COALITION OF

Wound Care Manufacturers

April 29, 2013

Dr. Earl Berman
Cigna Government Services
Two Vantage Way
Nashville, TN 37228
Attn Medical Review

Submitted Electronically to Earl.Berman@cgsadmin.com

RE: Draft LCD - Application of Bioengineered Skin Substitutes: Ulcers (of Lower Extremities)

Dear Dr. Berman:

On behalf of the Coalition of Wound Care Manufacturers ("Coalition"), we are pleased to submit the following comments in response to Cigna Government Services ("CGS") draft LCD, "Application of Bioengineered Skin Substitutes: Ulcers (of Lower Extremities)". The Coalition represents leading manufacturers of wound care products used by Medicare beneficiaries for the treatment of wounds including those products that are subject to this draft policy. Since our members have a vested interest in the coverage of these products, this draft policy is of interest and concern to us. The Coalition appreciates the opportunity to offer our comments.

GENERAL COMMENTS

As stated in our specific comments below, the Coalition is concerned with CGS using the term "bioengineered skin substitutes" since it is not a technically accurate term and does not describe the technology that is either currently or will be in the marketplace. Instead, the Coalition recommends that CGS adopt the term "Cellular and/or tissue based products for wounds (CTPs)" which is accurate, broad, and inclusive of both current and future technology. Thus, we will be using the acronym "CTPs" instead of "skin substitutes in this document.

The Coalition recognizes the challenges and difficulties that the A/B MAC contractors such as CGS are facing in managing the LCD development process with new CTPs entering the marketplace. We know that CGS has attempted to establish a fair, balanced and accurate coverage policy and has taken into account the various forms of clinical evidence on which to establish coverage for these important CTPs. However, this draft policy falls short and the Coalition has significant issues with this draft policy as our specific comments will reflect.

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There are many new CTPs coming into the marketplace that are clinically efficacious as well as cost effective –yet this policy is limited in the products it does cover. While we appreciate that CGS has included all types of CTPs for coverage in their policy – including Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps) - the Coalition would like to better understand the threshold for what is acceptable for clinical evidence submission in order for a product to be covered in the CGS policy. We would like to see more choices available to treat patients.

There are also several inconsistencies in the document that we have identified in our specific comments below. We believe that any inconsistencies need to be addressed and corrected prior to issuing this policy in final.

The Coalition is also concerned with how CGS has released this draft policy for comments. It is our understanding that the A/B MACs must have a public meeting. We did not see one posted on your website or communicated in any way to stakeholders. In addition, while CGS noted on the draft LCD that this policy was posted on March 13, 2013 it was not posted to the public for comment until March 29, 2013. Therefore CGS did not adhere to the 45 day comment period. This policy is a significant departure from the previous CGS policy and the public should be afforded the full 45 days to comment. Thus, the comment period should actually end on May 13, 2013 and not April 29, 2013.

The following are our specific comments which are presented in the order of the draft LCD rather than in order of importance. Our format for addressing them is to state the issue, identify the language in the draft LCD, address our concerns and offer our recommendations. The issues are as follows:

SPECIFIC COMMENTS

The Term "Bioengineered Skin Substitute" is Clinically Inaccurate and Should be Replaced with the More Inclusive Descriptor "Cellular and/or Tissue Based Products for Wounds (CTPs)".

The Coalition is concerned with CGS using the term "bioengineered skin substitutes" since it is not a technically accurate term and does not describe the technology that is either currently or will be in the marketplace. Instead, the Coalition recommends that CGS adopt the term "Cellular and/or tissue based products for wounds (CTPs)" which does accurately describe and is broad and inclusive of both current and future technology. A clinical, non-profit, multidisciplinary association (the Alliance of Wound Care Stakeholders) recently voted positively on the adoption of this term – and we agree with the new term as

it describes these products more accurately. As a result, as mentioned above, we will be using the acronym "CTPs" when referring to Cellular and/or tissue based products for wounds in this document.

The Coalition submits that the term "skin substitute" is misleading and inaccurate to describe the products that are the subject of this LCD for the following reasons:

- This term is not used by either regulatory agency--FDA in its classification of these biologic products nor by CMS in its coding descriptors.
- The CMS division that addresses HCPCS coding for these biologic products abandoned the term "skin substitute" effective in 2010 when a manufacturer requested that CMS delete this term since it was an incorrect descriptor. The manufacturer stated at the 2010 CMS HCPCS Public Meeting that that this language was wrong since allografts are mislabeled as "skin substitutes." Allografts differ in structure, tissue origin, and in some cases differ from biologic products in terms of how they are approved by the FDA (human skin for transplantation not devices). CMS thus changed the descriptors and eliminated the term "skin substitutes" from all of its Q codes for these items.
- In addition, the Agency for Healthcare Research and Quality (AHRQ), in its 2011 draft technology assessment on skin substitutes stated that these products were not "skin substitutes."

As we understand it, the following were the criteria used by the Alliance of Wound Care Stakeholders to select the new term:

- be based on science
- be inclusive of all products in marketplace today with eye towards what is in the "pipeline"
- be neutral in regards to FDA--- nothing that would be offensive and not allow manufacturers to get their products approved in the future if needed
- ensure that all products are eligible for Medicare coverage as drugs and biologicals consistent with their USP monographs
- easily understood by clinicians
- easily linked to the existing CPT codes for the application of the products

Recommendation: Based on the information provided above, the Coalition recommends that CGS not utilize the term "skin substitutes" in its policy and use the term "cellular and/or tissue based wound care products for wounds (CTPs)".

Provision of Specific Criteria for Coverage is Necessary

The current policy for CTPs was well written and was in a format that was easy to follow and understand. We have often referred to your policy as one that set the standard which others should follow when submitting comments to other contractors. The Coalition would have preferred if CGS would have maintained the previous policy and just made a couple of modifications to that policy (such as changing the terminology used to describe these products and provide more information regarding the coverage it will use for determining coverage) instead of rewriting the policy.

That being said, the Coalition appreciates that CGS has attempted to provide criteria it will use for determining coverage for any CTP so as to guide the wound care community in its research and publication efforts. The draft policy states, "we have determined to cover those which we are satisfied have achieved at least a threshold minimum of literature supporting their efficacy". However, the policy does not indicate what the minimum threshold is and whether companies that are seeking coverage will have to meet the same or greater threshold. While we believe that there are areas that still need to be clarified in this policy, providing information to the wound care community regarding the type of information CGS is seeking in order for products to be considered for coverage is necessary. This will allow for a more transparent process for manufacturers when submitting their product for coverage.

The Coalition believes that evidence can be established for coverage not only through RCTs but also through a combination of retrospective clinical studies (relevant since the populations of patients that demonstrate a need for the products in question would be *eliminated* in many and most RCTs), scientific evidence and expert knowledge. This approach is consistent with the widely accepted definition of evidence based medicine but also adopted by the newly created important organization Patient Centered Outcomes Research Institute (PCORI). We believe that payers should cover these CTPs if the manufacturers provide clinical evidence in peer reviewed journals showing positive outcomes of their products without regard of how they are regulated by the FDA—Class II, III or HCT/Ps. There are examples of A/B MAC policies [NHIC] which have applied this approach and have broader product coverage of CPT products, some with additional indications for wounds with deeper tissue exposure of muscle, tendon and bone, not provided by this draft coverage policy.

In addition to our general comments, we recognize the challenges and difficulties that CGS is facing in managing the LCD development process with new CTPs entering the marketplace. However, your current policy would make it easier for CGS to accept new products without having to reissue your LCD every time a new CTP is approved for coverage. The format of the current policy with "general indications and limitations to Medicare coverage and payment" applied "to all materials and services related to skin substitute/replacement" with the more specific coverage information pertaining to the individual biologic products are included in the local coverage articles (LCAs) – which is very beneficial. This type of format should be advantageous to CGS since the contractor would not need to revise its LCD every time it makes the decision to cover a new biological product; it could merely write a new LCA.

Recommendation: The Coalition would like to recommend that CGS not utilize the draft LCD format but rather continue utilizing the current LCD format with the "general indications and limitations to Medicare coverage and payment" applied "to all materials and services related to skin substitute/replacement" with the more specific coverage information pertaining to the individual CTPs included in the LCAs.

