Miro3D®
Wound Matrix

MiroTract®
Wound Matrix

2026 Coding and Billing Guide

For additional assistance in coding and billing visit reprisereimbursement.com or call our Reimbursement Hotline at 888-249-6793

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 2026 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 and MiroTract Wound Matrix are 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 MiroTract Wound Matrix, and the surgical procedures they are 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.

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Miro3D®
Wound Matrix

Miro3D is a three-dimensional, porous sheet scaffolding structure, derived from the highly vascularized porcine liver, that provides a protective environment for wound management. Miro3D is perfusion decellularized and processed in a phosphate buffered aqueous solution, then dried and packaged.

MiroTract®
Wound Matrix

Like Miro3D, MiroTract is a three-dimensional, collagen sheet scaffold that is derived from porcine liver. MiroTract consists of a wound matrix that is loaded onto a guidewire and radially compressed for easy delivery into wounds with tunneling and undermining. Once hydrated, the wound matrix is designed to relax and expand to provide full wound wall coverage as an intact sheet.

Miro3D and MiroTract are sterile medical devices that should be stored in a clean, dry location at room temperature, in the original package. Avoid prolonged exposure to elevated temperatures as it may compromise device functionality. Expiration dates are indicated in the format year (4 digits), month (2 digits), and day (2 digits).

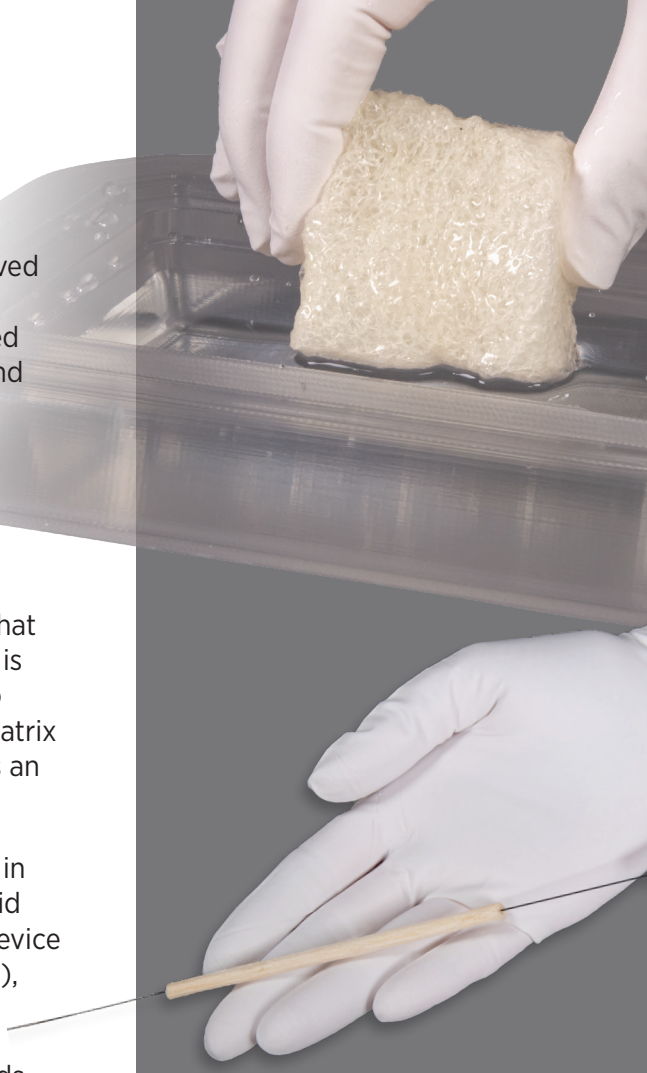
Both Miro3D and MiroTract are indicated for the management of wounds, including: partial and full-thickness wounds; pressure ulcers; venous ulcers; chronic vascular ulcers; diabetic ulcers; tunneled, undermined wounds; trauma wounds (abrasion, lacerations, partial thickness burns, skin tears); drainage 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.

PLACING AN ORDER

Email: customerservice@reprisebio.com
Phone: 952-377-8238
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 or UPS 2-Day Delivery (The customer can elect to have product shipped FedEx or UPS Priority Overnight and pay the shipping difference)
- Thursday shipments will be scheduled for delivery on the 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

Reimbursement Hotline Phone & Fax

P: 888-249-6793
F: 763-317-1977

R^3 Reimbursement Resources Portal

RepriseReimbursement.com

CMS Medicare Skin Substitute Update[1,2,3,4]

(effective January 1st, 2026)

Per the CY 2026 PFS Final Rule and the CY 2026 OPPS Rule, CMS will unpackage skin substitute products from the payment for their application.

Miro3D/MiroTract

Product Coding and Payment

- Miro3D (HCPCS A2025) and MiroTract (HCPCS A2029) are billed per cubic centimeter.
- Both Miro3D and MiroTract are also subject to MAC GPCI adjustments for POS 11, 12 and 32. Check your local MAC for pricing information.
- For facility outpatient/ASC settings, CMS designates applicable product HCPCS codes link to APC 6001 510(k) Skin Substitute Products with Status Indicator of 1 (S1) to identify separate payment of product.
    - All HCPCS product codes assigned to APC 6001 will be considered add-on codes assigned status indicator ZZZ to indicate that they receive separate payment. Unlike under the Medicare PFS, payments for skin substitute products under the OPPS will not be geographically adjusted.

Application Payment (CPT 15271-15278)

- Regardless of facility (office/hospital) or product type, CMS provides separate payment for the application procedure codes (e.g., CPT 15271-15278).
- See pages 9-11 of this Guide for details on 2026 CMS Fee Schedules.

