETER
Q4159	AFFINITY, PER SQUARE CENTIMETER
Q4160	NUSHIELD, PER SQUARE CENTIMETER
Q4187	EPICORD, PER SQUARE CENTIMETER
Q4203	DERMA-GIDE, PER SQUARE CENTIMETER

COVERED SKIN SUBS – DFUs & VLUs

HCPCS	Product Description
Q4101	APLIGRAF, PER SQUARE CENTIMETER
Q4102	OASIS WOUND MATRIX, PER SQUARE CENTIMETER
Q4106	DERMAGRAFT, PER SQUARE CENTIMETER
Q4151	AMNIOBAND OR GUARDIAN, PER SQUARE CENTIMETER
Q4186	EPIFIX, PER SQUARE CENTIMETER

NOT-COVERED SKIN SUBS

For DFUs or VLUs

HCPCS	Product Description
A2001	INNOVAMATRIX AC
A2002	MIRRAGEN ADVANCED WOUND MATRIX
A2004	XCELLISTEM, 1 MG
A2005	MICROLYTE MATRIX
A2006	NOVOSORB SYNPATH DERMAL MATRIX
A2007	RESTRATA
A2008	THERAGENESIS
A2009	SYMPHONY
A2010	APIS
A2011	SUPRA SDRM
A2012	SUPRATHEL
A2013	INNOVAMATRIX FS
A2014	OMEZA COLLAGEN MATRIX, PER 100 MG
A2015	PHOENIX WOUND MATRIX
A2016	PERMEADERM B
A2018	PERMEADERM C
A2020	AC5 ADVANCED WOUND SYSTEM (AC5)
A2021	NEOMATRIX
A2022	INNOVABURN OR INNOVAMATRIX XL
A2023	INNOVAMATRIX PD, 1 MG
A2024	RESOLVE MATRIX OR XENOPATCH
A2025	MIRO3D, PER CUBIC CM
C9358	DERMAL SUBSTITUTE, NATIVE, NON-DENATURED COLLAGEN, FETAL BOVINE ORIGIN (SURGIMEND COLLAGEN MATRIX), PER 0.5 Sq CMS
C9360	DERMAL SUBSTITUTE, NATIVE, NON-DENATURED COLLAGEN, NEONATAL BOVINE ORIGIN (SURGIMEND COLLAGEN MATRIX), PER 0.5 Sq CMS
C9363	SKIN SUBSTITUTE, INTEGRA MESHED BILAYER WOUND MATRIX
C9364	PORCINE IMPLANT, PERMACOL
Q4103	OASIS BURN MATRIX
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD)
Q4108	INTEGRA MATRIX
Q4111	GAMMAGRAFT
Q4112	CYMETRA, INJECTABLE, 1 CC
Q4113	GRAFTJACKET XPRESS, INJECTABLE, 1 CC
Q4114	INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1 CC
Q4115	ALLOSKIN
Q4116	ALLODERM
Q4117	HYALOMATRIX
Q4118	MATRISTEM MICROMATRIX, 1 MG
Q4123	ALLOSKIN RT
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX
Q4125	ARTHROFLEX
Q4126	MEMODERM, DERMASPAN, TRANZGRAFT OR INTEGUPLY
Q4127	TALYMED
Q4130	STRATTICE TM
Q4132	GRAFIX CORE AND GRAFIXPL CORE
Q4134	HMATRIX
Q4135	MEDISKIN
Q4136	EZ-DERM
Q4137	AMNIOEXCEL, AMNIOEXCEL PLUS OR BIODEXCEL
Q4138	BIODFENCE DRYFLEX
Q4139	AMNIOMATRIX OR BIODMATRIX, INJECTABLE, 1 CC
Q4140	BIODFENCE
Q4141	ALLOSKIN AC
Q4142	XCM BIOLOGIC TISSUE MATRIX
Q4143	REPRIZA
Q4145	EPIFIX, INJECTABLE, 1 MG
Q4146	TENSIX
Q4147	ARCHITECT, ARCHITECT PX, OR ARCHITECT FX, EXTRACELLULAR MATRIX
