Skin Substitute Grafts Coding Reference Guide

ZIMMER BIOMET
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AmnioRepair® Allograft is a lyophilized placental membrane allograft that is aseptically processed to preserve the native extracellular matrix and endogenous proteins. AmnioRepair is indicated for use as a biological barrier or wound cover. AmnioRepair is a Human Cellular and Tissue Based Product (HCT/P) per 21 CFR Part 1271. Each allograft is restricted to homologous use for use in procedures on a single occasion by a licensed physician or surgeon.

DermaSpan™ Acellular Dermal Matrix is carefully processed to offer biocompatibility and preserve biomechanical strength. DermaSpan Matrix can be used in various practices, including orthopedics, plastic surgery, and general surgery, for the repair and replacement of damaged or inadequate integumental tissue (wound coverage). DermaSpan can also be used for supplemental support, protection, reinforcement, or covering of tendon.

Physician	
CPT® Code	**Description**
Implantation	
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (list separately in addition to code for primary procedure)
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
Application	
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
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
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
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; 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)
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
15276	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; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
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
15278	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; 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)
Implantation/Tendon Repair	
27650	Repair, primary, open or percutaneous, ruptured achilles tendon
27652	Repair, primary, open or percutaneous, ruptured achilles tendon; with graft (includes obtaining graft)
27654	Repair, secondary, achilles tendon, with or without graft

CPT Coding Guidance:

- Skin substitute graft application code selection is based on defect site location and size. Add together the surface area of multiple wounds in the same anatomical locations as indicated in the code descriptions group, such as face and scalp. Do not add together multiple wounds at different anatomic site groups.
- CPT coding guidance states that the skin substitute graft application codes include simple tissue debridement. Therefore, this debridement procedure is not separately reported or reimbursed.
- Code also the supply of the skin substitute product (refer to HCPCS coding section).

Hospital Inpatient: ICD-10-PCS Code and Description			
Ø Medical and Surgical **H** Skin and Breast **R** Replacement			
Body Part	**Approach**	**Device**	**Qualifier**
Select the appropriate character for the "Body Part" position	**X** External	**K** Nonautologous Tissue	**4** Partial Thickness
Ø Medical and Surgical **L** Tendon **U** Supplement			
Select the appropriate character for the "Body Part" position	**Ø** Open	**K** Nonautologous Tissue	**Z** No Qualifier

Hospital Inpatient: Medicare Severity-Diagnosis Related Group (MS-DRG)	
MS-DRG	**Description**
MS-DRG assignment will be based upon the patient's diagnosis(es) and procedure(s) performed. Other MS-DRGs may be applicable.	
463	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders with MCC
464	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders with CC
465	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders without CC/MCC
573	Skin Graft for Skin Ulcer or Cellulitis with MCC
574	Skin Graft for Skin Ulcer or Cellulitis with CC
575	Skin Graft for Skin Ulcer or Cellulitis without CC/MCC
576	Skin Graft Except for Skin Ulcer or Cellulitis with MCC
577	Skin Graft Except for Skin Ulcer or Cellulitis with CC
578	Skin Graft Except for Skin Ulcer or Cellulitis without CC/MCC
622	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders with MCC
623	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders with CC
624	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders withoutCC/MCC
904	Skin Grafts for Injuries with CC/MCC
905	Skin Grafts for Injuries without CC/MCC
927	Extensive Burns or Full Thickness Burns with Mechanical Ventilation >96 Hours with Skin Graft
928	Full Thickness Burn with Skin Graft or Inhalation Injury with CC/MCC
929	Full Thickness Burn with Skin Graft or Inhalation Injury without CC/MCC
957	Other O.R. Procedures for Multiple Significant Trauma with MCC
958	Other O.R. Procedures for Multiple Significant Trauma with CC
959	Other O.R. Procedures for Multiple Significant Trauma without CC/MCC

CC – Complication and/or Comorbidity.
MCC – Major Complication and/or Comorbidity.

Hospital Outpatient and Ambulatory Surgery Center (ASC)

Skin substitutes with pricing information but without claims data to calculate a geometric mean unit cost (MUC) or product per day cost (PDC) will be assigned to either the high-cost or low-cost category based on the product's Average Sales Price (ASP) +6 percent payment rate as compared to the MUC threshold. If ASP is not available, CMS will use Wholesale Acquisition Cost (WAC) +3 percent to assign a product to either the high cost or low cost category.

High-cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by CPT codes 15271-15278. Low-cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278.

Source: Calendar Year 2020 Medicare Outpatient Prospective Payment System, Final Rule, Federal Register, November 12, 2019, 61327-61335.

Note: ASCs should not separately bill for packaged skin substitutes (ASC PI=N1) since packaged codes are not reportable under the ASC payment system

Hospital Outpatient and Ambulatory Surgical Center (ASC)				
CPT® Code	**Description**	**OPPS Status Indicator**	**Ambulatory Payment Classification**	**ASC Payment Indicator**
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	T	5054	G2
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	N	--	N1
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	T	5055	G2
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; 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	--	N1
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	T	5054	G2
15276	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; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	N	--	N1
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	T	5054	G2
15278	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; 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	--	N1
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (list separately in addition to code for primary procedure)	N	--	N1
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	Q1	5051	NA
27650	Repair, primary, open or percutaneous, ruptured achilles tendon	J1	5114	A2
27652	Repair, primary, open or percutaneous, ruptured achilles tendon; with graft (includes obtaining graft)	J1	5114	A2
27654	Repair, secondary, achilles tendon, with or without graft	J1	5114	A2

OPPS - Outpatient Prospective Payment System; APC - Ambulatory Payment Classification
Status Indicator: J1 - Hospital Part B services paid through a comprehensive APC; N – Items and Services Packaged into APC Rates; payment is packaged into payment for other services. Therefore, there is no separate APC payment; Q1 - STV-Packaged Codes; T - Procedure or Service, Multiple Procedure Reduction Applies
APC: 5051 - Level 1 Skin Procedures; 5054 –Level 4 Skin Procedures; 5055 –Level 5 Skin Procedures; APC 5114 – Level 4 Musculoskeletal Procedures
Payment Indicator: A2 – Payment based on OPPS relative payment weight; G2 -Non office-based surgical procedure added in CY 2008 or later; payment based on OPPSrelative payment weight; N1 – Packaged service/item; no separate payment made; NA – This procedure is not on Medicare's ASC Covered Procedures List (CPL).

HCPCS (Healthcare Common Procedure Coding System)	
Code	**Description**
Q4126	MemoDerm, DermaSpan, TranZgraft or IntegüPly, per sq cm
Q4235	Amniorepair, per square centimeter

Note: Q-codes are temporary codes used to pay health care providers for supplies, drugs and biologicals to which no permanent code has been assigned.

HCPCS Modifiers	
Code	**Description**
JC	Skin substitute used as a graft
JD	Skin substitute not used as a graft
JW	Drug amount discarded/not administered to any patient
KX	Requirements specified in the medical policy have been met

