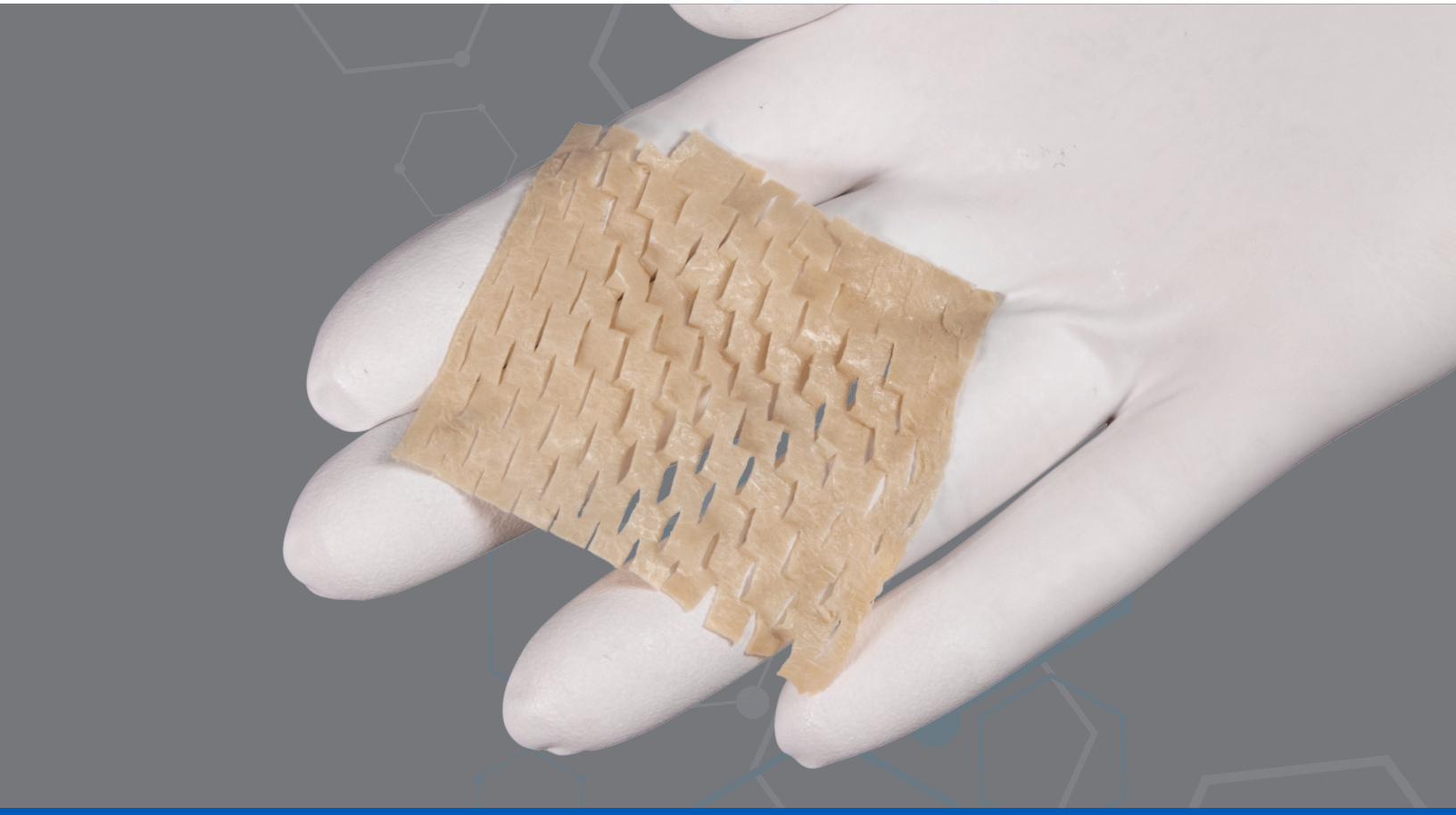
MiroDerm®
Biologic Wound Matrix

2024 Coding and Billing Guide



For additional assistance in coding and billing call our Reimbursement Hotline at 888-994-9095

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 2024 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 American Medical Association (AMA), relevant medical societies, the Centers for Medicare and Medicaid Services (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.

