

Cahaba Medicare Policy Primer^{1,2}

MAC A: AL, GA & TN | MAC B: AL, GA, & TN | Carrier B: MS | LCD# 31428 | Active Date: 1/1/12

<p>Indications</p>	<ul style="list-style-type: none"> Applied to partial- or full-thickness ulcers of the lower extremities (see individual product information for labeled indications) as adjunctive therapy only after failing treatment with standard wound therapy. Failure to respond to standard wound therapy occurs when there are no documented measurable signs of healing for at least 30 consecutive days. Standard wound therapy includes: assessment of a patient's vascular status (e.g. presence of acceptable: lower extremity pulses, Doppler toe signals, Ankle-Brachial Index) and correction of any vascular problems in the affected limb if possible, optimization of nutritional status, optimization of glucose control (when applicable), debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, appropriate off-loading, and necessary treatment to resolve any infection that might be present
<p>Limitations</p>	<ul style="list-style-type: none"> During an initial course of treatment, repeat applications of skin substitutes/replacements are not indicated when applications were unsuccessful. Initiation of retreatment of healed ulcers that have recurred is not indicated Medicare payment for Apligraf® is limited to five applications per ulcer A pink, viable, fenestrated BSS can be debrided peripherally and left in place. Medicare would not expect removal and reapplication more frequently than every ten days. Exceptions with more frequent timing (every seven days) should be documented with appropriate narrative.
<p>Documentation</p>	<ul style="list-style-type: none"> This LCD supports the electronic health record (EHR) initiative. The initial application of the BSS should be documented in the medical record with at least one color photograph. The exact location and measurements (depth, width, and length or diameter) of each ulcer treated must be included in the medical record per visit. The record must document failure of standard wound therapy, as noted in the 'Indications'. Documentation supporting medical necessity should be legible, maintained in the patient's medical record and made available to Medicare upon request. Documentation must support CMS 'legible identifier' guidelines as described in the Medicare Program Integrity Manual (Pub. 100-08), Chapter 3, Section 3.4.1.1.D. <p>Product Wastage</p> <p>Medicare provides payment for the amount of the BSS product that is reasonable and necessary to treat the patient's ulcer. If the physician has made good faith efforts to minimize the unused portion of the BSS product in how patients are scheduled and how he/she ordered, accepted, stored and used the product, and made good faith efforts to minimize the unused portion of the product in how it is supplied, the program will cover the amount of product discarded along with the amount used to treat the ulcer. Documentation requirements for unused/discarded materials are provided in coverage in interpretive manuals: Internet Only Manual (IOM): Medicare Claims Processing Manual – Pub. 100-04, Chapter 17, Section 40.</p> <p style="text-align: right;"><i>Continued on next page ></i></p>

Cahaba MAC A and MAC B Policy Primer^{1,2} (continued)

Coding

CPT/HCPCS⁵

- **Q4101:** Apligraf, per square centimeter

Application Codes for Leg

- **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
- **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)
- **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
- **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 (List separately in addition to code for primary procedure)

Application Codes for Foot

- **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
- **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)
- **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
- **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 (List separately in addition to code for primary procedure)

ICD-9-CM

- **VSU:** 454.0, 454.2, 459.31, 459.33
- **DFU:** 250.80-250.83, & 707.12-707.15

¹ Source: www.cms.com ² This document is for informational purposes only. Use of this information does not guarantee coverage or payment for these services by Medicare or other payors. Physicians and other providers should use independent judgment when selecting codes that most appropriately describe the services provided to a patient. Physicians and hospitals are solely responsible for compliance with Medicare and other payors' laws, rules, and requirements. ³ VSU = Venous Stasis Ulcer. ⁴ DFU = Diabetic Foot Ulcer. ⁵ CPT © American Medical Association. All Rights Reserved.

