Documentation Guidelines

Initial Assessment:

- Must be done on each patient. Assessment should include documentation of chronic wound greater than 30 days, with failed prior conservative treatments and interventions to include treatment response and compliance. Baseline wound measurements, location, stage/severity, duration and testing (culture) for infection should be submitted in the initial ulcer assessment. Pre and post completion of at least 4 weeks of standard of care treatment, prior to advance treatment of grafts. Must show evidence of failed standard wound care & conservative treatments including but not limited to debridement, dressings to maintain moist environment, compression, off-loading, medications/ointments and that wound has increased in size or depth or has not changed in baseline size or depth with no indication that improvement is likely if continued conservatively. Documentation of written orders on collaboration with PCP on treatment and/or other providers/nurses rendering wound care
- ABN should be obtained from patient on initial assessment. And cost of treatment should be as accurate as possible, you can always add to it if exceeded.

Consult Notes:

- Patient Information: Include the patient's first and last name, date of birth (no nicknames), date of service, and rendering provider. This must match the billing report.
- Wound Measurements: Ensure these are accurate and correspond with the invoice. Must include L cm x W cm x D cm
- Diagnosis: Must match the clinical notes and wound location. (Avoid Unspecified, Unstageable)
- Follow-Ups: Include details about the treatment and the treatment plan. Documentation or provision of wound environment to promote healing and protection from trauma/contaminants. E.g. Waterproof bandages, elevation, nutrition, smoking cessation. Documentation of pressure redistributing devices for wheelchair bound and bed confined patients. Documentation of conditions that have been treated and resolved. Documentation of glucose monitoring and H1C on diabetic patients. If debriding, notes should contain the amount of slough/granulation present in the wound bed prior and post debridement. Documentation of written orders on collaboration with PCP on treatment and/or other providers/nurses rendering wound care.

- Standard treatment is 4-10 treatments for 12 weeks. Greater than this are subject to review for medical necessity. If wound is not showing progression after 4 treatments/4 weeks, grafting is considered unsuccessful and not medically necessary
- Amount of graft utilized and wasted must be clearly documented in the procedure note with the following minimum information.

- Date, time and location of ulcer treated
- Name of skin substitute and how product supplied
- Amount of product unit used
- Amount of product unit discarded
- Reason for wastage
- Manufacturers serial/lot/batch

- File Naming: Name the file(s) as: First Name Initial, Last Name, Content of file, Date of Service (xx/xx/xx) (e.g., J.DoeNote010124.pdf , J.DoeInvoice010124.pdf, etc.).

Wound Care Photos:

- Should be saved as e.g. J.DoePrephoto010124.pdf , J.DoePostphoto010124.pdf
- **Before Photos:** Include 3 photos with the patient's identifiers (name, DOB, date of service). Photos should include ruler to prove measurement of wound. Photo cannot reflect slough or look infected. Clear the wound before applying products.
- **After Photos:** Include 3 after photos with the same patient identifiers.

  Make sure to identify which photos are Pre and Post

- **Instructions:** Ensure the wound always uncovered and clearly visible when taking the photos. Wound measurements documented in note must align with measurements in photos. Make sure there are no contradictions within the progress note on wound measurements.

Notes must be signed, dated and time stamped (Cross outs must be Initialed by the provider who is signing the clinical record, always)