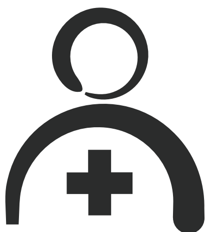
2024 Coding and Medicare Payment Information
Physician and Other Qualified Healthcare Professionals (QHP)

Mirragen® Advanced Wound Matrix
Bioactive Glass



ETS
ENGINEERED TISSUE SOLUTIONS

Mirragen® Advanced Wound Matrix is a synthetic glass fiber technology intended to support the natural healing processes. It is a resorbable and biocompatible borate-based glass fiber specifically designed for wound management. Synthetic advanced wound matrix products such as Mirragen are considered skin substitutes per Centers for Medicare and Medicaid Services (CMS)[6].

Indications:
The Mirragen Advanced Wound Matrix is intended for use in the management of wounds.

Wound types include:

- Partial and full-thickness wounds
- Pressure ulcers
- Venous ulcers
- Diabetic ulcers
- Chronic vascular ulcers
- Tunneled/ undermined wounds
- Surgical wounds (donor sites/grafts, post-Moh's surgery, post laser surgery, podiatric, wound dehiscence)
- Trauma wounds (abrasions, lacerations, first and second degree burns, skin tears)
- Draining wounds[5].

Product & Skin Substitute Application Procedure Codes

HCPCS Product Code	Code Description
A2002	Mirragen® Advanced Wound Matrix, per square centimeter

Synthetic advanced wound matrix products such as Mirragen are considered skin substitutes per Medicare. "A" HCPCS product codes have been established by Medicare for synthetic skin substitutes.

The physician/QHP should report A2002 (with any applicable modifiers), on the same claim as the appropriate procedure code(s).

CPT Code[1]	Code Description	Work RVU[2]	2024 Medicare MPFS Non-Facility/Office Rates**[2]	2024 Medicare MPFS Facility Rates**[2]
Application to Wound Surface Area Less Than 100 Sq. Cm.*				
15271	Application of skin substitute graft to **trunk, arms, legs,** total wound surface area up to 100 sq. cm; first 25 sq. cm. or less wound surface area	1.50	$154	$83
+15272	Each additional 25 sq. cm. wound surface, or part thereof (list separately in addition to code for primary procedure)	0.33	$25	$17
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	1.83	$159	$92
+15276	Each additional 25 sq. cm. wound surface, or part thereof (list separately in addition to code for primary procedure)	0.50	$32	$25
Application to Wound Surface Area Equal to or Greater Than 100 Sq. Cm.*				
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	3.50	$308	$193
+15274	Each additional 100 sq. cm. wound surface, or part thereof, or 1% of body area of infants and children (list separately in addition to code for primary procedure)	0.80	$81	$44
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	4.00	$340	$220
+15278	Each additional 100 sq. cm. wound surface, or part thereof, or 1% of body area of infants and children (list separately in addition to code for primary procedure)	1.00	$95	$55

* The wound surface area applies to the size of the recipient site, not to the size of product purchased.
** Medicare Physician Fee Schedule (MPFS) rates are nationally unadjusted average amounts and do not account for certain adjustments, including 1) differences in payment due to geographic variation and 2) impact of 2% sequestration adjustment.
Work RVU: Work Relative Value Units
NOTE: Emphasis in code descriptions added in bold.
NOTE: For coding purposes, the wrists are considered part of the arm and the ankles are considered part of the leg.

Skin Replacement Surgery

The use of CPT application codes 15271-15278 implies skin replacement surgery was rendered. Skin replacement surgery consists of surgical application and topical placement of an autograft or skin substitute graft. The graft is anchored using the individual's choice of fixation. When services are performed in the office, routine dressing supplies are not reported separately[7]. It is important to document "fixation" of the skin substitute product as rendered per the provider's choice. Please review your specific Medicare Administrative Contractor (MAC) and commercial payer documentation requirements.

Coding and Billing for Skin Substitutes

Please review your specific MAC and commercial payer coverage policies, medical necessity requirements and billing guidance.

- Skin substitute application code selection is based on defect site location and size. Add together area of multiple wounds in the same anatomical locations as indicated in the code description group, such as leg and arm.
- Do not add size of multiple wounds at different anatomic site groups.
- Skin substitute application codes include simple tissue debridement therefore debridement procedures are not separately reported or reimbursed[1].
- Skin substitute billing entails coding for the application procedure and the skin substitute product.
- Bill appropriate ICD-10-CM diagnosis codes that include type of ulcer and diabetes per payer policy.
- Billing evaluation and management (E/M) service with each skin replacement surgical procedure (application of skin substitute graft) in an episode of care is inappropriate unless the patient's condition required a separately identified service.
- Some payers may require prior authorization or other utilization management for review of specific product, dosage, and medical necessity.
- The payment limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based either on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under OPPS where the payment limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the A/B MACs follow the methodology specified in Publication. 100-04, Chapter 17, Section 20.4 Drugs and Biologicals, for calculating the AWP, but substitute WAC for AWP. The payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC. [3].
- The Wholesale Acquisition Cost (WAC) for Mirragen® is published and available for CMS access.
- In the physician office setting, Mirragen Advanced Wound Matrix, A2002, is contractor-priced and paid by MACs at either (1) wholesale acquisition cost (WAC) plus 6 percent or (2) the invoice, when A2002 is reported on the same claim with Current Procedural Terminology (CPT®)‡ codes 15271 – 15278. Specific policies vary across different MACs and the physician/QHP should check with the MAC that processes their Medicare fee-for-service claims.
- If required per payer, physician/QHP offices should 1) obtain the total invoice cost for the product purchased for the patient and 2) report the amount from the invoice on block 19 of the CMS-1500 paper claim form or its electronic equivalent of Loop 2400 Segment NTE02 in the following format (including cents): Example Inv. $__. Some MACs also require the name and size of the product: Example: Mirragen Advanced Wound Matrix 5.1cm x 5.1cm Inv. $__.

