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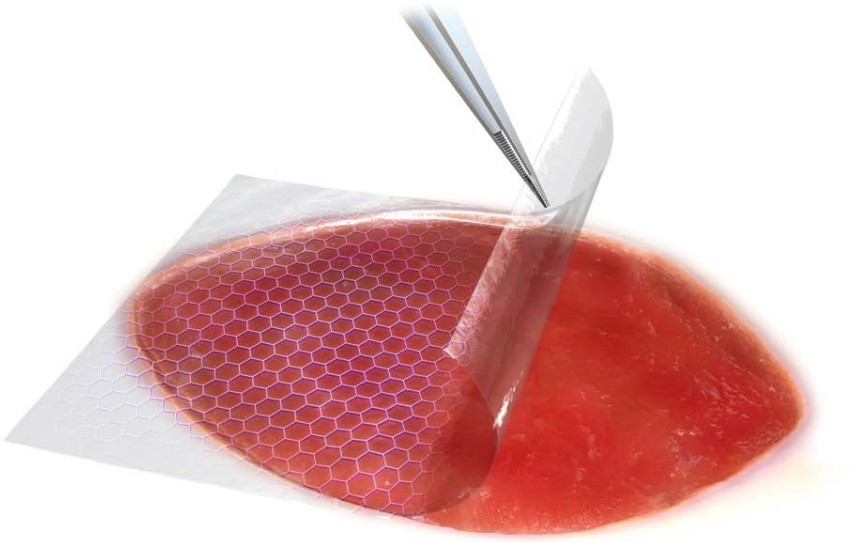
BioSkin®

2022 Reimbursement Guide

Physician & Facility



Reimbursement helpline:
800-698-9985

Contents

Physician Reimbursement

Medicare reimburses physicians according to the Medicare Physician Fee Schedule (MPFS), which is based on Relative Value Units (RVUs) and payment varies by geographical region.

Wound Care and Debridement are reported with CPT® codes 97597, 97598 and 11042-11047. Active wound care procedures are performed to remove devitalized and/or necrotic tissue to promote healing. Debridement is the removal of foreign material and/or devitalized or contaminated tissue from or adjacent to a traumatic or infected wound until surrounding healthy tissue is exposed. These services are billed when an extensive cleaning of a wound is needed prior to the application of primary dressings or skin substitutes placed over or onto a wound that is attached with secondary dressings.

CPT® codes 15271-15278 are used to report the application of a skin substitute graft. The selection of code is based upon the location and size of the defect.

CY 2022 Final Physician Payment

CPT® code[1]	Description	Facility (POS 21, 22 or 24)		Non-Facility (POS 11)	
		RVUs	Medicare National Average Payment[2]	RVUs	Medicare National Average Payment[2]
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.76	$61	3.87	$134
+11045	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (use 11045 in conjunction with 11042)	0.77	$27	1.21	$42
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue; if performed); first 20 sq cm or less	4.51	$156	6.92	$239
+11046	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (use 11046 in conjunction with 11043)	1.63	$56	2.18	$75
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	6.60	$228	9.19	$318
+11047	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (use 11047 in conjunction with 11044)	2.85	$99	3.57	$124
15002	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or less	6.45	$223	10.40	$360
+15003	"Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)"	1.34	$46	2.09	$72
15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children	7.66	$265	11.81	$409

CPT® code[1]	Description	Facility (POS 21, 22 or 24)		Non-Facility (POS 11)	
		RVUs	Medicare National Average Payment[2]	RVUs	Medicare National Average Payment[2]
+15005	"Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)"	2.68	$93	3.50	$121
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	2.46	$85	4.62	$160
+15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	0.52	$18	0.75	$26
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	5.82	$201	9.47	$328
+15274	"Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)"	1.34	$46	2.51	$87
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	2.74	$95	4.75	$164
+15276	"Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)"	0.75	$26	0.97	$34
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	6.63	$229	10.39	$360
+15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.67	$58	2.90	$100
97597	Debridement (eg, high pressure waterjet with/ without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instructions (s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less	1.06	$37	3.03	$105

CPT® code[1]	Description	Facility (POS 21, 22 or 24)		Non-Facility (POS 11)	
		RVUs	Medicare National Average Payment[2]	RVUs	Medicare National Average Payment[2]
97598	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.74	$26	1.35	$47
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session	0	Bundled*	0	Bundled*

POS=Place of Service

*Status Code Indicator B: Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident.