2012 Cahaba Medicare Apligraf® Sample UB-02 Claim Form

1 Anytown Hospital 123 Medical Drive Anytown, NJ 00000		2		3a PAT. CNTL.# b. MED. REC.# HIC 012345678A		4 TYPE OF BILL 131	
				5 FED. TAX NO. 01-2345678		6 STATEMENT COVERS PERIOD FROM 01012012	
						7 THROUGH 01012012	

8 PATIENT NAME a Smith, Jane		9 PATIENT ADDRESS a 111 Maple Avenue									
b		b Anytown				c NJ		d 00000		e	

10 BIRTHDATE 01011935		11 SEX F		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC		16 DHR		17 STAT		18		19		20		21		22		23		24		25		26		27		28		29 ACDT STATE 30	
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31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		35 OCCURRENCE CODE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH	
-------------------------	--	-------------------------	--	-------------------------	--	-------------------------	--	-------------------------	--	---------------------------------	--	---------------------------------	--

All dates should be in eight digit format.

Jane Smith
111 Maple Avenue
Anytown, NJ 00000

38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
a		b		c		d	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 636	Apligraf	Q4101 JC	01012012	44	XXX.XX		
2 360	Application, first 25 sq cm	15271	01012012	1	XXX.XX		
3 360	Application, each additional 25 sq cm	15272	01012012	1	XXX.XX		

Enter appropriate revenue codes for all services provided.
Revenue code 636 should be used when billing for Apligraf.

15271 and 15272 should be used based on the size of the wound. For example, a LEG wound measuring 30 sq cm, would be billed using 15271 (first 25 sq cm or less) and 15272 (additional 25 sq cm or part thereof).

Apligraf is supplied in 44 units.

PAGE ____ OF ____		CREATION DATE		TOTALS →	
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50 PAYER NAME A Medicare		51 HEALTH PLAN ID A987654X		52 REL. INFO		53 ASG. BEN.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	
												57 OTHER PRV ID	

58 INSURED'S NAME A Smith, Jane			59 P. REL.		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.	
B			C		A		B		C	

63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME		
A			B			C		

VSU: 454.0, 454.2, 459.31, 459.33
DFU: 250.80-250.83, & 707.12-707.15

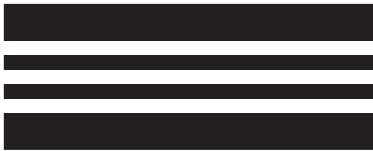
66 DX XXX.XX		68	
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69 ADMIT DX		70 PATIENT REASON DX		71 FPS CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE CODE DATE		a. OTHER PROCEDURE CODE DATE		b. OTHER PROCEDURE CODE DATE		75		76 ATTENDING NPI QUAL	
								LAST FIRST	
c. OTHER PROCEDURE CODE DATE		d. OTHER PROCEDURE CODE DATE		e. OTHER PROCEDURE CODE DATE				77 OPERATING NPI QUAL	
								LAST FIRST	

80 REMARKS		81CC a		b		c		d		78 OTHER NPI QUAL		79 OTHER NPI QUAL	
										LAST FIRST		LAST FIRST	

2012 Cahaba Medicare

PLEASE DO NOT STAPLE IN THIS AREA



Apligraf®
Sample CMS-1500 Claim Form
Physician Services in an Outpatient Setting

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 123-45-6789A	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Jane		3. PATIENT'S BIRTH DATE MM DD YY 12 13 35 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Smith, Jane		5. PATIENT'S ADDRESS (No., Street) 123 Any Street	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 123 Any Street	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS CITY ANYTOWN STATE NJ	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who 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 _____ DATE _____	

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY 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 FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		23. PRIOR AUTHORIZATION NUMBER		24. RESERVED FOR LOCAL USE	
1. <u>XXX</u> . <u>XX</u>		2. <u>XXX</u> . <u>XX</u>		24. A B C D E F G H I J K	
DATE(S) OF SERVICE From MM DD YY To MM DD YY		Place of Service		Type of Service	
PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS ICD-9-CM		\$ CHARGES	
RESERVED FOR LOCAL USE		RESERVED FOR LOCAL USE		RESERVED FOR LOCAL USE	
01 01 12 01 01 12 22		15271		←	
01 01 12 01 01 12 22		15272		←	

VSU: 454.0, 454.2, 459.31, 459.33
DFU: 250.80-250.83, & 707.12-707.15

15271 and 15272 should be used based on the size of the wound. For example, a LEG wound measuring 30 sq cm, would be billed using 15271 (first 25 sq cm or less) and 15272 (additional 25 sq cm or part thereof).

