Wound & Burn

Reimbursement & Coding Guide

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Reimbursement and Coding Guide

MicroMatrix® and Cytal™ products are medical devices that maintain and support a healing environment through constructive remodeling. Comprised of naturally-occurring urinary bladder matrix (UBM), these devices maintain an intact epithelial basement membrane. MicroMatrix and Cytal wound devices are appropriate for acute wounds and chronic wounds.

Reimbursement and eligibility for coverage for the use of these products and associated procedures varies by Medicare and payers. Coverage policies, prior authorizations, contract terms, billing edits, and site of service influence reimbursement. It is recommended that providers verify coverage and billing policies.

The following information is shared for educational purposes only to help answer common coding and reimbursement questions. While ACell believes this information to be correct, information is subject to change without notice.

For assistance with reimbursement questions, contact the Reimbursement Hotline at
reimbursement@acell.com or call 800-826-2926 x7.

PLEASE NOTE: The payments specified in this document reflect Medicare national unadjusted published payments from the Centers for Medicare & Medicaid Services (CMS). Actual payment rates will vary based on geographical adjustments. As such, all codes provided herein are for illustrative purposes and shall not be construed as a warranty, statement, promise or guarantee that these codes are accurate or that the product will be covered in all instances, and if covered, that reimbursement in the amounts specified will be received.

The decision of how to complete a reimbursement claim form, including codes and amounts to bill, is exclusively the responsibility of the QHPs and other providers. Coding requirements are subject to change at any time; please check with your local payer regularly for updates.

Rx ONLY - Refer to IFU with each device for indications, contraindications, and precautions. US Toll-Free 800-826-2926 ©2017 ACell, Inc. All Rights Reserved.

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Applicable FARS/DFARS Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Indications for Use

Refer to Product Label for Full Instructions for Use

Cytal™ Wound Matrix* (1-Layer, 2-Layer, 3-Layer, 6-Layer) (sheets) is intended for the management of wounds including: partial and full-thickness wounds, pressure ulcers, venous ulcers, diabetic ulcers, chronic vascular ulcers, tunneled/undermined wounds, surgical wounds (donor sites/grafts, post-Mohs surgery, post-laser surgery, podiatric, wound dehiscence), trauma wounds (abrasions, lacerations, second-degree burns, skin tears) and draining wounds. This device is intended for one-time use.

MicroMatrix®* (particles) is intended for the management of topical wounds including: partial and full-thickness wounds, pressure ulcers, venous ulcers, diabetic ulcers, chronic vascular ulcers, tunneled undermined wounds, surgical wounds (donor sites/grafts, post-Mohs surgery, post-laser surgery, podiatric, wound dehiscence), trauma wounds (abrasions, lacerations, second-degree burns, skin tears and draining wounds. This device is intended for one-time use.

Cytal™ Burn Matrix* (sheets) is intended for the management of wounds including: second-degree burns, partial and full-thickness wounds, pressure ulcers, venous ulcers, diabetic ulcers, chronic vascular ulcers, tunneled/undermined wounds, surgical wounds (donor sites/grafts, post-Mohs surgery, post-laser surgery, podiatric, wound dehiscence), trauma wounds (abrasions, lacerations, skin tears) and draining wounds. This device is intended for one-time use. Contraindicated for third-degree burns.

*Also marketed as MatriStem® Wound Matrix, MatriStem MicroMatrix, and MatriStem Burn Matrix

Skin Graft Procedures: CPT Codes and Medicare Payments

Physician

Skin graft procedures performed by physicians are reported with CPT codes 15271-15278. The selection of the code is based upon the location and size of the defect. Ensure the medical record reflects these elements with a procedure description including the fixation method.

The supply of the skin substitute graft is reported separately from 15271-15278. (See HCPCS codes on page 6). Private payers and Medicare may allow separate payment for the products when applied in the physician office. Policies and payment methods vary.

Coding Tips:

- AMA CPT Guidance (CPT Assistant Dec. 2012) and local Medicare contractors have specified that non-graft wound dressings (e.g., gels, ointment, liquids, gels, particles, etc.), should not be billed with skin graft procedure CPT codes 15271-15278.
- When MicroMatrix® (particles) are used, the service may be reported with wound management codes (97597-97610), debridement codes (11042-11047), or Evaluation/ Management codes (99211-99215).