Outpatient Facility Reimbursement

The payment for skin substitute products that do not qualify for hospital outpatient prospective payment system (OPPS) pass-through status are packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. The skin substitute products are divided into two groups for packaging purposes: 1) high cost skin substitute products and 2) low cost skin substitute products. BioSkin Amniotic Would Matrix has been assigned to the high cost category and should be used in combination with one of the skin application procedures (CPT® codes 15271-15278).

CY 2022 Final Hospital Outpatient and Ambulatory Surgical Center Payment

CPT® code[1]	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	5052	$353	T	$353	A2
+11045	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (use 11045 in conjunction with 11042)	N/A	Packaged	N	Packaged	N1
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue; if performed); first 20 sq cm or less	5053	$535	T	$535	A2
+11046	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (use 11046 in conjunction with 11043)	N/A	Packaged	N	Packaged	N1
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	5072	$1,437	J1	$1200	A2
+11047	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (use 11047 in conjunction with 11044)	N/A	Packaged	N	Packaged	N1
15002	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or less	5054	$1,749	T	$1749	A2

CPT® code[1]	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
+15003	"Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)"	N/A	Packaged	N	Packaged	N1
15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children	5054	$535	T	$535	A2
+15005	"Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)"	N/A	Packaged	N	Packaged	N1
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	5054	$1,749	T	$1749	G2
+15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	N/A	Packaged	N	Packaged	N1
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	5055	$3,596	T	$3,596	G2
+15274	"Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof List separately in addition to code for primary procedure)"	N/A	Packaged	N	Packaged	N1
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	5054	$1,749	T	$1749	G2
+15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	N/A	Packaged	N	Packaged	N1

CPT® code[1]	Description	Hospital Outpatient (POS 22)		Ambulatory Surgical Center (POS 24)		
		APC	Medicare National Average Payment[3]	SI	Medicare National Average Payment[3]	PI
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	$1,749	T	$1749	G2
+15278	"Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)"	N/A	Packaged	N	Packaged	N1
97597	Debridement (eg, high pressure waterjet with/ without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed andinstructions(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less	5051	$183	T	Nonsurgical procedure not Medicare allowable in an ASC	N/A
97598	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	N/A	Packaged	N	Nonsurgical procedure not Medicare allowable in an ASC	N/A
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to- moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session	5051	$180	Q1	Nonsurgical procedure not Medicare allowable in an ASC	N/A

