



Wound & Burn

Reimbursement & Coding Guide





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MicroMatrix® and Cytal® devices facilitate the remodeling of functional, site-appropriate tissue. Comprised of ACell's proprietary MatriStem UBM™ (Urinary Bladder Matrix) technology, these biologically-derived devices maintain an intact epithelial basement membrane which facilitates cellular infiltration and capillary ingrowth. 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 Support Center by phone at **800-826-2926, x 7** or by email at acell@thepinnaclehealthgroup.com.

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 ©2019 ACell, Inc. All Rights Reserved.

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Applicable FARS/DFARS Restrictions Apply to Government Use.

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Indications for Use

Refer to Product Label for Full Instructions for Use

MicroMatrix[®] (particulate) 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.

Cytal[®] **Wound Matrix** (1-Layer, 2-Layer, 3-Layer, 6-Layer) 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.

Cytal[®] **Burn Matrix** (meshed 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. Cytal Burn Matrix is contraindicated for third-degree burns.

Skin Graft Procedures: CPT and HCPCS Codes and Medicare Payments

Coding Definitions and Information

- AMA CPT defines skin substitutes graft to "include non-autologous human skin (dermal or epidermal, cellular or acellular) grafts (eg, homograft, allograft), non-human skin substitute grafts (ie, xenograft), and biological products that form a sheet scaffolding for skin growth."
- AMA CPT Guidance (CPT Assistant Dec. 2012, Oct. 2017) and local Medicare contractors have specified that the application of non-graft wound dressings (e.g., gels, ointment, liquids, particles, etc.), should not be reported with procedures that describe the application of a skin substitute graft (CPT codes 15271-15278 or HCPCS codes C5271-C5278).

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.

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.

The 2019 Medicare payment rates, listed in the following table, are national unadjusted payment rates. Check with your MAC for payment rates specific to your region.

CPT Code	Description	Facility	Non-Facility (Office)
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	\$87.21	\$149.20
+15272	Each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	\$18.02	\$27.39
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	\$210.47	\$314.62
+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)	\$47.93	\$77.48
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	\$98.75	\$157.49
+15276	Each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	\$26.31	\$35.32

(Table continues on next page)

Skin Graft Procedures: CPT and HCPCS Codes and Medicare Payments

Physician (continued)

CPT Code	Description	Facility	Non-Facility (Office)
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	\$237.86	\$344.17
+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)	\$59.82	\$91.54

+ Add-on code

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 the payer has adopted the C5271-C5278 codes or continues to use CPT codes 15271-15278.

Coding for Low Cost Skin Substitute Graft Procedures

For 2019, 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.

The 2019 Medicare payment rates, listed in the following table, are national unadjusted payment rates. Check with your MAC for payment rates specific to your region.

HCPCS Code	Description	APC	Outpatient Hospital		ASC	
			Status Indicator	Payment	Status Indicator	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	\$482.89	G2	\$248.63
+C5272	Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)		N	Packaged	N1	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	\$1,548.96	G2	\$797.53
+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	Packaged	N1	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	\$482.89	G2	\$248.63
+C5276	Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)		N	Packaged	N1	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	\$482.89	G2	\$248.63
+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	Packaged	N1	Packaged

+ Add-on code

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

N Items and services are packaged into Ambulatory Payment Classification (APC)

N1 Packaged service/item; no separate payment made

T Significant procedure, multiple reduction applies

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 square centimeter (sq. cm.) units described in the HCPCS Q code product descriptor. Examples of calculating the sq. cm.:
 - Cytal Wound Matrix Size 3 x 7 cm Multiply 3 x 7 = 21 sq. cm.
 - Cytal Burn Matrix Size 5 x 5 cm Multiply 5 x 5 = 25 sq. cm.

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 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)										20. OUTSIDE LAB? YES NO		\$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below										22. RESUBMISSION CODE		ORIGINAL REF. NO.									
A. _____		B. _____		C. _____		D. _____		E. _____		23. PRIOR AUTHORIZATION NUMBER											
E. _____		F. _____		G. _____		H. _____		I. _____		K. _____		L. _____									
24. A. DATE From MM DD Y		B. _____		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			
1						15275															
2				Q4166		JC						25									
3																					
4																					
5																					
6																					
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, Inguinal 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, Inguinal 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

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

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
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	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

The 2019 Medicare payment rates, listed in the following tables, are national unadjusted payment rates. Check with your MAC for payment rates specific to your region.

Skin Graft - Hospital Inpatient

MS-DRG	Description*	Payment**
463	Wound debridement and skin graft except hand, for musculoskeletal-connective tissue disease with mcc	\$31,333
464	Wound debridement and skin graft except hand, for musculoskeletal-connective tissue disease with cc	\$17,975
465	Wound debridement and skin graft except hand, for musculoskeletal-connective tissue disease without cc/mcc	\$11,218
570	Skin debridement with mcc	\$18,528
571	Skin debridement with cc	\$10,397
572	Skin debridement without cc/mcc	\$7,196
573	Skin graft for skin ulcer or cellulitis with mcc	\$32,063
574	Skin graft for skin ulcer or cellulitis with cc	\$18,597
575	Skin graft for skin ulcer or cellulitis without cc/mcc	\$10,737
576	Skin graft except for skin ulcer or cellulitis with mcc	\$29,799
577	Skin graft except for skin ulcer or cellulitis with cc	\$15,320
578	Skin graft except for skin ulcer or cellulitis without cc/mcc	\$9,340

* Comorbidities and Complications/Major Comorbidities and Complications (cc/mcc)

** MS-DRG Payment calculations assumes Wage Index = 1 and uses Table Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.35 Percent)

Burn - Hospital Inpatient

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	Description*	Payment**
927	Extensive burns or full thickness burns with mechanical ventilation 96+ hours with skin graft	\$112,246
928	Full thickness burn with skin graft or inhalation injury with cc/mcc	\$35,873
929	Full thickness burn with skin graft or inhalation injury without cc/mcc	\$18,147

* Comorbidities and Complications/Major Comorbidities and Complications (cc/mcc)

** MS-DRG Payment calculations assumes Wage Index = 1 and uses Table Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.35 Percent)

Product Payment

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

Sources

- CPT® 2019 Professional (2018) American Medical Association.
- CPT® Assistant through 2018
- CPT® Changes through 2018
- Medicare - National Correct Coding Initiative Policy Manual, Revision Date Effective January 1, 2019
- 2019 Medicare Hospital Outpatient Prospective Payment System (CMS-1695-FC) Addendum B
- 2019 Ambulatory Surgery Center Prospective Payment System (CMS-1695-FC) Addendum AA
- CMS-1695 FC Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019/Downloads
- FY 2019 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (CMS 1694-CN), Effective October 1, 2018
- 2019 Physician Fee Schedule RVU File
- 2019 ICD-10-PCS The Complete Official Code Set



The ACell Reimbursement Support Center

Monday - Friday: 8:30 am - 6:00 pm, Eastern

800-826-2926, x 7 | acell@thepinnaclehealthgroup.com

ACell's Reimbursement Support Center is dedicated to providing answers to all of your reimbursement questions. Services available for all ACell products include benefit verification, prior authorizations, claim appeals, and general coding and billing questions.



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