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER 01-2345678 SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 012345678		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>	
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# _____	

2012 Cahaba Medicare

PLEASE DO NOT STAPLE IN THIS AREA



Apligraf®
Sample CMS-1500 Claim Form
Physician Services in an Office Setting

APPROVED OMB-0938-0008

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS CITY ANYTOWN STATE NJ	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who 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 _____ DATE _____	
14. DATE OF CURRENT: MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)	
22. MEDICAID 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 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		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	
25. FEDERAL TAX I.D. NUMBER 01-2345678 SSN EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 012345678	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ XXX	
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 #		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	

VSU: 454.0, 454.2, 459.31, 459.33
DFU: 250.80-250.83, & 707.12-707.15

Apligraf is supplied in 44 units.

15271 and 15272 should be used based on the size of the wound. For example, a LEG wound measuring 30 sq cm, would be billed using 15271 (first 25 sq cm or less) and 15272 (additional 25 sq cm or part thereof).

Model Documentation Form for Cahaba

Pretreatment:

1. Duration of ulcer (**DFU**: 3 weeks, **VSU**: greater than 1 month)
_____ weeks
2. Exact location of ulcer and measurements
3. Diagnosis of patient
VSU: 454.0, 454.2, 459.31, 459.33
DFU: 250.80-250.83, 707.12 – 707.15
4. Document failure to respond to conservative measures (failure to respond to standard wound therapy occurs when there are no documented measurable signs of healing for at least 30 consecutive days.)
5. Document other conservative measures that were used (e.g. saline moistened dressing, non-weight bearing regimen).
6. Document that wound is free of infection, tunnels and tracts (for DFU), and free of cellulitis, eschar or obvious necrotic material for both DFU and VSU.
7. For DFU, document that ulcer is full thickness.
8. For VSU, document that ulcer is partial or full thickness.
9. For VSU, document correction of any vascular problems in the affected limb.
10. Document adequate arterial blood supply to support tissue growth.

Continued on next page >

This document is for informational purposes only. Use of this information does not guarantee coverage or payment for these services by Medicare or other payors. LCDs are updated by Medicare and Medicare contractors on a regular basis. Physicians and other providers should regularly refer to the applicable Medicare local coverage determinations (LCDs) for complete information on medical necessity documentation requirements. Physicians, providers and hospitals are solely responsible for compliance with Medicare and other payors' laws, rules, and requirements. Information based on LCD# L28985.

Treatment:

11. Document measurement of ulcer (width and length or circumference and depth) immediately prior to application of Apligraf _____sq cm
12. Document whether this is an initial application of Apligraf or a reapplication (limited to no more than 5 applications per wound).
13. Document whether wound treatment with Apligraf is accompanied by appropriate adjunctive wound care measures (e.g. dressing changes during healing, off-loading, compressive dressings).
14. Document how Apligraf was fixated on the wound.

Modifiers:

15. JC – Skin substitute used as a graft (use for Apligraf)
16. JD – Skin substitute not used as a graft
17. The JC and JD modifiers should be used when billing for skin substitutes. The difference between them is whether the skin substitute is used as a graft or as a skin covering. The definition of a skin graft for this purpose is whether the skin substitute is implanted into the wound to be incorporated in the healing of the wound. If the skin substitute is used to cover a wound, to protect it from contamination or fluid loss, then it is not a graft, but a dressing.

Product Wastage Documentation Requirements:

18. Date:
19. Time:
20. Location of ulcer:
21. Approximate amount of product unit used:
22. Approximate amount of product unit discarded:
23. Reason for the wastage:
24. Manufacture's serial/lot/batch number

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ICD-9 CM Codes commonly used when billing for Apligraf¹

- 454.0** Varicose veins of lower extremities, with ulcer
- 454.1** Varicose veins of lower extremities, with inflammation
- 454.2** Varicose veins of lower extremities, with ulcer and inflammation
- 459.11** