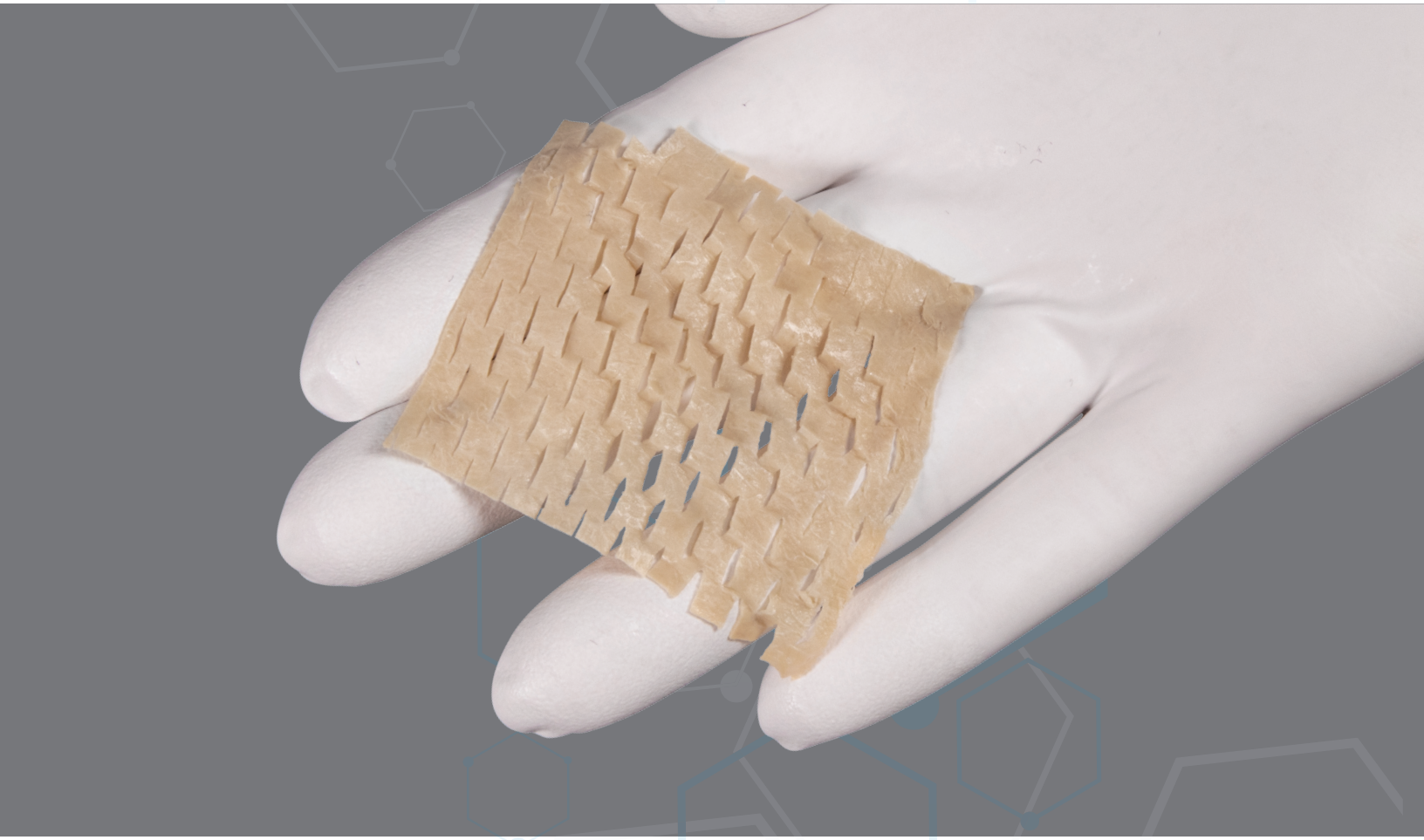
MiroDerm®
Biologic Wound Matrix

2023 Coding and Billing Guide



Disclaimer: This information is for educational/informational purposes only and should not be construed as authoritative. The information presented here is current as of January 2023 and is based upon publicly available source information. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third party payors is solely responsible for the accuracy of the codes assigned to the services or items in the medical record. When making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS your local Medicare Administrative Contractor and other health plans to which you submit claims. Items and services that are billed to payors must be medically necessary and supported by appropriate documentation. It is important to remember that while a code may exist describing certain procedures and/or technologies, it does not guarantee payment by payors.