Coverage

- The national skin substitute LCDs that had been scheduled to take effect January 1, 2026 were withdrawn on December 24, 2025. As a result, coverage for skin substitutes, including Miro3D and MiroTract, is currently governed by local MAC coverage policies and any published coverage articles, which may vary by jurisdiction.
- **MAC SKIN SUBSTITUTE PRIOR AUTHORIZATION (PA) REQUIREMENTS**
    - The CMS WISeR (Wasteful and Inappropriate Service Reduction) Model is planned to operate from January 1, 2026 to December 31, 2031 in the following 4 states and may require skin substitutes to obtain a PA from the local MAC: New Jersey, Ohio, Oklahoma, and Texas.

Application Coding

Non-FACILITY

- All skin substitute product codes are now converted to add-on codes with an indicator of ZZZ, which clarifies that only skin substitute products used with existing CPT application codes (CPT 15271-15278) are paid for and treated as supplies.
- CPT codes 15271 – 15278 are now also reported with a practice expense (PE)-only add-on Professional Component (PC) code indicator 3 that includes the resources involved in using the skin substitute product. PC/TC indicators are only paid under the PFS in the non-facility setting and apply to the payment for the supply itself, separate from the professional service of applying it. This means the facility or physician practice receives the payment for the product as a supply cost.

FACILITY: HCPCS C-codes describing the low-cost group (HCPCS codes C5271-C5278) will be deleted, while high-cost group CPT codes (15271-15278) remain. CPT 15271-15278 are assigned to APC 5044 or APC 5055.

- **Status Indicator S1:** CMS has created a new status indicator (S1) for skin substitute products to allow for separate payment.
- CPT add-on application codes 15272, 15274, 15276, and 15278 remain packaged in the hospital outpatient setting (e.g., 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) (CY 2026 OPPS Rule: https://www.federalregister.gov/d/2025-20907/p-2267)
- See pages 9-11 of this Guide for details on 2026 CMS Fee Schedules.

1. CY 2026 OPPS/ASC Final Rule: https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment#p-2267
2. CY 2026 PFS Final Rule: https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other
3. CMS issued a Correction Notice to the CY 2026 PFS Final Rule, which "corrects" the final payment rate for skin substitute products under the CY 2026 PFS Final Rule to align with the final payment rate for skin substitute products under the CY 2026 OPPS-ASC Final Rule.
4. https://www.cms.gov/priorities/innovation/innovation-models/wiser

CMS: Centers for Medicare and Medicaid Services, CY: Calendar Year, PFS: Prospective Fee Schedule, OPPS: Outpatient Prospective Payment Schedule, ASC: Ambulatory Surgical Center, HCPCS: Healthcare Common Procedure Coding System, PHS Act: Public Health Service Act, MAC: Medicare Administrative Contractor, CPT: Current Procedural Terminology, APC: Ambulatory Payment Classification

Miro3D Product Coding

Miro3D Coding - Physician Office[1,2,3]

Use A2025 to document **per cubic centimeter**. Document Miro3D use in Box 19 of the CMS-1500 Form or cost center description, if payer required.

CODE	DESCRIPTION	MEDICARE NATIONAL AVERAGE PAYMENT[4]
HCPCS A2025	Miro3D, per cubic centimeter	$127.14 per billing unit

MIRO3D SPECIFICATIONS			
Model	**Size (cm)**	**USE FOR MIRO3D A2025 BILLING UNITS* (total volume (cm^3); product is billed per cubic centimeter)**	**GTIN ID**
3000	2 x 2 x 2	8	00857072005316
3005	3 x 3 x 2	18	00857072005323
3006	5 x 2 x 2	20	00857072005620
3007	4 x 4 x 2	32	00857072005552
3009	10 x 2 x 2	40	00857072005637
3010	5 x 5 x 2	50	00857072005330
3011	6 x 5 x 2	60	00857072005644
3012	7 x 5 x 2	70	00857072005569
3013	8 x 5 x 2	80	00857072005651
3015	10 x 5 x 2	100	00857072005347

***JW/JZ Modifier and Wastage Billing Policy (Effective January 1, 2026)[5]**

CMS has clarified that, effective January 1, 2026, the JW and JZ modifiers are no longer applicable to skin substitute products that are not regulated as drugs or biological products under section 351 of the Public Health Service Act. CMS has further stated that it is not permissible under any circumstances for providers to bill Medicare for discarded units of non-BLA skin substitute products.

Accordingly, providers should not report JW or JZ modifiers when billing for Miro3D (HCPCS A2025) and should bill only for the units of product actually applied and documented in the medical record.

1. CY 2026 OPPS/ASC Final Rule: https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment#p-2267
2. CY 2026 PFS Final Rule: https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other
3. CMS issued a Correction Notice to the CY 2026 PFS Final Rule, which "corrects" the final payment rate for skin substitute products under the CY 2026 PFS Final Rule to align with the final payment rate for skin substitute products under the CY 2026 OPPS-ASC Final Rule.
4. Geographic Practice Cost Index (GPCI): 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. Note: CMS MACs adjust supply payment rates per geographic cost practice index (GPCI). Healthcare providers are encouraged to contact their local MAC regarding their local MAC GPCI payment amounts.
5. www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

MiroTract Product Coding

MiroTract Coding - Physician Office[1,2,3]

Use A2029 to document **per cubic centimeter**. Document MiroTract use in Box 19 of the CMS-1500 Form or cost center description, if payer required.

CODE	DESCRIPTION	MEDICARE NATIONAL AVERAGE PAYMENT[4]
HCPCS A2029	MiroTract, per cubic centimeter	$127.14 per billing unit

MIROTRACT SPECIFICATIONS				
Model	**Wound Matrix Outer Diameter (Dry)**	**Wound Matrix Length**	**USE FOR MIROTRACT A2029 BILLING UNITS* (total volume (cm^3); product is billed per cubic centimeter)**	**GTIN ID**
5000	3mm	5cm	8	00857072005453
5010	3mm	9cm	14	00857072005477
5020	5mm	5cm	10	00857072005460
5030	5mm	9cm	19	00857072005484

***JW/JZ Modifier and Wastage Billing Policy (Effective January 1, 2026)[5]**

CMS has clarified that, effective January 1, 2026, the JW and JZ modifiers are no longer applicable to skin substitute products that are not regulated as drugs or biological products under section 351 of the Public Health Service Act. CMS has further stated that it is not permissible under any circumstances for providers to bill Medicare for discarded units of non-BLA skin substitute products.

Accordingly, providers should not report JW or JZ modifiers when billing for MiroTract (HCPCS A2029) and should bill only for the units of product actually applied and documented in the medical record.

1. CY 2026 OPPS/ASC Final Rule: https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment#p-2267
2. CY 2026 PFS Final Rule: https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other
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5. www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

Place-of-Service Codes[1]

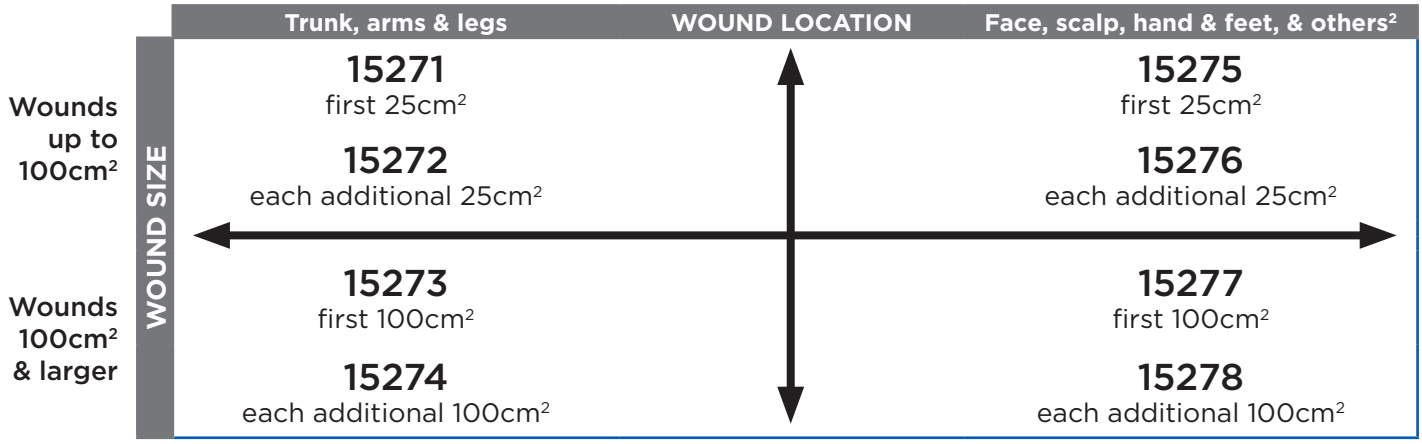
Place-of-service codes are 2-digit numbers included on health care professional claims to indicate the setting in which a service was provided. The Centers for Medicare and Medicaid Services (CMS) maintain place-of-service codes used throughout the health care industry. Listed below are place-of-service 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.
31	**Skilled Nursing Facility**	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	**Nursing Facility**	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.

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 [1]
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, or 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 25cm² or 100cm² 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® 2026 coding book for further instructions.

1. AMA CPT 2026 Skin Substitutes: Skin substitute grafts include non-autologous human skin (dermal or epidermal, cellular) and acellular grafts, (e.g. homograft, allograft) non-human skin substitutes graft (i.e., xenograft) and biological products that form a sheet scaffolding for skin growth. AMA CPT Code set 15271-15278 instructs provider to bill skin substitutes application per sq cm.

2026 Physician Services - Medicare Payment

2026 Medicare National Average Payment

CPT® CODE[1,6]	PHYSICIAN SERVICES IN NON-FACILITY[2,3]	PHYSICIAN SERVICES IN FACILITY[2,3]	DESCRIPTION
15271	$157.98	$75.15	App of skin sub to trunk, arms, legs up to 100 sq. cm; 1st 25 sq. cm
+15272	$25.72	$14.69	Each additional 25 sq. cm
15273	$321.98	$171.67	App of skin sub to trunk, arms, legs to >100 sq. cm, 1st 100 sq. cm
+15274	$86.84	$38.74	Each additional 100 sq. cm
15275	$160.32	$84.17	App of skin sub to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, multiple digits up to 100 sq. cm; 1st 25 sq. cm
+15276	$33.73	$22.04	Each additional 25 sq. cm
15277	$361.39	$197.39	App of skin sub to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, multiple digits >100 sq. cm
+15278	$101.20	$48.76	Each additional 25 sq. cm

Product Billing

HCPCS	DESCRIPTION	MEDICARE NATIONAL AVERAGE PAYMENT[4]
A2025	Miro3D, per cubic centimeter	Payment rate is $127.14 per billing unit Note: CMS MACs adjust supply payment rates per geographic cost practice index (GPCI). Healthcare providers are encouraged to contact their local MAC regarding their local MAC GPCI payment amounts.
A2029	MiroTract, per cubic centimeter	

CPT 15271-15278: AMA CPT Code set 15271-15278 instructs provider to bill skin substitutes application per sq cm.

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[7]: 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.