It is recommended that providers check individual payer and Medicare local coverage determinations (LCD) coverage policies prior to performing skin substitute graft procedures to determine indications and limitations. Private payers may require prior authorization; identify both procedures and products.

CPT	Description	Physician Facility: 2017 National Average Payment	Physician Non- Facility (office): 2017 National Average Payment
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	$87.57	$142.84
+15272	Each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	$17.94	$27.63
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	$210.67	$306.49
+15274	Each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	$47.73	$73.21
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	$99.05	$151.81
+15276	Each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	$26.20	$35.53

Skin Graft Procedures:
CPT Codes and Medicare Payments

Physician (continued)

CPT	Description	Physician Facility: 2017 National Average Payment	Physician Non- Facility (office): 2017 National Average Payment
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	$236.15	$334.12
+15278	Each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	$59.93	$87.57

Hospital Outpatient and Ambulatory Surgical Center (ASC)

Medicare has designated specific HCPCS codes (C5271-C5278) for facilities to report skin graft procedures when used with low cost skin substitute products. These codes are used in place of the CPT skin graft procedure codes. The selection of the code is based upon the location and size of the defect. Ensure the medical record reflects these elements and a procedure description including the fixation method.

The supply of the skin substitute graft is reported separately from the skin graft C5271-C5278. (See HCPCS codes on page 6). Based on Medicare outpatient facility payment policy, skin substitute products are not separately paid with some exceptions. The products are included in the procedure payment.

It is recommended that providers check individual payer and Medicare local coverage determinations (LCD) coverage policies prior to performing skin substitute graft procedures to determine indications and limitations. Private payers may require prior authorization; identify procedures and products. As payment policies differ among payers, check with private payers to determine if the product is separately paid. In addition, also verify if that payer has adopted the C5271-C5278 codes or continues to use CPT codes 15271-15278.

Coding for Low Cost Skin Substitute Graft Procedures

For 2017, ACell Wound and Burn Matrix multi-layer product sheets (Cytal™) are classified as Low Cost Skin Substitutes by Medicare when applied as a skin substitute graft. Report HCPCS procedure codes C5271-C5278 when Medicare patients are treated with skin graft procedures in the outpatient facility.

Coding Tips:

- The HCPCS code for Cytal Wound and Burn Matrix products is Q4166, Cytal, per sq. cm. (See page 6).
- AMA CPT Guidance (CPT Assistant Dec. 2012) and local Medicare contractors have specified that non-graft wound dressings (e.g., gels, ointment, liquids, gels, particles, etc.), should not be billed with skin graft procedure CPT codes.
- MicroMatrix® (particles) may be reported with wound management codes (97597-97610), debridement codes (11042-11047), or Evaluation/ Management codes (99211-99215).

HCPCS	Description	APC	Status Indicator (SI) Outpatient Hospital and (ASC)		2017 Medicare Hospital Outpatient National Average Payment	2017 ASC Medicare: National Average Payment
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	5053	T	(G2)	$452.91	$244.63
+C5272	Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)		N	(N)	Packaged	Packaged
C5273	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	5054	T	(G2)	$1,427.16	$770.84
+C5274	Each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)		N	(N)	Packaged	Packaged
C5275	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	5053	T	(G2)	$452.91	$244.63
+C5276	Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)		N	(N)	Packaged	Packaged
C5277	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	5053	T	(G2)	$452.91	$244.63
+C5278	Each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure		N	(N)	Packaged	Packaged

T: Significant procedure, multiple reduction applies

N: Items and services are packaged into payment for other services

G2 Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight

N1 Packaged service/item; no separate payment made

ACell Wound and Burn Devices

HCPCS Codes and Modifiers

For Medicare:

- Products are packaged (not separately paid) when applied in the hospital inpatient or outpatient/ASC setting; products may be reported.
- Payment for product used in the physician office is contractor dependent; products may be reported.