LCD only Pertains to Lower Extremity Wounds

Issue: The title of the draft LCD - Application of Bioengineered Skin Substitutes: Ulcers (Lower Extremities) is significantly different than CGS's previous policy title—"Biologic Products for Wound Treatment and Surgical Interventions." Instead of having a broad focus, it now has a narrow one of ulcers of the lower extremity. The policy has gone from surgical procedures to ulcers of the lower extremity. This policy is no longer inclusive of how and where these products are applied.

Language in the Policy: The Policy Title is "Application of Bioengineered Skin Substitutes: Ulcers (of lower extremity).

Concerns: The Coalition is concerned that in this draft policy the coverage of CTPs are limited to lower extremity wounds. This is a clear departure from the previous LCD and therefore it is unclear whether other wound types will be covered by CGS. Previously, CGS covered acute postoperative wounds, deep tissue reconstruction and/or replacements or burns in this policy. We question whether they would still be covered based on medical necessity. If not, the beneficiaries with these other wounds will lose access to state-of-the-art technology.

Indications and Limitations for Coverage of Products

Issue 1: Within this section of the draft LCD, CGS separates out each of the products that are covered and provides their indications for use. However the language contained in this section is not consistent. If CGS decides to keep this section in the policy, the Coalition believes that the language needs to be consistent with the FDA labeling for the products and therefore changed prior to the policy becoming final.

Language in the Draft LCD:

First CGS states:

Limitations for use:

There should be no fewer than two weeks between applications for venous stasis ulcers and there should be no fewer than three weeks between applications for neuropathic diabetic foot ulcers. More frequent applications should be documented in the patient's medical records.

Treatment of any ulcer will typically last no more than twelve weeks.

Then CGS goes on to state:

Apligraf® (Q4101) Indications:
• Full-thickness neuropathic diabetic foot ulcer
• Venous stasis ulcer

Apligraf® (Q4101) Limitations:
• Apligraf® is limited to five applications per ulcer, though more than three applications to a single wound are usually unnecessary

- Medicare does not cover continued reapplication of Apligraf when the treatment is unsuccessful after 30 days of treatment
- Medicare does not cover retreatment of an ulcer following an unsuccessful course of treatment.
- Medicare does not cover retreatment of a successfully-treated, healed ulcer.

Oasis® (Q4102; Q4124) Indications:
• Neuropathic diabetic foot ulcer.
• Venous stasis ulcer.

Oasis® (Q4102; Q4124) Limitations:
• Medicare payment for Oasis® is limited to12 weeks of therapy per ulcer.
• Medicare does not covered continued reapplication of Oasis when the treatment is unsuccessful after 30 days of treatment
• Medicare does not cover retreatment of an ulcer following an unsuccessful course of treatment.
• Medicare does not cover retreatment of a successfully-treated, healed ulcer.

Dermagraft® (Q4106) Indications:
• Full thickness diabetic foot ulcers

Dermagraft® (Q4106) Limitations:
• Studies have documented that, for Q4106, survival of the dermal substitute decreases significantly when the 24 steps noted in the FDA labeling are not followed. Therefore, the 24 steps must be followed and documented.
• Frequency is limited to 8 applications per ulcer.
• Medicare does not cover continued reapplication of Dermagraft for the same ulcer if satisfactory and reasonable healing progress is not noted after 12 weeks of treatment.
• Medicare does not cover continued reapplication of Dermagraft when the treatment is not successful after 30 days of treatment.
• Medicare does not cover retreatment of an ulcer following an unsuccessful course of treatment.
• Medicare does not cover retreatment of a successfully-treated, healed ulcer.

GraftJacket® (Q4107) Indications:
- Full-thickness diabetic foot ulcers
- Patient does not have a current HbA1C reading exceeding 12%
- Underlying disease process(es) contributing to the ulcer, e.g., diabetes, is adequately treated and documented; and
- Ulcers located on the foot or toes and are free of infection, redness, drainage, underlying osteomyelitis, surrounding cellulitis, tunnels or tracts, eschar or any necrotic material that could interfere with the adherence of GRAFTJACKET® and the process of wound healing.

GraftJacket® (Q4107) Limitations:
- Medicare payment for GraftJacket® is limited to 1 application per ulcer. Note: Treatment with Graftjacket® is usually expected to last no more than twelve (12) weeks and to involve a maximum of two applications for any ulcer that initially qualifies for treatment.
- Medicare does not cover retreatment of an ulcer following an unsuccessful course of treatment.