Non-Physician Practitioners (NPP)[5]: CMS reimburses NPP professional services at 80% of the lesser of the actual charge or 85% of the amount a physician gets under the "https://www.cms.gov/medicare/physician-fee-schedule/search/overview" Physician Fee Schedule (PFS) when furnished outside a hospital or SNF setting. CMS reimburses https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-practice-providers/incident-services-supplies "incident to" services provided by auxiliary personnel (outside a hospital or SNF setting) at 85% of the amount a physician gets under the PFS.

1. 2026 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. Reference: CY2026 MPFS: https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other
3. CY2026 Outpatient/ASC Final Rule: https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment
4. CMS National Average Payment for APC 6001 = $127.14 per billing unit. Note: CMS MACs adjust supply payment rates per geographic cost practice index (GPCI). Healthcare providers are encouraged to contact their local MAC regarding their local MAC GPCI payment amounts.
5. https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-practice-nonphysician-practitioners/advanced-practiceregistered-nurses-aprn; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf#page%3D125 Section 120 of the Medicare Claims Processing Manual, Chapter 12; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf#page%3D149 Section 200 of the Medicare Benefit Policy Manual, Chapter 15
6. CPT codes 15271 – 15278 are now also reported with a practice expense (PE)-only add-on Professional Component (PC) code indicator 3 that includes the resources involved in using the skin substitute product. PC/TC indicators are only paid under the PFS in the nonfacility setting and apply to the payment for the supply itself, separate from the professional service of applying it. This means the facility or physician practice receives the payment for the product as a supply cost.
7. https://sgp.fas.org/crs/misc/R45106.pdf

2026 Hospital Outpatient/ASC - Medicare

CMS Coding/Payment[1]

Effective January 1st 2026, CMS Outpatient/ASC Final Rule links these HCPCS codes to APC 6001, 510(k) skin substitute products.

HCPCS	Description	CMS National Average Payment
A2025	Miro3D, per cubic centimeter	CMS Outpatient/ASC payment links these HCPCS codes to APC 6001, 510(k) skin substitute products. CMS payment for APC 6001 = $127.14 per billing unit. Check with your local MAC regarding local coverage criteria or other statutory and regulatory guidance.
A2029	MiroTract, per cubic centimeter	

CHRONIC WOUND REPAIR		OUTPATIENT HOSPITAL			ASC	
CPT Code	Description	APC[6]	OPSI Code	Medicare National Avg Allowance[4]	Payment Indicator[7]	Medicare National Avg Allowance[5]
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	5053	T	$755.08	G2	$404.93
+15272	each additional 25 sq. cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	-	N	$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	5054	T	$2,107.97	G2	$1,128.57
+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)	-	N	$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	5053	T	$755.08	P3	$94.66
+15276	each additional 25 sq. cm wound surface area, or part thereof (List separately in additional to code for primary procedure)	-	N	$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	$2,107.97	G2	$1,128.57
+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)	-	N	$0.00	N1	$0.00

OPSI (Outpatient Payment Status Indicator): T: Significant procedure, multiple reduction applies N: Items and services are packaged into payment for other services G2 Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight N1 Packed service/item; no payment made

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. CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 11164, Published 12-21-2021; MLM Matters: https://www.cms.gov/files/document/mm12451.pdf
2. https://sgp.fas.org/crs/misc/R45106.pdf
3. 2026 Hospital Outpatient/ASC Final Rule and OPPS Addenda: https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf and http://www.cms.gov%2Ffiles%2Fdocument%2F2024-nfrm-oppsaddenda-table-contents.pdf. CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 12241 published 12.23.2023 https://www.cms.gov/files/document/r12421cp.pdf for Outpatient. CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 12349 published 1.02.2024 https://www.cms.gov/files/document/r12439cp.pdf for ASC. See Outpatient Addenda A lines 429-430.
4. CMS National Average Payment for APC 6001 = $127.14 per billing unit. Note: CMS MACs adjust supply payment rates per geographic cost practice index (GPCI). Healthcare providers are encouraged to contact their local MAC regarding their local MAC GPCI payment amounts.
5. CMS Addendum AA = ASC Covered Surgical Procedures for CY 2026 https://www.cms.gov/license/ama?file=/files/zip/january-2025-asc-approved-hcpcs-code-and-payment-rates.zip
6. CMS finalized its proposal to reassign certain application procedure codes to different APCs in light of the new policy that unpackages payment for the skin substitute product from payment for the underlying application procedure. Under the CY 2026 OPPS-ASC Final Rule, CPT codes 15271 and 15275 are assigned to APC 5053, and CPT codes 15273 and 15277 are assigned to APC 5054. CMS also "specif[ies] that CPT add-on administration codes 15272, 15274, 15276, and 15278 would still be packaged in the outpatient hospital setting" under the CY 2026 OPPS-ASC Final Rule.
7. CMS finalized its proposals to create new ASC payment indicator "S2" (skin substitute supply group; paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate).

Hospital Inpatient — Medicare
2026 Medicare MS-DRG* National Averages

MS-DRG	MS-DRG DESCRIPTION	MEDICARE NATIONAL AVERAGE PAYMENT[1]
570	SKIN DEBRIDEMENT W MCC	$19,860
571	SKIN DEBRIDEMENT W CC	$11,408
572	SKIN DEBRIDEMENT W/O CC/MCC	$7,742
573	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	$44,239
574	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	$23,441
575	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	$12,134
576	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	$33,095
577	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	$17,899
578	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	$10,847
579	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	$21,868
580	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	$11,668
581	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	$9,744
622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	$24,033
623	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	$12,113
624	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	$8,453
628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	$25,165
629	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	$14,712
630	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	$9,855
904	SKIN GRAFTS FOR INJURIES W CC/MCC	$24,803
905	SKIN GRAFTS FOR INJURIES W/O CC/MCC	$10,016
907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	$25,925
908	OTHER O.R. PROCEDURES FOR INJURIES W CC	$13,472
909	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	$8,864

The table above provides potential MS-DRGs assignments for hospitals when applying Miro3D or MiroTract. These are 2026 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, 2025 - September 30, 2026. 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 2026 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://www.federalregister.gov/documents/2025/08/04/2025-14681/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-ipps-and

ICD-10-CM[1] Diagnosis Code Examples Appendix

ICD-10 diagnosis codes identify a patient's condition, while ICD-10 procedure codes identify the services or treatments a patient receives.