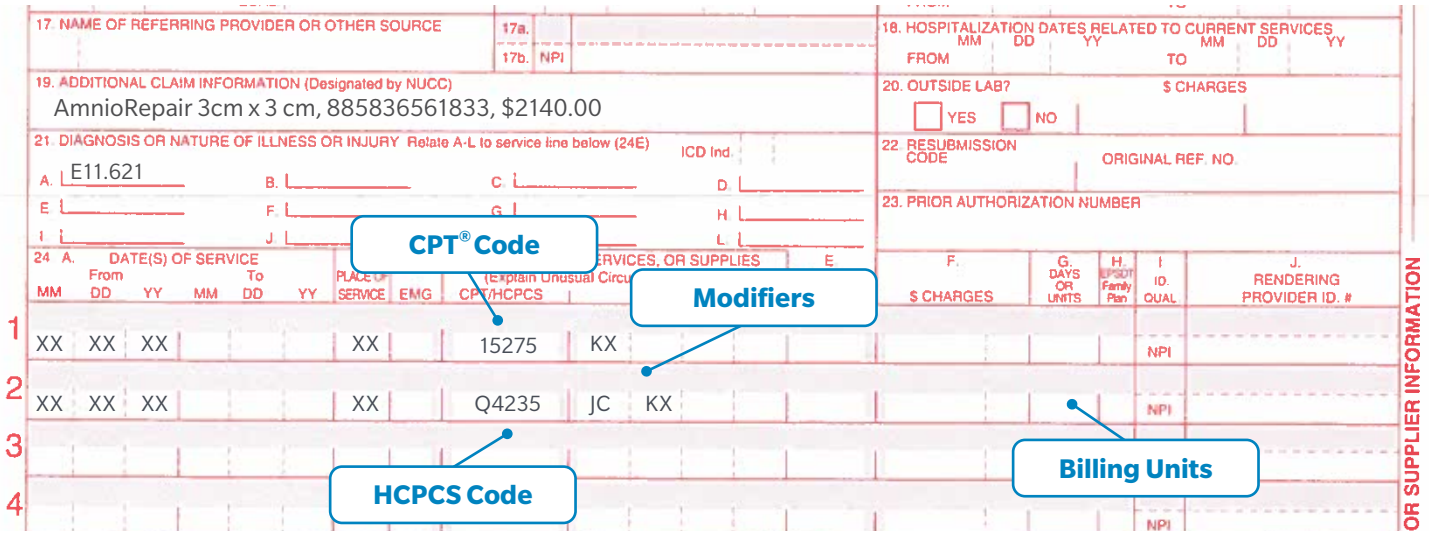
Coding and Billing for Skin Substitute Grafts

- Prior authorization/pre-determination is recommended prior to administration of a skin substitute graft. The payer will want to review the specific product proposed for use, dosage, and medical necessity.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in Publication 100-04, Chapter 17, Drugs and Biologicals, for calculating the AWP, but substitute WAC for AWP. The payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

  MACs shall develop payment allowance limits for covered drugs when CMS does not supply the payment allowance limit on the ASP drug pricing file. At the contractors' discretion, contractors may contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting contractor or via posting an MS Excel file on the CMS Web site.

  Source: Medicare Claims Processing Manual, Chapter 17 – Drugs and Biologicals, 20.1.3 – Exceptions to Average Sales Price (ASP) Payment Methodology
- The Wholesale Acquisition Cost (WAC) of both AmnioRepair Allograft and Dermaspan Acellular Dermal Matrix is published and available. Providers should be able to direct Medicare Administrative Contractors (MACs) to the published WAC before having to manually submit invoice documentation.
- It is recommended providers bill for the skin substitute graft showing the product name along with the product's NDC/UPC/HRIC, WAC or invoice price, and HCPCS code as reflected on the sample CMS-1500 claim form below.
- Ensure that the appropriate number of units is reported in field 24G. For example, because the respective skin substitute grafts are billed per square cm, if an entire 4cm x 4cm graft is used, the number of billing units to report is 16.
- If an entire graft is not used and there is wastage of the remaining product, an additional line should be reported with the appropriate HCPCS code and the JW modifier. The approximate number of sq cm wasted should be reported in field 24G.

Sample CMS-1500 Claim Form



Field 19: Enter the product name, the NDC\UPC\HRIC, and the WAC or invoice price. Price must be in currency format, include decimal
Field 21: Enter the ICD-10-CM diagnosis code(s)
Field 23: Enter the payer prior authorization number received during the benefit investigation
Field 24D: Enter the CPT/HCPCS code(s) for the services/products provided and any appropriate modifiers
Field 24F: Enter the charge amount for each listed service.
Field 24G: Enter the number of days or units.

For further assistance with reimbursement questions, contact the Zimmer Biomet Reimbursement Hotline at 866-946-0444 or reimbursement@zimmerbiomet.com, or visit our reimbursement web site at zimmerbiomet.com/reimbursement.

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