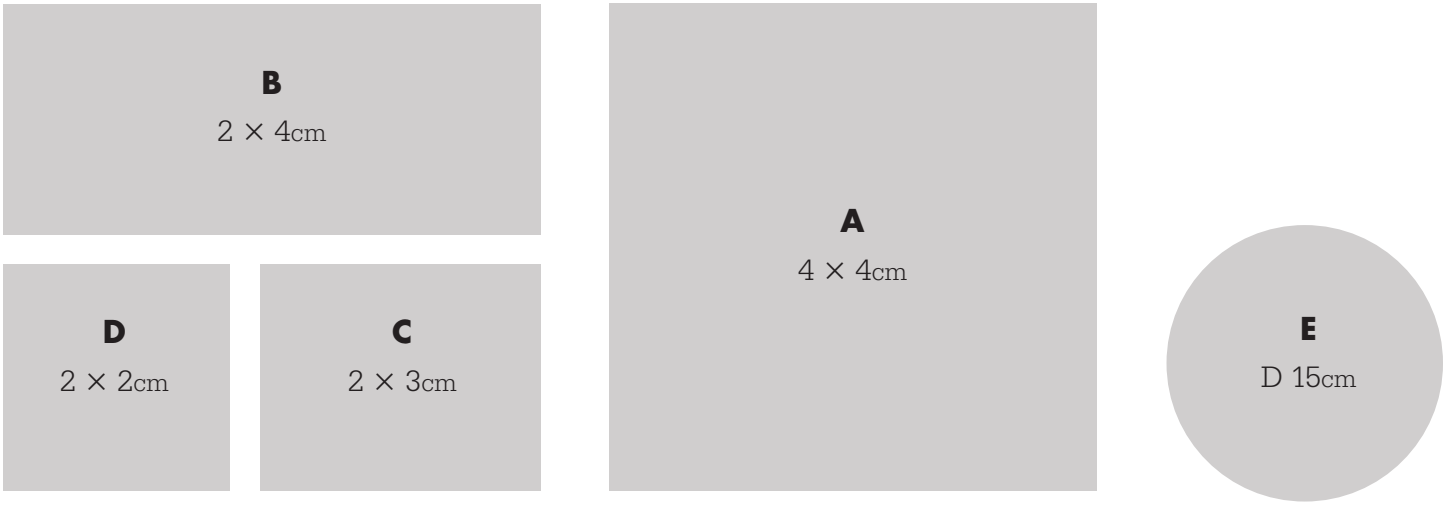
HCPCS Codes and Billing Units

HCPCS code	Description
Q4163	Woundex, BioSkin, per square centimeter (high cost skin substitute)
Q4100	Skin substitute, not otherwise specified

BioSkin is reimbursed by Medicare based on the Average Sales Price (ASP) published quarterly by CMS on the cms.gov website under the ASP Drug Pricing File. The ASP rate is per square centimeter. The quarterly ASP can be obtained from Stryker's Reimbursement Hotline.

BioSkin Amniotic Wound Matrix is billed per square centimeter (cm2). 1 cm^2 = 1 billable unit. The chart below lists billable units per product size.

Key	SKU/Product No.	Description and size	Square cm	Units
A	WA204X04	BioSkin 4x4 cm	16 cm^2	16
B	WA202X04	BioSkin 2x4 cm	8 cm^2	8
C	WA202X03	BioSkin 2x3 cm	6 cm^2	6
D	WA202X02	BioSkin 2x2 cm	4 cm^2	4
E	WA20D015	BioSkin D15 mm	1.77 cm^2	2



Medically Unlikely Edit (MUE)

The MUE is the maximum number of units of skin substitute graft reimbursed in one application per date of service.
> The MUE for BioSkin Amniotic Wound Matrix (Q4163) is 32 units (cm2).

Modifiers

Please check with the patient's insurer or Medicare Administrative Contractor (MAC) to inquire if modifiers are required with HCPCS Q4163 and/or the CPT® codes used (15271—15278). Some of the modifiers will impact reimbursement while others are informational only.

Modifier	Description
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant surgery
JC	Skin substitute used as graft
JW	Drug amount discard/not administered to any patient
KX	Requirements in medical policy have been met (This modifier may also apply to the application procedure code)
22	**Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.
26	**Professional Component:** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.
51	**Multiple Procedures:** When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes.
58	**Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period:** It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure.
59	**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.
Effective January 1, 2015 CMS established four new modifiers to define specific subsets of the 59 modifier. Modifier 59 is still recognized but should not be used when a more descriptive modifier is available. The X{EPSU} modifiers are below[4]	
XE	**Separate Encounter:** A service that is distinct because it occurred during a separate encounter
XS	**Separate Structure:** A service that is distinct because it was performed on a separate organ/structure
XP	**Separate Practitioner:** A service that is distinct because it was performed by a different practitioner
XU	**Unusual Non-Overlapping Service:** The use of a service that is distinct because it does not overlap usual components of the main service
80	**Assistant Surgeon:** Surgical assistant services may be identified by adding the modifier 80 to the usual procedure numbers. This modifier should be reported to identify surgical assistant services performed in a non-teaching setting or in a teaching setting when a resident was available, but the surgeon opted not to use the resident. In the latter case, the service is generally not covered by Medicare.