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 dcode 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

ICD-10-CM Procedure Code Examples (PCE)[1] Appendix

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.

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ICD-10-CM Procedure Code Examples

ICD-10 PCS	ICD-10 DESCRIPTION	COMMON MS-DRG ASSIGNMENT
Pressure Ulcers and Hidradenitis Suppurativa		
0RBL0ZZ	Excision of Right Elbow Joint, Open Approach	570, 571, 572, 573, 574, 575
0RBM0ZZ	Excision of Left Elbow Joint, Open Approach	
0JB70ZZ	Excision of Back Subcutaneous Tissue and Fascia, Open Approach	
0HB6XZZ	Excision of Back Skin, External Approach	
0HX6XZZ	Transfer Back Skin, External Approach	
0JB70ZZ	Excision of Back Subcutaneous Tissue and Fascia, Open Approach	
0HB6XZZ	Excision of Back Skin, External Approach	
0JX70ZB	Transfer Back Subcutaneous Tissue and Fascia with Skin and Subcutaneous Tissue, Open Approach	
0JB70ZZ	Excision of Back Subcutaneous Tissue and Fascia, Open Approach	
0HB6XZZ	Excision of Back Skin, External Approach	
0QB10ZZ	Excision of Sacrum, Open Approach	
0QTS0ZZ	Resection of Coccyx, Open Approach	
0QB10ZZ	Excision of Sacrum, Open Approach	
0JBL0ZZ	Excision of Right Upper Leg Subcutaneous Tissue and Fascia, Open Approach	
0JBM0ZZ	Excision of Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach	
0QB20ZZ	Excision of Right Pelvic Bone, Open Approach	
0QB30ZZ	Excision of Left Pelvic Bone, Open Approach	
0QB60ZZ	Excision of Right Upper Femur, Open Approach	
0QB70ZZ	Excision of Left Upper Femur, Open Approach	
0YBC0ZZ	Excision of Right Upper Leg, Open Approach	
0YBD0ZZ	Excision of Left Upper Leg, Open Approach	
0JBL0ZZ	Excision of Right Upper Leg Subcutaneous Tissue and Fascia, Open Approach	
0JBM0ZZ	Excision of Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach	
0QB20ZZ	Excision of Right Pelvic Bone, Open Approach	
0QB30ZZ	Excision of Left Pelvic Bone, Open Approach	
0QB60ZZ	Excision of Right Upper Femur, Open Approach	
0QB70ZZ	Excision of Left Upper Femur, Open Approach	
0JXC0ZC	Transfer Pelvic Region Subcutaneous Tissue and Fascia with Skin, Subcutaneous Tissue and Fascia, Open Approach	
0HB8XZZ	Excision of Buttock Skin, External Approach	
0JB90ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Open Approach	
0HB8XZZ	Excision of Buttock Skin, External Approach	
0JB90ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Open Approach	
0HX8XZZ	Transfer Buttock Skin, External Approach	
0JX90ZB	Transfer Buttock Subcutaneous Tissue and Fascia with Skin and Subcutaneous Tissue, Open Approach	
0HB8XZZ	Excision of Buttock Skin, External Approach	
0JB90ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Open Approach	
0JBL0ZZ	Excision of Right Upper Leg Subcutaneous Tissue and Fascia, Open Approach	
0JBM0ZZ	Excision of Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach	
0QB20ZZ	Excision of Right Pelvic Bone, Open Approach	
0QB30ZZ	Excision of Left Pelvic Bone, Open Approach	
0QB60ZZ	Excision of Right Upper Femur, Open Approach	
0QB70ZZ	Excision of Left Upper Femur, Open Approach	
0SBG0ZZ	Excision of Left Ankle Joint, Open Approach	
0SBF0ZZ	Excision of Right Ankle Joint, Open Approach	
0SBG0ZZ	Excision of Left Ankle Joint, Open Approach	
0SBF0ZZ	Excision of Right Ankle Joint, Open Approach	
0HBMXZZ	Excision of Right Foot Skin, External Approach	
0HBNXZZ	Excision of Left Foot Skin, External Approach	
0HBMXZZ	Excision of Right Foot Skin, External Approach	
0HBNXZZ	Excision of Left Foot Skin, External Approach	
0HB0HZZ	Excision of Scalp Skin, External Approach	
0JB00ZZ	Excision of Scalp Subcutaneous Tissue and Fascia, Open Approach	
0JBN0ZZ	Excision of Right Lower Leg Subcutaneous Tissue and Fascia, Open Approach	
0JBN0ZZ	Excision of Right Lower Leg Subcutaneous Tissue and Fascia, Open Approach	
0JBQ0ZZ	Excision of Right Foot Subcutaneous Tissue and Fascia, Open Approach	
0JBR0ZZ	Excision of Left Foot Subcutaneous Tissue and Fascia, Open Approach	
0HXHXZZ	Transfer Right Upper Leg Skin, External Approach	
0HXJXZZ	Transfer Left Upper Leg Skin, External Approach	
0JB93ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Percutaneous Approach	
0JB90ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Open Approach	
0JBB0ZZ	Excision of Perineum Subcutaneous Tissue and Fascia, Open Approach	
0JBB3ZZ	Excision of Perineum Subcutaneous Tissue and Fascia, Percutaneous Approach	
0JBD0ZZ	Excision of Right Upper Arm Subcutaneous Tissue and Fascia, Open Approach	
0JBD3ZZ	Excision of Right Upper Arm Subcutaneous Tissue and Fascia, Percutaneous Approach	
0JBF0ZX	Excision of Left Upper Arm Subcutaneous Tissue and Fascia, Open Approach, Diagnostic	
0JBF0ZZ	Excision of Left Upper Arm Subcutaneous Tissue and Fascia, Open Approach	
0JBF3ZZ	Excision of Left Upper Arm Subcutaneous Tissue and Fascia, Percutaneous Approach	