- Medicare does not cover retreatment of a successfully treated, healed ulcer.

PriMatrix® (Q4110) Indications:

- Partial and full-thickness wounds

PriMatrix® (Q4110) Limitations:

- adequate arterial blood supply as evidenced by ankle-brachial index (ABI) of 0.65 or greater in limb undergoing the procedure
- Full thickness ulcers of at least 3 weeks in duration and which extend through dermis
- Medicare does not cover retreatment of the same ulcer using PriMatrix ® following an unsuccessful course of treatment.
- Medicare does not cover retreatment of a successfully treated, healed ulcer.

Theraskin® (Q4121) Indications:

- Ulcers located on foot and toes
- free of infection, redness, drainage, underlying osteomyelitis, surrounding cellulitis, tunnels and tracts, eschar or any necrotic material

Theraskin® (Q4121) Limitations:

- adequate arterial blood supply as evidenced by ankle-brachial index (ABI) of 0.65 or greater in limb undergoing the procedure
- full thickness ulcers of at least 3 weeks in duration and which extend through dermis
- Medicare does not cover retreatment of the same ulcer using Theraskin ® following an unsuccessful course of treatment.
- Medicare does not cover retreatment of a successfully treated, healed ulcer.

Concerns: The Coalition's concerns are that the manner in which CGS describes the limitations for use are not consistent for all of the CTPs—some are applications per ulcer versus others are weeks of use. For instance, Apligraf describes applications per ulcer, Oasis describes 12 weeks of therapy, while Primatrix does not provide any specific limitations on the number of applications. This inconsistency will cause confusion in the clinical community and needs to be uniform.

Furthermore, TheraSkin is currently covered by CGS under its existing LCD and LCA for treatment of both DFUs and VLUs, however, the draft LCD only includes TheraSkin treatment for DFUs.

Recommendations: The Coalition recommends that CGS eliminate the language that states, "There should be no fewer than two weeks between applications for venous stasis ulcers and there should be no fewer than three weeks between applications for neuropathic diabetic foot ulcers. More frequent applications should be documented in the patient's medical records" and "Treatment of any ulcer will typically last no more than twelve weeks." Furthermore, the Coalition recommends that the language regarding the number of applications should read:

The number of applications per ulcer is based on the FDA labeling and the dosage levels reported in published clinical trials for the product.

Finally, the Coalition recommends that prior to release of a final policy, CGS should consider an indication correction for Theraskin along with clinical evidence from the manufacturer to support DFU, VLU, and other indications as suggested in their package label.

Issue 2: An additional issue within this section pertains to the language that retreatment of a successfully healed ulcer is not covered nor is retreatment of an ulcer following an unsuccessful course of treatment. This is hugely problematic as patients can - down the road - develop another ulcer in the same location or can have further breakdown OR can be placed on another type of product after an unsuccessful course of treatment on one type of product.

Language in the Policy: Retreatment of an ulcer following an unsuccessful course of treatment is not covered. Retreatment of a successfully treated healed ulcer is not treated.

Recommendations: The Coalition does not agree with the language as drafted in this policy as it is not appropriate to eliminate coverage for a Medicare beneficiary if they have further breakdown after a successful treatment of a wound or if a particular product was tried unsuccessfully on a patient and the clinician determines that another product may be used to help heal the wound. We therefore recommend that this language be eliminated from the policy as it is not clinically sound.

Biologic Wound Dressing Terminology is not correct

Issue*:* CGS has stated that it would cover Apligraf, Dermagraft, Graftjacket, Oasis, Primatrix and Theraskin products as all other CTPs are considered at most "biologic wound dressings". There are many other products that are in the marketplace that are CTPs and they should not be classified as biologic wound dressings as that terminology

does not accurately describe the products nor is that terminology used by the FDA or CMS to describe any of the devices or products listed in this draft LCD.