  NOTE: Do not submit the retail amount or the amount the physician/QHP office charged in block 19 or the electronic equivalent.
- If the MAC reimburses based on the invoice amount and the physician/QHP office does not include the actual invoice amount on the claim, the MAC may send an additional development request (ADR) requesting the invoice or may deny the claim. In addition, the MAC will monitor these claims on a post payment basis to ensure accurate claims processing or take other action (e.g., deny the claim).

- Ensure that the appropriate number of units (sq cm) is reported in field 24G.
- If the entire graft is not used and there is wastage, the amount discarded should be reported on a separate line with the appropriate HCPCS code and the JW modifier. If there is no wastage and the entire graft is used, the JZ modifier should be appended to the HCPCS code.

Modifiers -
May not be all inclusive. Some MAC's and commercial payers require certain modifiers to be reported for skin substitutes. To identify which modifiers are required, each provider should check with their specific payers.

- JZ Zero amount discarded/not administered to any patient (effective Jan. 1, 2023, required July 1, 2023)[6]
- JW Discarded skin substitute, not used

Sample

Providers should review their individual MAC and commercial payer policies for billing requirements. Below sample may not be applicable for all claims.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

(1) Mirragen® 5.1 CM X 5.1 CM, INV. $__

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

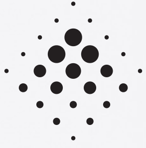
23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	XX XX XX		XX		(2) 15271						NPI	
2	XX XX XX		XX		(3) A2002	(4) JZ			(5) 26		NPI	
3											NPI	
4											NPI	
5											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

1. BOX 19 - Add product name, size, & invoice amount as required per MAC
2. CPT application code(s)
3. HCPCS product code
4. Add appropriate modifiers
5. Billing Units - add total amount of product utilized/wasted

Description	Size	Billable Units[11]	GTIN
Mirragen Advanced Wound Matrix	1.5 cm x 1.5 cm	3	00812005030209
Mirragen Advanced Wound Matrix	2.5 cm x 2.5 cm	7	00812005030285
Mirragen Advanced Wound Matrix	3.5 cm x 3.5 cm	13	00812005030278
Mirragen Advanced Wound Matrix	4.5 cm x 4.5 cm	21	00812005030391



Mirragen® Bioactive Glass Reimbursement Support Program

Engineered Tissue Solutions (ETS), in partnership with The Pinnacle Health Group, offers services for patient benefit verification, patient prior authorization, appeals, coding and coverage information as part of our Mirragen Reimbursement Support program.

Our program simplifies access to reimbursement information and patient support including:

- Benefit verification & patient coverage
- Prior authorization & preservice appeals
- Mirragen coding & coverage questions
- Appeal support & documentation

We are committed to supporting our customers' needs by providing reimbursement support to help navigate the complex healthcare environment. To engage with the ETS reimbursement support team, please call, fax, or send an e-mail to us.

Mirragen REIMBURSEMENT SUPPORT PROGRAM

P: 1-866-369-9290

F: 1-877-499-2986

Hours: Monday - Friday, 8:30 am - 6:00 pm, EST

Email: ETS@ThePinnacleHealthGroup.com

Disclaimer: Information on coding and payment is provided as a courtesy for educational purposes only and shall not be construed as a guarantee of coverage or payment. ETS Wound Care and its agents make no guarantees regarding reimbursement for any item or service. ETS Wound Care and its agents also make no representations regarding the availability of payment at any particular level. Physicians/QHPs should confirm coding, coverage, and payment guidelines from each patient's payer, because each payer may have differing policies. Payer policies are subject to frequent change, including frequent changes to the rules governing Medicare coverage and reimbursement. ETS Wound Care does not guarantee or warrant that the information provided herein is or will remain applicable. Physicians/QHPs are solely responsible for accurate completion of all reimbursement or coverage related documentation, including information submitted on claims and documentation of patient conditions and of the medical necessity for each product that is ordered

References:

1. ‡CPT® 2024 Current Procedural Terminology (CPT) copyright 2024 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.
2. 2024 Medicare Physician Fee Schedule RVU multiplied by conversion factor, effective March 9, 2024.
3. Medicare Claims Processing Manual, ch. 17 § 20.1.3; see also 83 Fed. Reg. 59,452, 59,666 (Nov. 23, 2018)
4. CMS, Practitioner Services MUE Table (effective Jan. 1, 2024), available at https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits
5. FDA, K161067 Indications for Use 3, available at https://www.accessdata.fda.gov/cdrh_docs/pdf16/K161067.pdf
6. 87 Fed. Reg 69,404, 69,650 (Nov. 18, 2022).
7. AMA, CPT Newsletter, Skin Replacement Surgery (Jan. 2012, last updated Oct. 2013)
8. CMS, Billing and Coding: JW and JZ Modifier Billing Guidelines, Medicare Claims Processing Manual, ch. 8 § 60.2.1, ch. 3 § 20.7.3. JW-JZ Modifier FAQs: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

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