ICD-10-CM Procedure Code Examples

ICD-10 PCS	ICD-10 DESCRIPTION	COMMON MS-DRG ASSIGNMENT
Pilonidal Sinus Disease		
0H98X0Z	Drainage of Buttock Skin with Drainage Device, External Approach	907, 908, 909
0H98XZZ	Drainage of Buttock Skin, External Approach	
0J9900Z	Drainage of Buttock Subcutaneous Tissue and Fascia with Drainage Device, Open Approach	
0J990ZZ	Drainage of Buttock Subcutaneous Tissue and Fascia, Open Approach	
0J9930Z	Drainage of Buttock Subcutaneous Tissue and Fascia with Drainage Device, Percutaneous Approach	
0J993ZZ	Drainage of Buttock Subcutaneous Tissue and Fascia, Percutaneous Approach	
0Y9000Z	Drainage of Right Buttock with drainage Device, Open Approach	
0Y900ZZ	Drainage of Right Buttock, Open Approach	
0Y9030Z	Drainage of Right Buttock with Drainage Device, Percutaneous Approach	
0Y903ZZ	Drainage of Right Buttock, Percutaneous Approach	
0Y9040Z	Drainage of Right Buttock with Drainage Device, Percutaneous Endoscopic Approach	
0Y904ZZ	Drainage of Right Buttock, Percutaneous Endoscopic Approach	
0Y9100Z	Drainage of Left Buttock with Drainage Device, Open Approach	
0Y910ZZ	Drainage of Left Buttock, Open Approach	
0Y9130Z	Drainage of Left Buttock with Drainage Device, Percutaneous Approach	
0Y913ZZ	Drainage of Left Buttock, Percutaneous Approach	
0Y9140Z	Drainage of Left Buttock with Drainage Device, Percutaneous Endoscopic Approach	
0Y914ZZ	Drainage of Left Buttock, Percutaneous Endoscopic Approach	
0HB8XZZ	Excision of Buttock Skin, External Approach	
0JB93ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Percutaneous Approach	
0JB90ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Open Approach	
0HR8X72	Replacement of Buttock Skin with Autologous Tissue Substitute, Cell Suspension Technique, External Approach	
0HR8X73	Replacement of Buttock Skin with Autologous Tissue Substitute, Full Thickness, External Approach	
0HR8X74	Replacement of Buttock Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HR8XJ3	Replacement of Buttock Skin with Synthetic Substitute, Full Thickness, External Approach	
0HR8XJ4	Replacement of Buttock Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HR8XJZ	Replacement of Buttock Skin with Synthetic Substitute, External Approach	
0HR8XK3	Replacement of Buttock Skin with Nonautologous Tissue Substitute, Full Thickness, External Approach	
0HR8XK4	Replacement of Buttock Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	

ICD-10 PCS	ICD-10 DESCRIPTION	COMMON MS-DRG ASSIGNMENT
Perirectal Abscess		
0D9P00Z	Drainage of Rectum with Drainage Device, Open Approach	570, 571, 572, 579, 580, 581
0D9P0ZZ	Drainage of Rectum, Open Approach	
0D9P30Z	Drainage of Rectum with Drainage Device, Percutaneous Approach	
0D9P3ZZ	Drainage of Rectum, Percutaneous Approach	
0D9P40Z	Drainage of Rectum with Drainage Device, Percutaneous Endoscopic Approach	
0D9P4ZZ	Drainage of Rectum, Percutaneous Endoscopic Approach	
0D9P70Z	Drainage of Rectum with Drainage Device, Via Natural or Artificial Opening	
0D9P7ZZ	Drainage of Rectum, Via Natural or Artificial Opening	
0D9P80Z	Drainage of Rectum with Drainage Device, Via Natural or Artificial Opening Endoscopic	
0D9P8ZZ	Drainage of Rectum, Via Natural or Artificial Opening Endoscopic	
0D9P00Z	Drainage of Rectum with Drainage Device, Open Approach	
0D9P0ZZ	Drainage of Rectum, Open Approach	
0D9P30Z	Drainage of Rectum with Drainage Device, Percutaneous Approach	
0D9P3ZZ	Drainage of Rectum, Percutaneous Approach	
0D9P40Z	Drainage of Rectum with Drainage Device, Percutaneous Endoscopic Approach	
0D9P4ZZ	Drainage of Rectum, Percutaneous Endoscopic Approach	
0D9P70Z	Drainage of Rectum with Drainage Device, Via Natural or Artificial Opening	
0D9P7ZZ	Drainage of Rectum, Via Natural or Artificial Opening	
0D9P80Z	Drainage of Rectum with Drainage Device, Via Natural or Artificial Opening Endoscopic	
0D9P8ZZ	Drainage of Rectum, Via Natural or Artificial Opening Endoscopic	
0D9Q00Z	Drainage of Anus with Drainage Device, Open Approach	
0D9Q0ZZ	Drainage of Anus, Open Approach	
0D9Q30Z	Drainage of Anus with Drainage Device, Percutaneous Approach	
0D9Q3ZZ	Drainage of Anus, Percutaneous Approach	
0D9Q40Z	Drainage of Anus with Drainage Device, Percutaneous Endoscopic Approach	
0D9Q4ZZ	Drainage of Anus, Percutaneous Endoscopic Approach	
0D9Q70Z	Drainage of Anus with Drainage Device, Via Natural or Artificial Opening	
0D9Q7ZZ	Drainage of Anus, Via Natural or Artificial Opening	
0D9Q80Z	Drainage of Anus with Drainage Device, Via Natural or Artificial Opening Endoscopic	
0D9Q8ZZ	Drainage of Anus, Via Natural or Artificial Opening Endoscopic	
0D9QX0Z	Drainage of Anus with Drainage Device, External Approach	
0D9QXZZ	Drainage of Anus, External Approach	