HCPCS and CPT coding is universal, however, coverage and payment of medical and surgical services can vary among government (Medicare, Medicaid, TRICARE) and private health insurance companies. The procedures described in this reimbursement guide are widely covered by government and commercial insurers when MiroDerm Biologic Wound Matrix is applied in hospitals (both in and outpatient), ambulatory surgery centers (ASCs) and clinic-based practices. Accurate coding is important to guide how MiroDerm and the surgical procedures it is used with are covered and paid appropriately. Commercial insurer payment methodologies and payment levels will vary from Medicare and other government payers. It is not possible to capture all insurers' payment methodologies in this guide. Providers should contact their patients' insurers directly to obtain information on unique billing, coverage and payment requirements.

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MiroDerm®
Biologic Wound Matrix

MiroDerm wound matrix is indicated for the management of wounds, including: partial and full-thickness wounds; pressure ulcers; venous ulcers; chronic vascular ulcers; diabetic ulcers; tunneled, undermined wounds; trauma wounds (abrasion, lacerations, second-degree burns, skin tears); drainage wounds; and surgical wounds (donor sites/grafts, post-Mohs surgery, post-laser surgery, podiatric, wound dehiscence). See Instructions For Use (IFU) for full prescribing information, including indications, contraindications, precautions, and potential complications.

MiroDerm Biologic Wound Matrix is a non-crosslinked acellular wound matrix that is derived from the highly vascularized porcine liver and is available in two forms: Fenestrated and Fenestrated Plus. The fenestrations on the mesh offer a left-to-right stretch which increases the surface area available to contact the wound. It is perfusion decellularized and processed in a phosphate buffered aqueous solution, is packaged in an inner sterile pouch and outer non-sterile pouch and is intended for single use only. MiroDerm is a sterile medical device that should be stored in a clean, dry location at room temperature, in its original package. The product expiration date is indicated as year (4 digits) and month (2 digits). The product expires after the last day of the month indicated.

MiroDerm Ordering Information

Model	SIZE (cm)	TOTAL CM^2
MiroDerm Fenestrated		
BLM-200-02-0815	8cm x 15cm	120
BLM-200-02-0710	7cm x 10cm	70
BLM-200-02-0808	8cm x 8cm	64
BLM-200-02-0505	5cm x 5cm	25
BLM-200-02-0307	3cm x 7cm	21
BLM-200-02-0404	4cm x 4cm	16
BLM-200-02-0303	3cm x 3cm	9
BLM-200-02-0203	2cm x 3cm	6
BLM-200-02-0202	2cm x 2cm	4
MiroDerm Fenestrated Plus		
BLM-200-03-0815	8cm x 15cm	120
BLM-200-03-0808	8cm x 8cm	64
BLM-200-03-0505	5cm x 5cm	25
BLM-200-03-0303	3cm x 3cm	9

PLACING AN ORDER
Email: customerservice@reprisebio.com
Phone: 952-377-8238 or Fax: 952-856-5085

Delivery time: Two business days from receipt of purchase order.
Use the following guidelines:

- Orders received by 3 p.m. Central Time will be shipped via FedEx 2-Day Delivery (The customer can elect to have product shipped FedEx Priority Overnight and pay the shipping difference)
- Thursday shipments will be scheduled for delivery on following Monday
- Friday shipments will be scheduled for delivery on the following Tuesday
- Please call Customer Service with urgent requests.

Billing questions: ap@reprisebio.com and Phone: 763-284-6771

Product Coding

MiroDerm Coding
MiroDerm should be reported per square centimeter.

PHYSICIAN OFFICE	
HCPCS	**DESCRIPTION**
Q4175	MiroDerm, per sq cm
MODIFIERS	
JC	Skin Substitute used as graft
JW	Drug amount discarded/not administered to any patient
JZ	No discarded amount: full amount administered

Important Billing Instructions:
MiroDerm is not included on the Medicare Part A and B Average Sales Price (ASP) File published quarterly by the Centers for Medicare and Medicaid Services (CMS)

- ASP information is published quarterly by the Centers for Medicare and Medicaid Services (CMS) in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File. Providers are encouraged to review the ASP Pricing files posted quarterly by CMS and listed by the HCPCS on CMS.gov
- 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, are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the contractors follow the methodology specified in Publication. 100-4, Chapter 17, Drugs and Biologicals, for calculating the AWP, but substitute WAC for AWP.
- Providers should check with local payers to determine if an invoice is required to be submitted with the claim in Box 19.
- Providers should check with local payers regarding appropriate use of modifiers.
- JW Modifier must be reported for dates of service on or after January 1, 2023.
- JZ Modifier must be reported for dates of service on or after July 1, 2023.

Use either JW or JZ Modifiers to detail wastage or lack of wastage:

Providers and suppliers are required to report the JW or JZ modifier on Medicare Part B drug claims for discarded drugs and biologicals. Also, providers and suppliers must document the amount of discarded drugs or biologicals in Medicare beneficiaries' medical record including:

- Date, time, and location of ulcer treated
- Name of skin substitute and how product supplied
- Approximate amount of product unit used
- Approximate amount of product unit discarded
- Reason for the wastage
- Manufacturer's serial/lot/batch or other unit identification number on graft material

The amount discarded should be billed on a separate line with the JW modifier. The unit field should reflect the amount of tissue discarded. The modifier is not required if no discarded portion is being billed to any payer.

Please refer to: https://www. cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9603.pdf and the FAQs at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/JWModifier-FAQs.pdf.

Use modifier JZ on billing claims to attest there was no discarded amount from the single-dose vial or single-use package that is normally paid under Part B. Reference (IOM 100-4 Chapter 17, Sections 40-40.1) or page 621 of the CMS CY2023 OPPS/ASC Final Rule: https://public-inspection.federalregister.gov/2022-23918.pdf.

Place-of-Service Codes[1]

Place-of-service codes are 2-digit numbers included on health care professional claims to indicate the setting in which a service was provided. The Centers for Medicare and Medicaid Services (CMS) maintain place-of-service codes used throughout the health care industry. Listed below are place-of-service and descriptions that typically apply to our products. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payors for reimbursement policies regarding these codes.

PLACE-OF-SERVICE CODE	PLACE-OF-SERVICE NAME	PLACE-OF-SERVICE DESCRIPTION
11	**Office**	Location other than hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or Local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	**Home**	Location other than a hospital or other facility, where the patient receives care in a private residence.
21	**Inpatient Hospital**	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	**Outpatient Hospital**	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. Description change effective January 1, 2016.
24	**Ambulatory Surgical Center**	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

1. https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

CPT® Coding

The Current Procedural Terminology (CPT) code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payors for administrative, financial, and analytical purposes.

CPT®	DESCRIPTIONS FOR APPLICATION OF SKIN SUBSTITUTES
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface up to 100 sq. cm; first 25 sq. cm or less wound surface area.
+15272	Each additional 25 sq. cm up to 100 sq. cm wound surface area, or part thereof. List separately in addition to code 15721 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, 1% of body area of infants and children.
+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 15273 for primary procedure.
15275	Application of skin substitute graft to face, scalp eyelids, mouth, neck, orbits, genitalia, hands feet, and/or multiple digits, total wound surface area up to 100 sq. cm; first 25cm or less wound surface area.
+15276	Each additional 25 sq. cm wound surface area, or part thereof. List separately in addition to code 15275 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.
+15278	Each additional 100 sq. cm wound surface area, part thereof. List separately in addition to code 15277 for primary procedure.

CPT® Codes 15271-15278:

- Billing Units = 1 unit per service for CPT® 15271, 15273, 15275 and 15277 (daily limitations apply)
- Add-on codes 15272, 15274, 15276 and 15278 are billed as 1 unit for each additional amount of graft material as specified; either each additional 25cm^2 or 100cm^2 applied.