Q4148	NEOX CORD 1K, NEOX CORD RT, OR CLARIX CORD 1K
Q4149	EXCELLAGEN, 0.1 CC
Q4150	ALLOWRAP DS OR DRY
Q4152	DERMAPURE
Q4153	DERMAVEST AND PLURIVEST
Q4154	BIOVANCE
Q4155	NEOXFLO OR CLARIXFLO, 1 MG
Q4156	NEOX 100 OR CLARIX 100
Q4157	REVITALON
Q4161	BIO-CONNEKT WOUND MATRIX
Q4162	WOUNDEX FLOW, BIOSKIN FLOW, 0.5 CC
Q4163	WOUNDEX, BIOSKIN
Q4164	HELICOLL
Q4165	KERAMATRIX OR KERASORB
Q4166	CYTAL
Q4167	TRUSKIN
Q4168	AMNIOBAND, 1 MG
Q4169	ARTACENT WOUND
Q4170	CYGNUS
Q4171	INTERFYL, 1 MG
Q4173	PALINGEN OR PALINGEN XPLUS
Q4174	PALINGEN OR PROMATRX, 0.36 MG PER 0.25 CC
Q4175	MIRODERM
Q4176	NEOPATCH OR THERION
Q4177	FLOWERAMNIOFLO, 0.1 CC
Q4178	FLOWERAMNIOPATCH
Q4179	FLOWERDERM
Q4180	REVITA
Q4181	AMNIO WOUND
Q4182	TRANSCYTE
Q4183	SURGIGRAFT
Q4184	CELLESTA OR CELLESTA DUO
Q4185	CELLESTA FLOWABLE AMNION (25 MG PER CC); PER 0.5 CC
Q4188	AMNIOARMOR
Q4189	ARTACENT AC, 1 MG
Q4190	ARTACENT AC
Q4191	RESTORIGIN
Q4192	RESTORIGIN, 1 CC
Q4193	COLL-E-DERM
Q4194	NOVACHOR
Q4195	PURAPLY
Q4196	PURAPLY AM
Q4197	PURAPLY XT
Q4198	GENESIS AMNIOTIC MEMBRANE
Q4199	CYGNUS MATRIX
Q4200	SKIN TE
Q4201	MATRION
Q4202	KEROXX (2.5G/CC), 1CC
Q4204	XWRAP
Q4205	MEMBRANE GRAFT OR MEMBRANE WRAP
Q4206	FLUID FLOW OR FLUID GF, 1 CC
Q4208	NOVAFIX, PER Sq CENITMETER
Q4209	SURGRAFT
Q4211	AMNION BIO OR AXOBIOMEMBRANE
Q4212	ALLOGEN, PER CC
Q4213	ASCENT, 0.5 MG
Q4214	CELLESTA CORD
Q4215	AXOLOTL AMBIENT OR AXOLOTL CRYO, 0.1 MG
Q4216	ARTACENT CORD
Q4217	WOUNDFIX, BIOWOUND, WOUNDFIX PLUS, BIOWOUND PLUS, WOUNDFIX XPLUS OR BIOWOUND XPLUS
Q4218	SURGICORD
Q4219	SURGIGRAFT-DUAL
Q4220	BELLACELL HD OR SUREDERM
Q4221	AMNIOWRAP2
Q4222	PROGENAMATRIX
Q4225	AMNIOBIND OR DERMABIND TL
Q4226	MYOWN SKIN, INCLUDES HARVESTING AND PREPARATION PROCEDURES
Q4227	AMNIOCORE
Q4229	COGENEX AMNIOTIC MEMBRANE
Q4230	COGENEX FLOWABLE AMNION, PER 0.5 CC
Q4231	CORPLEX P, PER CC
Q4232	CORPLEX
Q4233	SURFACTOR OR NUDYN, PER 0.5 CC
Q4234	XCELLERATE
Q4235	AMNIOREPAIR OR ALTIPLY
Q4236	CAREPATCH
Q4237	CRYO-CORD
Q4238	DERM-MAXX
Q4239	AMNIO-MAXX OR AMNIO-MAXX LITE
Q4240	CORECYTE, FOR TOPICAL USE ONLY, PER 0.5 CC
Q4241	POLYCYTE, FOR TOPICAL USE ONLY, PER 0.5 CC
Q4242	AMNIOCYTE PLUS, PER 0.5 CC
Q4245	AMNIOTEXT, PER CC
Q4246	CORETEXT OR PROTEXT, PER CC
Q4247	AMNIOTEXT PATCH
Q4248	DERMACYTE AMNIOTIC MEMBRANE ALLOGRAFT
Q4249	AMNIPLY, FOR TOPICAL USE ONLY