Document checklist

BioSkin Amniotic Wound Matrix

The following information may be helpful when requesting prior authorization from the payer. This is not an exhaustive list. The provider should check with each payer directly for medical criteria requirements.

❏ Diagnosis of the wound and any contributing etiology
- Primary and Secondary ICD-10 codes

❏ Description of all previous wound therapies applied over >4 weeks course of care including standard of care

❏ Summary of treatment of any wound related disease states

❏ Management and monitoring activities for local wound vascular status

❏ Off-loading prescriptions and noted patient compliance

❏ No active infections or osteomyelitis present; treatment summary and evidence of infection remission, if applicable

❏ Treatment of any neuropathic conditions and current status of patient's condition, if applicable

❏ Wound measurements at patient interactions such as dressing changes, treatments, etc.
- Wound should be >1cm2 at therapy initiation

❏ Review of contributing social conditions such as tobacco use, alcohol use, drug use, diet, etc.

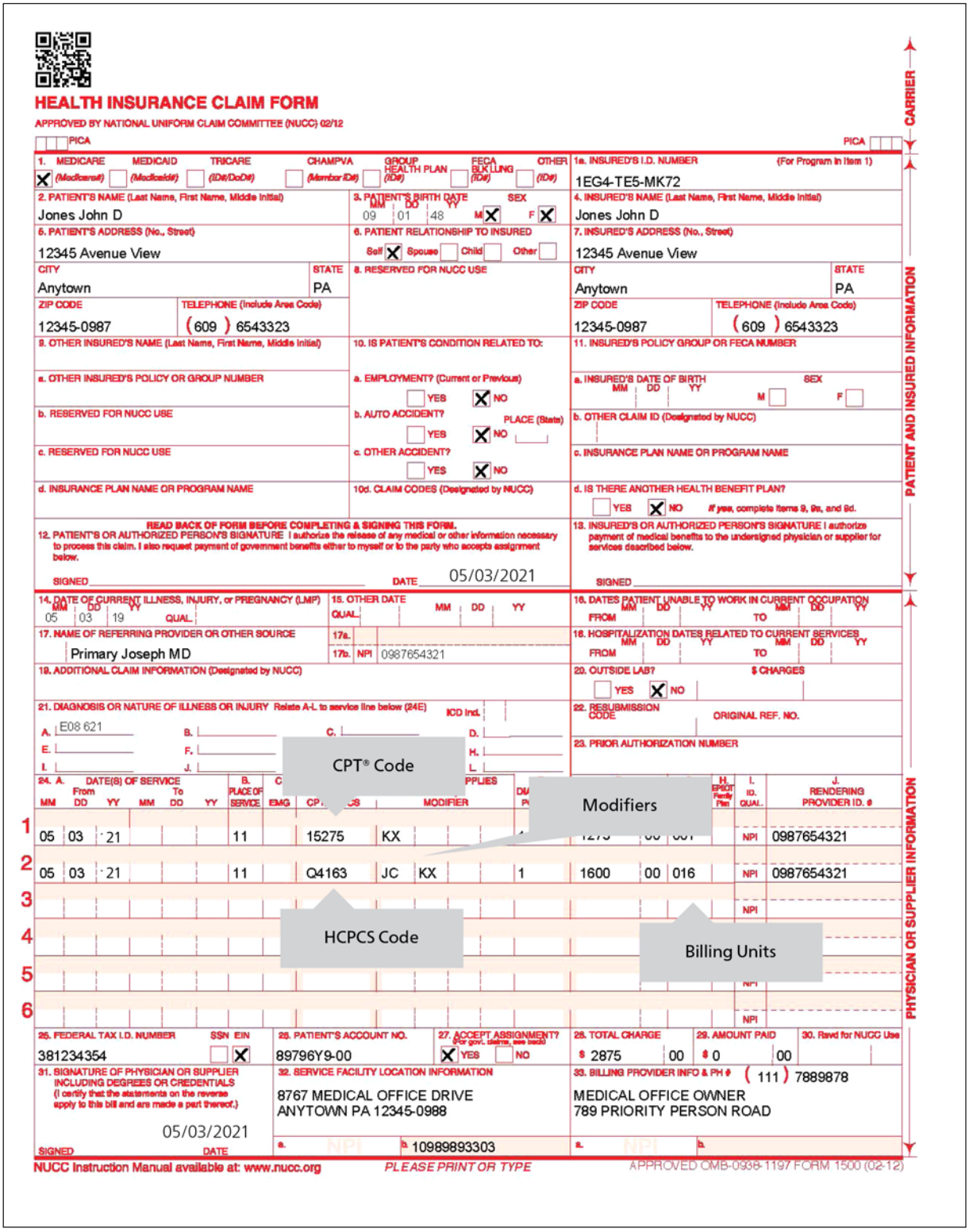
❏ Wound treatment plan including advanced therapies