Add-on Codes: The + symbol signifies an add-on code. An add-on code cannot be used alone but must be billed with the initial code above it. Please check the CPT® 2021 coding book for further instructions.

ICD-10 Diagnosis Codes[1]

It is recommended that providers select the most specific primary and secondary diagnosis codes to accurately describe the reason the wound is not healing properly, and codes that indicate the wound is chronic and describe the location, severity, and laterality for (lower extremity ulcers).

Examples of specific Diabetic Foot Ulcers (DFUs) codes:

- Primary diagnosis: E11.621, type 2 diabetes mellitus with a foot ulcer
- Secondary diagnosis: L97.522, non-pressure chronic ulcer of other part of the left foot with fat layer exposed

Example of specific Venous Leg Ulcers (VLUs) codes:

- Primary diagnosis: I87.312, chronic venous hypertension (idiopathic) with ulcer of the left lower extremity
- Seconday diagnosis: L97.222, non-pressure chronic ulcer of the left calf with fat layer exposed

1. The International Classification of Diseases Clinical Modification Edition 9 is developed by the National Center for Health Statistics (NCHS). ICD-9 CM and ICD-10 CM are copyrighted by the World Health Organization. WHO is the copyright holder of ICD-10, and can grant licenses for the use of ICD-10 worldwide for commercial and non-commercial uses.

ICD-10-CM Diagnosis Examples

The ICD-10-CM codes listed below represent some of the etiology diagnosis codes commonly associated with causes of lower extremity chronic ulcers. This is not meant to be an exhaustive list. The below list of codes includes an edit to use an additional ICD-10-CM manifestation code from the L97 non-pressure chronic ulcer code series as a secondary diagnosis.

CPT	DESCRIPTION
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.622	Type 1 diabetes mellitus with other skin ulcer
E11.621	Type 2 diabetes mellitus with foot ulcer
E11.622	Type 2 diabetes mellitus with other skin ulcer
E13.621	Other specified diabetes mellitus with foot ulcer
E13.621	Other specified diabetes mellitus with other skin ulcer
I83.012	Varicose veins of right lower extremity with ulcer of calf
I83.013	Varicose veins of right lower extremity with ulcer of ankle
I83.014	Varicose veins of right lower extremity with ulcer of heel & midfoot
I83.015	Varicose veins of right lower extremity with ulcer of other part of foot
I83.018	Varicose veins of right lower extremity with ulcer of other part of lower leg
I83.022	Varicose veins of left lower extremity with ulcer of calf
I83.023	Varicose veins of left lower extremity with ulcer of ankle
I83.024	Varicose veins of left lower extremity with ulcer of heel & midfoot
I83.025	Varicose veins of left lower extremity with ulcer of other part of foot
I83.028	Varicose veins of left lower extremity with ulcer of other part of lower leg
I83.212	Varicose veins of right lower extremity with both ulcer of calf and inflammation
I83.213	Varicose veins of right lower extremity with both ulcer of ankle and inflammation
I83.214	Varicose veins of right lower extremity with both ulcer of heel & midfoot and inflammation
I83.215	Varicose veins of right lower extremity with both ulcer of other part of foot and inflammation
I83.218	Varicose veins of right lower extremity with both ulcer of other part of lower extremity and inflammation
I83.222	Varicose veins of left lower extremity with both ulcer of calf and inflammation
I83.223	Varicose veins of left lower extremity with both ulcer of ankle and inflammation
I83.224	Varicose veins of left lower extremity with both ulcer of heel & midfoot and inflammation
I83.225	Varicose veins of left lower extremity with both ulcer of other part of foot and inflammation
I83.228	Varicose veins of left lower extremity with both ulcer of other part of lower extremity and inflammation
I87.2	Venous Insufficiency (chronic peripheral)
I87.311	Chronic venous hypertension (idiopathic) with ulcer of right lower extremity
I87.312	Chronic venous hypertension (idiopathic) with ulcer of left lower extremity
I87.313	Chronic venous hypertension (idiopathic) with ulcer of bilateral lower extremity
I87.331	Chronic venous hypertension (idiopathic) with ulcer and inflammation of right lower extremity
I87.332	Chronic venous hypertension (idiopathic) with ulcer and inflammation of left lower extremity
I87.333	Chronic venous hypertension (idiopathic) with ulcer and inflammation of bilateral lower extremity