Q4250	AMNIOAMP-MP
Q4251	VIM
Q4252	VENDAJE
Q4253	ZENITH AMNIOTIC MEMBRANE
Q4254	NOVAFIX DL
Q4255	REGUARD, FOR TOPICAL USE ONLY
Q4256	MLG-COMPLETE
Q4257	RELESE
Q4258	ENVERSE
Q4259	CELERA DUAL LAYER OR CELERA DUAL MEMBRANE
Q4260	SIGNATURE APATCH
Q4261	TAG
Q4262	DUAL LAYER IMPAX MEMBRANE
Q4263	SURGRAFT TL
Q4264	COCOON MEMBRANE
Q4265	NEOSTIM TL
Q4266	NEOSTIM MEMBRANE
Q4267	NEOSTIM DL
Q4268	SURGRAFT FT
Q4269	SURGRAFT XT
Q4270	COMPLETE SL
Q4271	COMPLETE FT
Q4272	ESANO A
Q4273	ESANO AAA
Q4274	ESANO AC
Q4275	ESANO ACA
Q4276	ORION
Q4278	EPIEFFECT
Q4279	VENDAJE AC
Q4280	XCELL AMNIO MATRIX
Q4281	BARRERA SL OR BARRERA DL
Q4282	CYGNUS DUAL
Q4283	BIOVANCE TRI-LAYER OR BIOVANCE 3L
Q4284	DERMABIND SL
Q4285	NUDYN DL OR NUDYN DL MESH
Q4286	NUDYN SL OR NUDYN SLW
Q4287	DERMABIND DL
Q4288	DERMABIND CH
Q4289	REVOSHIELD + AMNIOTIC BARRIER
Q4290	MEMBRANE WRAP-HYDRO
Q4291	LAMELLAS XT
Q4292	LAMELLAS
Q4293	ACESSO DL
Q4294	AMNIO QUAD-CORE
Q4295	AMNIO TRI-CORE AMNIOTIC
Q4296	REBOUND MATRIX
Q4297	EMERGE MATRIX
Q4298	AMNICORE PRO
Q4299	AMNICORE PRO+
Q4300	ACESSO TL
Q4301	ACTIVATE MATRIX
Q4302	COMPLETE ACA
Q4303	COMPLETE AA
Q4304	GRAFIX PLUS
Q4305	AMERICAN AMNION AC TRI-LAYER
Q4306	AMERICAN AMNION AC
Q4307	AMERICAN AMNION
Q4308	SANOPELLIS
Q4309	VIA MATRIX
Q4310	PROCENTA, PER 100 MG

Intellicure is not responsible for errors, payment, or legal ramifications caused by usage of this list.
This list was pulled from publicly available website on Nov. 19, 2024.

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Built by wound care clinical leaders and regulatory experts

Intellicure and its award-winning wound care EHR and SMART apps for Epic and Cerner were made to adapt to the ever-changing regulatory landscape of the wound care industry. Intellicure will take the November 2024 LCD on skin subs and create rules and algorithms to help clinicians select and apply the skin sub that will ensure optimal reimbursements from payers.

Since 2001, no clinician following the Intellicure method of charting patient encounters has ever been fined in an audit as a result of insufficient documentation. Plus, the robust documentation you create with each chart will lead to optimal payments and higher quality outcomes.

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