- Many Medicare contractors require providers to include the name of the product on the claim form.
- Coverage for MicroMatrix® and Cytal™ products vary by payers and Medicare contractors.
- Private payer payment policies vary based on contracts.
  - Verify coverage and payment of the procedure and product during the prior authorization process.
- Report accurate billing units of service consistent with the dosages described in the HCPCS Q code product descriptor.

HCPCS Code and Description	HCPCS Modifier
Q4118 - MicroMatrix®, 1 mg	JD skin substitute not used as a graft
Q4166 - Cytal™, per sq. cm.	JC skin substitute used as a graft JD skin substitute not used as a graft
JW - drug amount discarded, not administered Effective January 1, 2017, CMS requires providers to report discarded amounts of products on a separate claim line item by attaching the JW modifier to the HCPCS code to describe wastage.	

Sample CMS-1500 Claim Form-Physician Office

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Box 19-Enter Product Name, Product Size, and Invoice Pricing

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line bel

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE From MM DD Y | C. | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | REN PROV

Box 24 D.-Enter CPT or HCPCS Codes on separate lines: eg. 15275, Q4166

Line	D. CPT/HCPCS	MODIFIER	G. DAYS OR UNITS
1	15275		
2	Q4166	JC	25
3			
4			
5			
6			

NPI

Box 24 D.-Enter Modifier: e.g. JC, JD, JW

Box 24 G.-Enter Units, if 25 sq. cm of Cytal Wound Matrix is used, enter 25 units on the same line as Q4166

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. BA $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | 32. SERVICE FACILITY LOCATION INFORMATION | 33. BILLING PROVIDER INFO & PH # ( )

Hospital Inpatient Codes and Payments:

Medicare uses a prospective payment system to reimburse hospitals for inpatient services based on Medicare Severity Diagnosis Related Groups (MS-DRGs). Services are classified into clinically cohesive groups that exhibit similar use of hospital resources. Hospitals receive a single payment for all services provided during an inpatient admission based on the MS-DRG assigned, regardless of the actual length of stay or costs of services. Only one MS-DRG may be assigned per patient stay. The MS-DRG assignment to the categories of Complications or Comorbidities (CCs) and/or Major Complications or Comorbidities (MCCs) is influenced by the medical record documentation describing certain clinical circumstances. Diagnoses and procedures are reported with ICD-10 codes.

Skin Graft Inpatient Procedures that may be appropriate for coding purposes, where Cytal™ Wound and Burn Matrix products are applied (not an all-inclusive list; consult the ICD-10-PCS book for a complete list of procedures).

The following tables are examples of potential ICD-10-PCS procedure codes that are available for hospitals when reporting inpatient skin graft procedures.

Wound and Burn
ICD-10-PCS Skin Graft Procedures

OHR - Medical and Surgical
Skin and Breast - Replacement

Section:	**0** - Medical and Surgical
Body System:	**H** - Skin and Breast
Operation:	**R** - Replacement: Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part

Body Part	Approach	Device	Qualifier
0 - Skin, Scalp **1** - Skin, Face **2** - Skin, Right Ear **3** - Skin, Left Ear **4** - Skin, Neck **5** - Skin, Chest **6** - Skin, Back **7** - Skin, Abdomen **8** - Skin, Buttock **9** - Skin, Perineum **A** - Skin, Genitalia	**X** - External	**7** - Autologous Tissue Substitute **K** - Nonautologous Tissue Substitute	**3** - Full Thickness **4** - Partial Thickness
B - Skin, Right Upper Arm **C** - Skin, Left Upper Arm **D** - Skin, Right Lower Arm **E** - Skin, Left Lower Arm **F** - Skin, Right Hand **G** - Skin, Left Hand **H** - Skin, Right Upper Leg **J** - Skin, Left Upper Leg **K** - Skin, Right Lower Leg **L** - Skin, Left Lower Leg **M** - Skin, Right Foot **N** - Skin, Left Foot	**X** - External	**7** - Autologous Tissue Substitute **K** - Nonautologous Tissue Substitute	**3** - Full Thickness **4** - Partial Thickness

Wound and Burn
ICD-10-PCS Skin Graft Procedures

Body Part	Approach	Device	Qualifier
0 - Skin, Scalp **1** - Skin, Face **2** - Skin, Right Ear **3** - Skin, Left Ear **4** - Skin, Neck **5** - Skin, Chest **6** - Skin, Back **7** - Skin, Abdomen **8** - Skin, Buttock **9** - Skin, Perineum **A** - Skin, Genitalia **B** - Skin, Right Upper Arm **C** - Skin, Left Upper Arm **D** - Skin, Right Lower Arm **E** - Skin, Left Lower Arm **F** - Skin, Right Hand **G** - Skin, Left Hand **H** - Skin, Right Upper Leg **J** - Skin, Left Upper Leg **K** - Skin, Right Lower Leg **L** - Skin, Left Lower Leg **M** - Skin, Right Foot **N** - Skin, Left Foot	**X** - External	**J** - Synthetic Substitute	**3** - Full Thickness **4** - Partial Thickness **Z** - No Qualifier

Wound and Burn
ICD-10-PCS Skin Graft Procedures (continued)

OHR - Medical and Surgical
Skin and Breast - Replacement

Section:	**0** - Medical and Surgical
Body System:	**H** - Skin and Breast
Operation:	**R** - Replacement: Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part

Body Part	Approach	Device	Qualifier
Q - Finger Nail **R** - Toe Nail **S** - Hair	**X** - External	**7** - Autologous Tissue Substitute **J** - Synthetic Substitute **K** - Nonautologous Tissue Substitute	**Z** - No Qualifier

Body Part	Approach	Device	Qualifier
T - Breast, Right **U** - Breast, Left **V** - Breast, Bilateral	**0** - Open	**7** - Autologous Tissue Substitute	**5** - Latissimus Dorsi Myocutaneous Flap **6** - Transverse Rectus Abdominis Myocutaneous Flap **7** - Deep Inferior Epigastric Artery Perforator Flap **8** - Superficial Inferior Epigastric Artery Flap **9** - Gluteal Artery Perforator Flap **Z** - No Qualifier

Body Part	Approach	Device	Qualifier
T - Breast, Right **U** - Breast, Left **V** - Breast, Bilateral	**0** - Open	**7** - Autologous Tissue Substitute **J** - Synthetic Substitute **K** - Nonautologous Tissue Substitute	**Z** - No Qualifier

Body Part	Approach	Device	Qualifier
T - Breast, Right **U** - Breast, Left **V** - Breast, Bilateral	**3** - Percutaneous **X** - External	**7** - Autologous Tissue Substitute **J** - Synthetic Substitute **K** - Nonautologous Tissue Substitute	**Z** - No Qualifier

Body Part	Approach	Device	Qualifier
W - Nipple, Right **X** - Nipple, Left	**0** - Open **3** - Percutaneous **X** - External	**7** - Autologous Tissue Substitute **J** - Synthetic Substitute **K** - Nonautologous Tissue Substitute	**Z** - No Qualifier

Wound and Burn
ICD-10-PCS Application of a Wound Dressing

For inpatient procedures, the application of a wound dressing may be appropriate for coding purposes where Cytal™ Wound and Burn Matrix products are applied (not an all-inclusive list; consult ICD-10-PCS book for complete list of procedures).

2W2 - Placement
Anatomical Regions - Dressing

Section:	**2** - Placement
Body System:	**W** - Anatomical Regions
Operation:	**2** - Dressing: Putting material on a body region for protection

Body Part	Approach	Device	Qualifier
0 - Head **1** - Face **2** - Neck **3** - Abdominal Wall **4** - Chest Wall **5** - Back **6** - Inguinal Region, Right **7** - Inguinal Region, Left **8** - Upper Extremity, Right **9** - Upper Extremity, Left **A** - Upper Arm, Right **B** - Upper Arm, Left **C** - Lower Arm, Right **D** - Lower Arm, Left **E** - Hand, Right **F** - Hand, Left **G** - Thumb, Right **H** - Thumb, Left **J** - Finger, Right **K** - Finger, Left **L** - Lower Extremity, Right **M** - Lower Extremity, Left **N** - Upper Leg, Right **P** - Upper Leg, Left **Q** - Lower Leg, Right **R** - Lower Leg, Left	**X** - External	**4** - Bandage	**Z** - No Qualifier