❏ Retain copy of product's package insert and instructions for use (IFU) in patient's medical records.

Sample Claim Form

In this example claim form, a physician applies a 4x4cm square (or 16cm^2) of BioSkin Amniotic Wound Matrix in the physician office (POS 11) and submits a CMS-1500 claim form.

Not an actual claim, for illustrative purposes only



The Stryker Reimbursement Helpline staff can assist with the following:

- General coding and reimbursement questions
- Prior authorization and pre-determination questions
- Medicare unadjusted national average payment rates

For assistance with coding and reimbursement, please contact:

Reimbursement helpline: 800-698-9985, option 2

Fax: 949-449-8699

Email: orthoreimbursement@stryker.com

9 a.m. - 5 p.m. CT,
Monday through Friday

(except holidays and unexpected closures)

Visit us at www.stryker.com.

Status Indicator (SI) Definitions: J1 - Hospital Part B services paid through a Comprehensive APC; **N** - Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services; **Q1** - Packaged when billed on the same date of service with any other code with a status indicator of S, T, V, or X. If not, they are separately payable under a separate APC; **T** - Significant procedure, multiple procedure reduction applies.

Payment Indicator (PI) Definitions: A2 - Surgical procedure on ASC list in CY 2007, payment based on OPPS relative payment weight; **G2** - Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight; **N1**- Packaged service/item; no separate payment made.

References:

1. Current Procedural Terminology 2022. CPT® copyright 2020 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.
2. Calendar Year 2022 Medicare Physician Fee Schedule, Final Rule [CMS-1751-F]. Federal Register, November 19, 2021. PPRRVU January 2022 update December 15, 2021. Medicare national average physician payment rates listed in this document are based on the conversion factor of $34.6062. No geographic adjustments have been made to the reported payment rates.
3. Calendar Year 2022 Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, Final Rule [CMS-1753-FC], Federal Register, November 16, 2021 and its associated addenda posted on theCenters for Medicare and Medicaid Services web site on November 1, 2021.
4. MLN Matters® Fact Sheet. Proper Use of Modifiers 59 & -X{EPSU}. https://www.cms.gov/files/document/proper-use-modifiers-59-xepsu.pdf. (Accessed November 2021).
5. Fiscal Year 2022 Medicare Inpatient Prospective Payment System, Final Rule [CMS-1752-F], Federal Register, August 13, 2021 and Correcting Amendment [CMS-1752-F2], Federal Register October 20, 2021. Rates were calculated with a hospital Medicare base rate of $6,594.24.

Stryker
325 Corporate Drive
Mahwah, NJ 07430
t: 201 831 5000

Stryker.com

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