ICD-10-CM Diagnosis Examples

The ICD-10-CM codes listed below are specific manifestation diagnosis codes commonly associated with non-pressure chronic ulcers of the lower extremity. This is not meant to be an exhaustive list.

CPT	DESCRIPTION
L97	Series Non-Pressure Chronic Ulcer of Lower limb
L97.211	Non-Pressure Chronic Ulcer of Right calf limited to breakdown of skin
L97.212	Non-Pressure Chronic Ulcer of Right calf with fat layer exposed
L97.213	Non-Pressure Chronic Ulcer of Right calf with necrosis of muscle
L97.214	Non-Pressure Chronic Ulcer of Right calf with necrosis of bone
L97.221	Non-Pressure Chronic Ulcer of Left calf limited to breakdown of skin
L97.222	Non-Pressure Chronic Ulcer of Left calf with fat layer exposed
L97.223	Non-Pressure Chronic Ulcer of Left calf with necrosis of muscle
L97.224	Non-Pressure Chronic Ulcer of Left calf with necrosis of bone
L97.311	Non-Pressure Chronic Ulcer of Right ankle limited to breakdown of skin
L97.312	Non-Pressure Chronic Ulcer of Right ankle with fat layer exposed
L97.313	Non-Pressure Chronic Ulcer of Right ankle with necrosis of muscle
L97.314	Non-Pressure Chronic Ulcer of Right ankle with necrosis of bone
L97.321	Non-Pressure Chronic Ulcer of Left ankle limited to breakdown of skin
L97.322	Non-Pressure Chronic Ulcer of Left ankle with fat layer exposed
L97.323	Non-Pressure Chronic Ulcer of Left ankle with necrosis of muscle
L97.324	Non-Pressure Chronic Ulcer of Left ankle with necrosis of bone
L97.411	Non-Pressure Chronic Ulcer of Right heel & midfoot limited to breakdown of skin
L97.412	Non-Pressure Chronic Ulcer of Right heel & midfoot with fat layer exposed
L97.413	Non-Pressure Chronic Ulcer of Right heel & midfoot with necrosis of muscle
L97.414	Non-Pressure Chronic Ulcer of Right heel & midfoot with necrosis of bone
L97.421	Non-Pressure Chronic Ulcer of Left heel & midfoot limited to breakdown of skin
L97.422	Non-Pressure Chronic Ulcer of Left heel & midfoot with fat layer exposed
L97.423	Non-Pressure Chronic Ulcer of Left heel & midfoot with necrosis of muscle
L97.424	Non-Pressure Chronic Ulcer of Left heel & midfoot with necrosis of bone
L97.511	Non-Pressure Chronic Ulcer of Other part of right foot limited to breakdown of skin
L97.512	Non-Pressure Chronic Ulcer of Other part of right foot with fat layer exposed
L97.513	Non-Pressure Chronic Ulcer of Other part of right foot with necrosis of muscle
L97.514	Non-Pressure Chronic Ulcer of Other part of right foot with necrosis of bone
L97.521	Non-Pressure Chronic Ulcer of Other part of left foot limited to breakdown of skin
L97.522	Non-Pressure Chronic Ulcer of Other part of left foot with fat layer exposed
L97.523	Non-Pressure Chronic Ulcer of Other part of left foot with necrosis of muscle
L97.524	Non-Pressure Chronic Ulcer of Other part of left foot with necrosis of bone
L97.811	Non-Pressure Chronic Ulcer of Other part of right lower leg limited to breakdown of skin
L97.812	Non-Pressure Chronic Ulcer of Other part of right lower leg with fat layer exposed
L97.813	Non-Pressure Chronic Ulcer of Other part of right lower leg with necrosis of muscle
L97.814	Non-Pressure Chronic Ulcer of Other part of right lower leg with necrosis of bone
L97.821	Non-Pressure Chronic Ulcer of Other part of left lower leg limited to breakdown of skin
L97.822	Non-Pressure Chronic Ulcer of Other part of left lower leg with fat layer exposed
L97.823	Non-Pressure Chronic Ulcer of Other part of left lower leg with necrosis of muscle
L97.824	Non-Pressure Chronic Ulcer of Other part of left lower leg with necrosis of bone