A dressing is a material that is utilized for covering and protecting a wound, although they can be incorporated into the wound, they help shield the wound against the environment without exerting any direct biological effect in the wound bed. Yet products that maintain a "Q Code" all contain viable or non viable cells and/or are tissue-based with intrinsic biological activity, are usually not removed from the wound, are uniquely utilized for their biological influence on the healing process – whether they have a positive influence on the healing process without incorporation OR have the ability to stabilize or support healing through incorporation in whole or part into the regenerating tissue. All the products listed in this draft LCD are CTPs and are NOT wound dressings as they support wound healing by interacting directly or indirectly with the body.

Language in Draft LCD:

Coverage will not be provided under this LCD for any wound treatment that does not meet the definition of Q4101, Q4102, Q4106 Q4107, Q4110, Q4121 or Q4124. All other such products will be considered to be, at most, "biologic wound dressings."

Concerns: The Coalition disagrees with the terminology that CGS has used in its draft LCD, to state that coverage will not be provided for products that do not meet the definition of HCPCS codes Q4101, Q4102, Q4106 Q4107, Q4110, Q4121 or Q4124 and that all other products would be considered at most "biologic wound dressings." None of the CTPs included in this draft LCD are biologic wound dressings. They all support wound healing by interacting directly or indirectly with the body. There is much confusion about the use of these terms which raises the point that FDA and CMS use different terminology to describe these CTPs and cannot be used interchangeably.

It is inaccurate to describe these CTPs as "biologic wound dressings" since this term is neither used by CMS or FDA to describe these biologic products. These are not "biologic wound dressings" or "surgical dressings" in function or technology. Those dressings are intended to cover a wound, protect from contamination, and to manage the wound condition such as exudate, necrotic tissue or excess dryness. They are not interactive in the wound bed and are identified by CMS in the surgical dressing LCD as "A codes." On the other hand, the CTPs in this LCD are identified by CMS as "Q codes" - that interact with the body to support repair, and are not usually removable.

Furthermore, a product's eligibility for Medicare coverage purposes depends on (a) whether a product is considered a "drug or biological" under Medicare law, and (b) whether the product otherwise meets the requirements to be covered as a drug or biological provided "incident to" a physician's service.

Medicare defines the terms "drugs" and "biologicals" as those products that:

… are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary1, the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

Currently, several biologic products are the subject of USP monographs, including but not limited to: Small Intestinal Submucosa Wound Matrix (e.g., OASIS® Wound Matrix and OASIS® Ultra Tri-Layer Matrix), Cryopreserved Human Fibroblast-Derived Dermal Substitute (e.g., Dermagraft), and Graftskin (e.g., Apligraf). As such, these products are eligible for Medicare coverage as a "drug or biological" under Medicare law, notwithstanding FDA's classification of such products as a "wound dressing". In addition, other products that have been listed as non covered have USP issued monographs including, but not limited to "Human Acelluar Dermal Matrix" (e.g., Graftjacket® RTM), "Scaffold Human Dermis" (e.g. DermaCell) and "Human Amniotic Membrane Cryopreserved" (e.g. Grafix® PRIME and Grafix® CORE). Therefore, if these products meet the remaining "incident to" requirements, they should be eligible for Medicare coverage.

Recommendation: CGS should not classify any of the products listed in this draft LCD as "biologic wound dressings" as this description/terminology is simply incorrect. If CGS is trying to limit the number of products that are covered under this LCD then a better way of doing that is requiring studies to show a products efficacy. Sample language to be added to the LCD could include, "The contractor may determine a product use to be reasonable and necessary for the treatment of wounds or other conditions if, on the basis of available or presented evidence, it is shown to be safe and effective and does not violate national or local Medicare determinations and regulations. The approval will be limited to specific indications and/or patient populations, practitioner categories, procedures, and/or place of service."

Furthermore, the Coalition recommends, that consistent with Medicare law, if a product has a USP monograph, and meets the requirements to be covered as a biological provided "incident to" a physician's service, the Coalition recommends that those CTPs be covered under your policy. As such, we request that CGS re-review proposed non-covered items to determine whether they meet the Medicare standard for Part B coverage. We believe that there are other products that in fact do meet the coverage standard and are eligible for coverage under this LCD.

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On behalf of the Coalition of Wound Care Manufacturers, we appreciate the opportunity to submit these comments. If you have any questions of would like further information, please do not hesitate to contact me.

Sincerely,

Karen S Ravitz, JD
Senior Policy Advisor