Healthcare Common Procedural Coding System (HCPCS), Current Procedural Terminology (CPT) and International Coding Diagnosis and Procedural (ICD-10) coding is universal; however, coverage and payment of medical and surgical services can vary among government (Medicare, Medicaid, TRICARE) and private or Commercial health insurance companies. The procedures described in this guide are widely covered by government and commercial insurers when Miro3D Wound Matrix is applied in hospitals (both inpatient and outpatient), ambulatory surgery centers (ASCs), and other clinic-based practices. Accurate coding is important to guide how Miro3D Wound Matrix, 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' payment methodologies. It is not possible to capture all insurers' payment methodologies in this guide. Providers should contact their patients' specific insurers directly to obtain information on unique billing, coverage, and payment requirements.

Reprise™ Biomedical
17400 Medina Road, Suite 100
Plymouth, MN 55447
Reprisebio.com

Customer Service:
952-377-8238
customerservice@reprisebio.com

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), month (2 digits) and day (2 digits).

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.

For additional assistance in coding and billing call our Reimbursement Hotline at 888-994-9095 or email Reprisereimbursement@MCRA.com

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[1]:
MiroDerm is listed 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 each Medicare Administrative Contractor and other 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.

1. https://www.cms.gov/medicare/payment/all-fee-service-providers/medicare-part-b-drug-average-sales-price/asp-pricing-files

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-billing/place-of-service-codes/code-sets

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® 2024 coding book for further instructions.

CPT is a registered trademark of the American Medical Association

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.

ICD-10-CM DIAGNOSES CODES	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.

ICD-10-CM DIAGNOSES CODES	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
2024 Medicare MS-DRG* National Averages

MS-DRG	MS-DRG DESCRIPTION	MEDICARE NATIONAL AVERAGE PAYMENT[1]
570	SKIN DEBRIDEMENT W MCC	$18,531
571	SKIN DEBRIDEMENT W CC	$10,729
572	SKIN DEBRIDEMENT W/O CC/MCC	$7,227
573	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	$39,433
574	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	$21,598
575	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	$12,975
576	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	$36,041
577	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	$16,800
578	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	$10,213
579	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	$21,195
580	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	$11,076
581	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	$8,540
622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	$24,261
623	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	$11,804
624	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	$7,067
628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	$25,459
629	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	$14,350
630	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	$8,855
904	SKIN GRAFTS FOR INJURIES W CC/MCC	$20,650
905	SKIN GRAFTS FOR INJURIES W/O CC/MCC	$10,043
907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	$23,588
908	OTHER O.R. PROCEDURES FOR INJURIES W CC	$12,709
909	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	$8,601

The table above provides potential MS-DRGs assignments for hospitals when applying MiroDerm. These are 2024 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: 0HR5XK3

Replacement of Chest Skin with Nonautologous Tissue Substitute, Full Thickness, External Approach

Effective 10.01.2022, replacement of skin using a porcine liver-derived skin substitute procedure code moved from the new technology section to the medical and surgical section, skin and breast body system with device value as nonautologous.

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 October 1 2023 - September 30 2024. Beginning in FFY 2023, CMS adopted a permanent 10% cap on reductions to a MS-DRG's relative weight in a given year compared to the weight in the prior year, implemented in a budget-neutral manner. The cap will be applied regardless of the reason for the decrease and implemented in a budget-neutral manner.
2. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership; and Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction: https://public-inspection.federalregister.gov/2023-16252.pdf

2024 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[2,4]	Medicare National Avg [2,4]
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	$154.12	$83.22
+15272	each additional 25 sq. cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	$24.63	$16.64
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	$308.24	$193.07
+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)	$80.89	$43.94
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	$158.78	$92.21
+15276	each additional 25 sq. cm wound surface area, or part thereof (List separately in additional to code for primary procedure)	$32.29	$24.63
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	$340.20	$220.03
+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)	$94.54	$54.92