Hospital Inpatient — Medicare
2023 Medicare MS-DRG* National Averages

MS-DRG	MS-DRG DESCRIPTION	MEDICARE NATIONAL AVERAGE PAYMENT[1]
570	SKIN DEBRIDEMENT W MCC	$18,231
571	SKIN DEBRIDEMENT W CC	$10,303
572	SKIN DEBRIDEMENT W/O CC/MCC	$7,522
573	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	$16,689
574	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	$22,528
575	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	$12,809
576	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	$35,305
577	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	$16,366
578	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	$10,702
579	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	$19,697
580	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	$10,850
581	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	$8,821
622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	$22,631
623	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	$11,778
624	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	$6,181
628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	$22,779
629	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	$14,023
630	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	$8,776
904	SKIN GRAFTS FOR INJURIES W CC/MCC	$22,198
905	SKIN GRAFTS FOR INJURIES W/O CC/MCC	$9,749
907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	$24,159
908	OTHER O.R. PROCEDURES FOR INJURIES W CC	$12,852
909	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	$8,529

The table above provides potential MS-DRGs assignments for hospitals when applying MiroDerm. These are 2023 Medicare average rates and are provided as a benchmark. Rates nationwide can vary widely.

*Medicare reimburses hospital inpatient stays based on the Medicare Severity Diagnosis Related Group (MS-DRG) system. MS-DRGs represent a consolidated prospective payment for all services provided by the hospital during hospitalization, based on submitted claims data. With limited exceptions, the MS-DRG payment is inclusive of all services, products, and resources, regardless of the final cost to the hospital. Medicare and many private payors use the MS-DRG based system to reimburse facilities for inpatient services.

ICD-10-Procedure Code

XHRPXL2, skin substitute, Porcine Liver Derived

In 2016, a new table was created for replacement of the skin, subcutaneous tissue, fascia, and breast (XHR) to capture the application of a unique type of acellular wound matrix.

Hospital inpatient procedures are billed with ICD-10 CM Procedure Codes. These procedure codes are mapped to specific Diagnosis Related Groups (DRGs) for payment. Private payor claims processing protocol can vary, but often use the same DRG Grouper as Medicare resulting in assignment to the same DRGs.
NOTE: This list is not all inclusive. These procedure codes, when combined with appropriate ICD-10 CM diagnosis codes get mapped to DRGs for payment. The ICD-10 PCS system provides greater granularity in the reporting of procedures.

1. CMS Hospital Inpatient Final Rule is effective Oct. 1, 2022-September 30,2023.
2. 2023 MS-DRG relative weight multiplied by 2023 rate. NOTE: Payment rates will vary by facility. Calculation includes labor related, non-labor related and capital rates. EX-20-032. https://www/cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page

2023 Physician Services - Medicare Payment

Treatment of Chronic Wounds and Burns (CPT codes 15271 - 15278)

CHRONIC WOUNDS REPAIR		PHYSICIAN OFFICE	HOSPITAL/ASC
CPT Code[1]	Description	Medicare National Avg	Medicare National Avg
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface up to 100 sq. cm; first 25 sq. cm or less wound surface area	$155.88	$83.70
+15272	each additional 25 sq. cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	$24.40	$16.60
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	$315.83	$196.55
+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)	$84.04	$45.07
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	$160.63	$93.19
+15276	each additional 25 sq. cm wound surface area, or part thereof (List separately in additional to code for primary procedure)	$32.87	$25.08
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	$350.39	$225.35
+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 there of (List separately in addition to code for primary procedure)	$96.92	$55.91

Coinsurance/Deductibles: As with all products and services paid for under Medicare Parts A & B. Medicare will reimburse 80 percent of the allowable amount. The patient, or secondary/supplemental plan, is responsible for the remaining, 20 percent coinsurance amount. The appropriate annual deductions also apply.