ICD-10-CM Procedure Code Examples

ICD-10 PCS	ICD-10 DESCRIPTION	COMMON MS-DRG ASSIGNMENT
Necrotizing Fasciitis		
0JB00ZZ	Excision of Scalp Subcutaneous Tissue and Fascia, Open Approach	576, 577, 578, 904, 905
0JB40ZZ	Excision of Right Neck Subcutaneous Tissue and Fascia, Open Approach	
0JB50ZZ	Excision of Left Neck Subcutaneous Tissue and Fascia, Open Approach	
0JB60ZZ	Excision of Chest Subcutaneous Tissue and Fascia, Open Approach	
0JB70ZZ	Excision of Back Subcutaneous Tissue and Fascia, Open Approach	
0JB80ZZ	Excision of Abdomen Subcutaneous Tissue and Fascia, Open Approach	
0JB90ZZ	Excision of Buttock Subcutaneous Tissue and Fascia, Open Approach	
0JBB0ZZ	Excision of Perineum Subcutaneous Tissue and Fascia, Open Approach	
0JBC0ZZ	Excision of Pelvic Region Subcutaneous Tissue and Fascia, Open Approach	
0JBD0ZZ	Excision of Right Upper Arm Subcutaneous Tissue and Fascia, Open Approach	
0JBF0ZZ	Excision of Left Upper Arm Subcutaneous Tissue and Fascia, Open Approach	
0JBG0ZZ	Excision of Right Lower Arm Subcutaneous Tissue and Fascia, Open Approach	
0JBH0ZZ	Excision of Left Lower Arm Subcutaneous Tissue and Fascia, Open Approach	
0JBL0ZZ	Excision of Right Upper Leg Subcutaneous Tissue and Fascia, Open Approach	
0JBM0ZZ	Excision of Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach	
0JBN0ZZ	Excision of Right Lower Leg Subcutaneous Tissue and Fascia, Open Approach	
0JBP0ZZ	Excision of Left Lower Leg Subcutaneous Tissue and Fascia, Open Approach	
0JBQ0ZZ	Excision of Right Foot Subcutaneous Tissue and Fascia, Open Approach	
0JBR0ZZ	Excision of Left Foot Subcutaneous Tissue and Fascia, Open Approach	
0HR0X74	Replacement of Scalp Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HR0XJ4	Replacement of Scalp Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HR0XK4	Replacement of Scalp Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HR4X74	Replacement of Neck Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HR4XJ4	Replacement of Neck Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HR4XK4	Replacement of Neck Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HR5X74	Replacement of Chest Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HR5XJ4	Replacement of Chest Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HR5XK4	Replacement of Chest Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HR6X74	Replacement of Back Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HR6XJ4	Replacement of Back Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HR6XK4	Replacement of Back Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HR7X74	Replacement of Abdomen Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HR7XJ4	Replacement of Abdomen Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HR7XK4	Replacement of Abdomen Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HR8X74	Replacement of Buttock Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HR8XJ4	Replacement of Buttock Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HR8XK4	Replacement of Buttock Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HR9X74	Replacement of Perineum Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HR9XJ4	Replacement of Perineum Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HR9XK4	Replacement of Perineum Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HRAX74	Replacement of Inguinal Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HRAXJ4	Replacement of Inguinal Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HRAXK4	Replacement of Inguinal Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HRBX74	Replacement of Right Upper Arm Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HRBXJ4	Replacement of Right Upper Arm Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HRBXK4	Replacement of Right Upper Arm Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HRCX74	Replacement of Left Upper Arm Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HRCXJ4	Replacement of Left Upper Arm Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HRCXK4	Replacement of Left Upper Arm Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HRDX74	Replacement of Right Lower Arm Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HRDXJ4	Replacement of Right Lower Arm Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HRDXK4	Replacement of Right Lower Arm Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HREX74	Replacement of Left Lower Arm Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HREXJ4	Replacement of Left Lower Arm Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HREXK4	Replacement of Left Lower Arm Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HRHX74	Replacement of Right Upper Leg Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HRHXJ4	Replacement of Right Upper Leg Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HRHXK4	Replacement of Right Upper Leg Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HRJX74	Replacement of Left Upper Leg Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HRJXJ4	Replacement of Left Upper Leg Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HRJXK4	Replacement of Left Upper Leg Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HRKX74	Replacement of Right Lower Leg Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HRKXJ4	Replacement of Right Lower Leg Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HRKXK4	Replacement of Right Lower Leg Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HRLX74	Replacement of Left Lower Leg Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HRLXJ4	Replacement of Left Lower Leg Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HRLXK4	Replacement of Left Lower Leg Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HRMX74	Replacement of Right Foot Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HRMXJ4	Replacement of Right Foot Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HRMXK4	Replacement of Right Foot Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	
0HRNX74	Replacement of Left Foot Skin with Autologous Tissue Substitute, Partial Thickness, External Approach	
0HRNXJ4	Replacement of Left Foot Skin with Synthetic Substitute, Partial Thickness, External Approach	
0HRNXK4	Replacement of Left Foot Skin with Nonautologous Tissue Substitute, Partial Thickness, External Approach	