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[3]: Sequestration is a mechanism for 3 budget enforcement rules created by the 1) Statutory Pay-As-You-Go Act of 2010 (Statutory PAYGO; P.L. 111-139), 2) the Budget Control Act of 2011 (BCA; P.L. 112-25), and 3) the Fiscal Responsibility Act of 2023 (FRA; P.L. 118-5). In 2024, only the BCA sequester has been triggered and is in effect at 2%. Under the BCA, the sequestration of mandatory spending was originally scheduled to occur in FY2013 through FY2021. However, subsequent legislation extended sequestration for mandatory spending through FY2031 and the sequestration of only Medicare benefit payments spending through FY2032. (The sequestration to Medicare was temporarily suspended from May 1, 2020, through March 30, 2022, and was limited to 1% from April 1, 2022, through June 30, 2022.) The Statutory PAYGO sequester applies to mandatory funding, is current law, and can be triggered if associated budget enforcement rules are broken. Due to the potential impact of the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) on deficits, sequestration under PAYGO was expected to be triggered in early 2022. However, the Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) deferred the impact of ARPA to 2023. Subsequently, the Consolidated Appropriations Act, 2023, deferred the impact of ARPA and other legislation estimated to impact the deficit under PAYGO. Without related congressional action, reductions to Medicare under PAYGO could occur in 2025. The FRA sequester applies to discretionary funding, is current law, and can be triggered if associated budget enforcement rules are broken (and Congress does not take action to change or waive this rule).

Geographic Practice Cost Index (GPCI)[4]: 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. 2024 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.
2. Effective March 9, 2024, President Biden signed the Consolidated Appropriations Act of 2024, which updated the Medicare Physician Fee Schedule conversion factor for dates of service on or after March 9 through December 31, 2024 to $33.2875. Any claims with dates of service from January 1 to March 8, 2024 will be paid using the original conversion factor of $32.7442. Source: https://www.cms.gov/medicare/payment/fee-schedules/physician
3. https://sgp.fas.org/crs/misc/R45106.pdf
4. CY2024 MPFS: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule. CMS CY2024 MPFS Conversion factor = $32.74

CPT is a registered trademark of the American Medical Association.

2024 Hospital Outpatient/ASC - Medicare

CMS High-Cost Skin Substitutes Coding and Payment

In 2024, 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	$1739.33	G2	$945.99
+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	$3421.82	G2	$1861.08
+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	$1739.33	G2	$945.99
+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	$1739.33	G2	$945.99
+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[2]: Sequestration is a mechanism for 3 budget enforcement rules created by the 1) Statutory Pay-As-You-Go Act of 2010 (Statutory PAYGO; P.L. 111-139), 2) the Budget Control Act of 2011 (BCA; P.L. 112-25), and 3) the Fiscal Responsibility Act of 2023 (FRA; P.L. 118-5). In 2024, only the BCA sequester has been triggered and is in effect at 2%. Under the BCA, the sequestration of mandatory spending was originally scheduled to occur in FY2013 through FY2021. However, subsequent legislation extended sequestration for mandatory spending through FY2031 and the sequestration of only Medicare benefit payments spending through FY2032. (The sequestration to Medicare was temporarily suspended from May 1, 2020, through March 30, 2022, and was limited to 1% from April 1, 2022, through June 30, 2022.) The Statutory PAYGO sequester applies to mandatory funding, is current law, and can be triggered if associated budget enforcement rules are broken. Due to the potential impact of the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) on deficits, sequestration under PAYGO was expected to be triggered in early 2022. However, the Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) deferred the impact of ARPA to 2023. Subsequently, the Consolidated Appropriations Act, 2023, deferred the impact of ARPA and other legislation estimated to impact the deficit under PAYGO. Without related congressional action, reductions to Medicare under PAYGO could occur in 2025. The FRA sequester applies to discretionary funding, is current law, and can be triggered if associated budget enforcement rules are broken (and Congress does not take action to change or waive this rule).

Geographic Practice Cost Index (GPCI)[3]: 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. 2024 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.
2. https://sgp.fas.org/crs/misc/R45106.pdf
3. 2024 Hospital Outpatient/ASC: https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf and http://www.cms.gov%2Ffiles%2Fdocument%2F2024-nfrm-opps-addenda-table-contents.pdf

CPT is a registered trademark of the American Medical Association.

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. This collagen wound dressing is utilized for various 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 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.

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]

CAUTION: Federal (USA) law restricts this device to sale by or on the order of a physician.
Refer to the Instructions for Use for a complete listing of the indications, contraindications, warnings and precautions. Information in this material is not a substitute for the product Instructions for Use.

Reprise Biomedical and MiroDerm are trademarks or registered trademarks of Reprise Biomedical or its affiliates, in the U.S. and/or other countries. All other trademarks are property of their respective owners. ©2024 Reprise Biomedical. All Rights Reserved.

17400 Medina Road, Suite 100
Plymouth, MN 55447
763-284-6780 | **reprisebio.com**
SM-00066 Rev. N 03/24

Reprise Biomedical