Sequestration: Since April 1, 2013, all Medicare claims with dates-of-service on or after April 1st 2013 are subjected to a 2 percent sequestration amount. This 2 percent is deducted from the 80 percent allowable amount paid by Medicare to the provider and not to the beneficiary copayment amounts. The Protecting Medicare and American Farmers from Sequester Cuts Act in December 2021, suspended that sequestration amount through March 31, 2022, then permitted a 1% decrease for services rendered from April 1 through June 30. Effective July 1, 2022 for dates-of-service on or after July 1st 2022, the full 2 percent sequestration will apply to services.

Geographic Practice Cost Index (GPCI)[2] : The Medicare physician fee schedule amounts are adjusted to reflect the variation in practice costs from area to area. A GPCI has been established for every Medicare payment locality based on the RVUs for work, practice expense, and malpractice. The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component.

1. 2023 AMA CPT® Professional. Procedure coding should be based upon medical necessity, procedures and supplies provided to the patient. Coding and reimbursement information is provided for educational purposes and does not assure coverage of the specific item or service in a given case. Reprise Biomedical makes no guarantee of coverage or reimbursement of fees. These payment rates are nationally unadjusted average amounts and do not account for differences in payment due to geographic variation. Contact your Medicare Administrative Contractor (MAC) or CMS for specific information as payment rates listed are subject to change. To the extent that you submit cost information to Medicare, Medicaid or any other reimbursement program to support claims for services or items, you are obligate to accurately report the actual price paid for such items, including any subsequent adjustments. CPT five-digit numeric codes, descriptions, and numeric modifiers only are Copyright AMA. (Updated August 2022).
2. Reference: CY2023 MPFS: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1770-f. CMS CY2023 MPFS Conversion factor = $33.0777. On December 20 2022, President Biden signed The Consolidated Appropriations Act of 2023, a $1.7 trillion year-end spending (omnibus) bill that included several provisions impacting healthcare providers. The omnibus package included an increase to the Medicare Physician Fee Schedule (MPFS) conversion factor to partially offset reductions that had already been planned for 2023 and 2024. Specifically, the conversion factor, originally finalized as a -4.5% decrease, now includes an additional +2.5% which results in an overall cut of -2% reimbursement from 2022 to 2023. Therefore, effective 1.1.2023, the final CMS CY2023 MPFS conversion factor updated from $33.0607 to $33.8872." Note: The omnibus package also halts the looming statutory -4 percent Pay-As-You-Go (PAYGO) cuts in both 2023 and 2024.

2023 Hospital Outpatient/ASC - Medicare

CMS High-Cost Skin Substitutes Coding and Payment

In 2023, MiroDerm is assigned to the CMS high-cost skin substitute category and is reimbursed within the OPPS/ASC payment for skin substitute application procedures. High cost skin substitute products should only be used in conjunction with the performance of the skin substitute application procedures designated by CPT 15271-15278.

CHRONIC WOUND REPAIR		OUTPATIENT HOSPITAL			ASC	
CPT Code[1]	Description	APC	OPSI Code	Medicare National Avg Allowance	Payment Indicator	Medicare National Avg Allowance
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface up to 100 sq. cm; first 25 sq. cm or less wound surface area	5054	T	$1776.60	G2	$898.64
+15272	each additional 25 sq. cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	-	T	$0.00	N1	$0.00
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	5055	T	$3330.62	G2	$1693.83
+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)	-	T	$0.00	N1	$0.00
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	5054	T	$1776.60	G2	$898.64
+15276	each additional 25 sq. cm wound surface area, or part thereof (List separately in additional to code for primary procedure)	-	T	$0.00	N1	$0.00
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	5054	T	$3330.62	G2	$898.64
+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 there of (List separately in addition to code for primary procedure)	-	T	$0.00	N1	$0.00