Wound and Burn
ICD-10-PCS Application of a Wound Dressing (continued)

2W2 - Placement
Anatomical Regions - Dressing

Section:	**2** - Placement
Body System:	**W** - Anatomical Regions
Operation:	**2** - Dressing: Putting material on a body region for protection

Body Part	Approach	Device	Qualifier
S Foot, Right **T** Foot, Left **U** Toe, Right **V** Toe, Left	**X** - External	**4** - Bandage	**Z** - No Qualifier

MS-DRG (Skin Graft) - Hospital Inpatient

MS-DRG	Description	FY 2017 Medicare National Average Prospective Payment
463	Wound debridement & skin graft except hand, for musculoskeletal-connective tissue disease w mcc	$31,782.87
464	Wound debridement & skin graft except hand, for musculoskeletal-connective tissue disease w cc	$18,009.43
465	Wound debridement & skin graft except hand, for musculoskeletal-connective tissue disease w/o cc/mcc	$12,070.66
570	Skin debridement w mcc	$14,004.38
571	Skin debridement w cc	$8,499.73
572	Skin debridement w/o cc/mcc	$6,198.05
573	Skin graft for skin ulcer or cellulitis w mcc	$21,777.64
574	Skin graft for skin ulcer or cellulitis w cc	$16,873.65
575	Skin graft for skin ulcer or cellulitis w/o cc/mcc	$8,736.57
576	Skin graft except for skin ulcer or cellulitis w mcc	$25,513.36
577	Skin graft except for skin ulcer or cellulitis w cc	$13,518.88
578	Skin graft except for skin ulcer or cellulitis w/o cc/mcc	$8,170.16

Note: Grafting that occurs incident to a hospitalization for another primary clinical reason will group to other appropriate DRGs based on the patient diagnosis. Comorbidities and Complications/Major Comorbidities and Complications (cc/mcc)

MS-DRGs (Burns) - Hospital Inpatients

ACell product payment is included in the DRG payment; may be identified on the hospital claim using the HCPCS and/or revenue code; captured as a surgical supply for hospital cost accounting.

Burn Inpatient Procedures that may be appropriate for coding purposes where Cytal™ Wound and Burn Matrix products are applied (not an all-inclusive list; please consult ICD-10-PCS book for complete list of procedures).

MS-DRG	MS-DRG Title	FY 2017 Unadjusted National Payment
927	Extensive burns or full thickness burns w mechanical ventilation 96+ hours w skin graft	$85,341.61
928	Full thickness burn w skin graft or inhalation injury w cc/mcc	$30,681.35
929	Full thickness burn w skin graft or inhalation injury w/o cc/mcc	$15,112.40

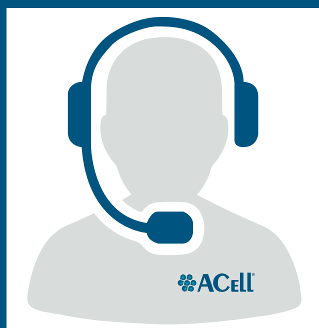
Note: Comorbidities and Complications/Major Comorbidities and Complications (cc/mcc)

Product payment:

- Is included in the DRG payment.
- May be identified on the hospital claim using the HCPCS or revenue code but it is not itemized for payment.
- Is captured as a surgical supply for hospital cost accounting.

Sources

- CPT® 2017 Professional Codebook
- CPT® Assistant through 2017
- CPT® Changes through 2017
- Medicare - National Correct Coding Policy Manual, Physician Version 22.3 Effective October 1, 2016
- 2017 Medicare Hospital Outpatient Prospective Payment System (CMS-1656-F) Addendum B
- 2017 Ambulatory Surgery Center Prospective Payment System (CMS-1656-F) Addendum A
- CMS-1654-F Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017/Downloads Physician Fee Schedule RVU File



The ACell Reimbursement Hotline

Monday - Friday: 9:00 am - 5:00 pm, Eastern

800-826-2926, x 7 | acellreimbursement@1jra.com

ACell's Reimbursement Hotline is dedicated to providing answers to all of your reimbursement questions. It also serves as a resource for obtaining accurate billing information and reimbursement support for ACell's surgical products.

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