ICD-10-CM Procedure Code Examples

ICD-10 PCS	ICD-10 DESCRIPTION	COMMON MS-DRG ASSIGNMENT
Diabetic Foot Ulcers		
0KBW0ZZ	Excision of left foot muscle open approach	622, 623, 624, 628, 629, 630
0KBV0ZZ	Excision of right foot muscle open approach	
0HBMXZZ	Excision of Right Foot Skin, External Approach	
0HBNXZZ	Excision of Left Foot Skin, External Approach	
0JBQ0ZZ	Excision of Right Foot Subcutaneous Tissue and Fascia, Open Approach	
0JBR0ZZ	Excision of Left Foot Subcutaneous Tissue and Fascia, Open Approach	
0MBS0ZZ	Excision of Right Foot Bursa and Ligament, Open Approach	
0MBT0ZZ	Excision of Left Foot Bursa and Ligament, Open Approach	

Acronym Key:
MS-DRG – Medical Severity Diagnosis Related Groups
CC – Comorbidities and Complications
MCC – Major Comorbidities and Complications

Miro3D Sample Claim Form†

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any [illegible] information necessary to process this claim. I also request payment of government benefits either to myself or to [illegible] accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT [illegible] ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

RESERVED FOR LOCAL USE

Miro3D 10cmx5cmx2cm (HCPCS A2025, Miro3D per cm3) - Invoice Available upon request

20. OUTSIDE LAB? YES ☐ NO ☐

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. F11.622

2.

3.

4.

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUM

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01	01	24	01	01	24	11		A2025		1		100				
2	01	01	24	01	01	24	11		15271		1		1				
3	01	01	24	01	01	24	11		15272		1		1				
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. BALANCE DUE $

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.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Field 19
Enter Miro3D, product size, A2025, pricing information

Field 21
Enter ICD-10 diagnosis code(s)

Field 24B
Enter place of service code - see pg 7 of this Guide

Field 24D
Enter corresponding HCPCS and CPT codes.

Field 24G
Enter Units - A2025 is billed per cubic cm/CPT is per sq cm - see pg 5 of this Guide

Refer to internal information for appropriate pricing information

Sticky note: Use List or Contracted Pricing

This is an example claim form utilizing Miro3D.

MiroTract Sample Claim Form†

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any [illegible] information necessary to process this claim. I also request payment of government benefits either to myself or to [illegible] accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

RESERVED FOR LOCAL USE

MiroTract 3mm x 5cm (HCPCS A2029, MiroTract per cm3) - Invoice available upon request

20. OUTSIDE LAB? YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

F11 622

3. ____ . __

4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 24	01 01 24	11		A2029		1	Refer to internal information for appropriate pricing information	8				
2 01 01 24	01 01 24	11		15271		1		1				
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. BALANCE DUE $

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.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Field 19
Enter MiroTract, product size, A2029, pricing information

Field 21
Enter ICD-10 diagnosis code(s)

Field 24G
Enter Units - A2029 is billed per cubic cm - see pg 6 of this Guide. Bill application units supported by medical documentation for product application.

Field 24B
Enter place of service code - see pg 7 of this Guide

Field 24D
Enter corresponding HCPCS and CPT codes.

This is an example claim form utilizing MiroTract.

Sample Letter of Medical Necessity*

[INSTRUCTION: PICK APPROPRIATE PRODUCT]

Date
Insurer Name
Insurer Address
City, State, Zip Code

RE: Medical Necessity for Miro3D Wound Matrix or MiroTract 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 **[insert product name]**. It is used 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, partial thickness burns, skin tears); drainage wounds; and surgical wounds (donor sites/grafts, post-Mohs surgery, post-laser surgery, podiatric, wound dehiscence).

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

[FOR MIRO3D WOUND MATRIX:] Miro3D Wound Matrix is a three-dimensional wound matrix derived from the highly vascularized porcine liver and was cleared by the FDA under 510(k) K221520 and K223257. Miro3D is a porous sheet scaffolding structure that provides a protective environment for wound management.

[FOR MIROTRACT WOUND MATRIX:] MiroTract Wound Matrix is a three-dimensional, collagen sheet scaffold that is derived from porcine liver and was cleared by the FDA under 510(k) K231614. MiroTract consists of a radially compressed wound matrix that is loaded onto a guidewire for easy delivery into wounds with tunneling and undermining. Once hydrated, the wound matrix will relax and expand to provide a protective environment for wound management.

[Include the following two paragraphs if the wound is an ulcer; otherwise, do not include them. Examples of wounds for which the paragraphs should NOT be used include pilonidal wounds or wound dehiscence.] **[Insert product name]**, being derived from porcine sources, is fully covered by National Coverage Decision (NCD) 270.5 - Porcine Skin and Gradient Dressings. The NCD's coverage criteria, which include "burns, donor sites of a homograft, and **decubiti and other ulcers**" (emphasis added), confirm that **[insert product name]** qualifies as a covered product for ulcers, as experienced by **[insert patient's name]**, when deemed reasonable and necessary by the treating provider. I believe the use of **[insert product name]** is reasonable, necessary, and beneficial for **[insert patient's name]**.

Reprise Biomedical manufactures **[insert product name]** 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 **[insert product name]**.

I have enclosed information regarding the clinical utility of **[insert product name]**.

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

Sincerely,
[Name] [Contact info]

*This sample letter contains content for both Miro3D and MiroTract. Please use the appropriate provided language for the desired product.

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†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 2026 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 Miro3D 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 Miro3D 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.

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.

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763-284-6780 | **reprisebio.com**
SM-00193 Rev. M 01/26

Reprise Biomedical