OPSI (Outpatient Payment Status Indicator)
Code T - Significant Procedure, Multiple Reduction Applies
Payment Indicator G2 - Non-office-based surgical procedure; payment based on OPPS relative payment weight
Payment Indicator N1 - Packaged service/item, no separate payment made
APC #5053 - Level III Skin Procedures; **APC #5054** - Level IV Skin Procedures; **APC #5055** - Level V Skin Procedures

Coinsurance/Deductibles: As with all products and services paid for under Medicare Parts A & B. Medicare will reimburse 80 percent of the allowable amount. The patient, or secondary/supplemental plan, is responsible for the remaining, 20 percent coinsurance amount. The appropriate annual deductions also apply.

Sequestration: Since April 1, 2013, all Medicare claims with dates-of-service on or after April 1st 2013 are subjected to a 2 percent sequestration amount. This 2 percent is deducted from the 80 percent allowable amount padi by Medicare to the provider and not to the beneficiary copayment amounts. The Protecting Medicare and American Farmers from Sequester Cuts Act in December 2021, suspended that sequestration amount through March 31, 2022, then permitted a 1% decrease for services rendered from April 1 through June 30. Effective July 1, 2022 for dates-of-service on or after July 1st 2022, the full 2 percent sequestration will apply to services.

Geographic Practice Cost Index (GPCI)[2]: The Medicare physician fee schedule amounts are adjusted to reflect the variation in practice costs from area to area. A GPCI has been established for every Medicare payment locality based on the RVUs for work, practice expense, and malpractice. The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component.

1. 2023 AMA CPT® Professional. Procedure coding should be based upon medical necessity, procedures and supplies provided to the patient. Coding and reimbursement information is provided for educational purposes and does not assure coverage of the specific item or service in a given case. Reprise Biomedical makes no guarantee of coverage or reimbursement of fees. These payment rates are nationally unadjusted average amounts and do not account for differences in payment due to geographic variation. Contact your Medicare Administrative Contractor (MAC) or CMS for specific information as payment rates listed are subject to change. To the extent that you submit cost information to Medicare, Medicaid or any other reimbursement program to support claims for services or items, you are obligate to accurately report the actual price paid for such items, including any subsequent adjustments. CPT five-digit numeric codes, descriptions, and numeric modifiers only are Copyright AMA. (Updated August 2022).
2. 2023 Hospital outpatient/ASC Final Rule: https://public-inspection.federalregister.gov/2022-23918.pdf

Sample Letter of Medical Necessity

Date
Insurer Name
Insurer Address
City, State, Zip Code

RE: Medical Necessity for MiroDerm Biologic Wound Matrix
Patient's Name:
Policy Number:
Group Number:
Date of Birth:

Dear [Insurance Contact Name]:

I am writing to notify you of my intent to treat Mr./Ms. [Patient's Name] with MiroDerm Biologic Wound Matrix, which is a collagen wound dressing, is used to treat a broad range of advanced and chronic wounds including: partial and full-thickness wounds, pressure ulcers, venous ulcers, diabetic ulcers, chronic vascular ulcers, tunneled and undermined wounds, surgical wounds, trauma wounds, and draining wounds.

The patient's medical history is as follows: [include relevant medical history]

MiroDerm Biologic Wound Matrix is an acellular wound matrix that is derived from the highly vascularized porcine liver and was cleared by the FDA under 510(k) K143426. Reprise Biomedical manufactures MiroDerm and is a medical device company focused on the development of clinically relevant biologic medical devices for the surgical and wound care space.

My patient has not responded to conservative care for [time frame] and has not responded to more advanced therapy including [product name(s) & type(s) of products]. More aggressive treatment is medically necessary to prevent further damage and [list risk(s) of non-closure]. I believe my patient will benefit from treatment with MiroDerm Biologic Wound Matrix.

I have enclosed information regarding the clinical utility of MiroDerm.

Please feel free to contact me if additional information is required to process my request for coverage.

Sincerely,
[Name]
[Contact info]

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Reprise Biomedical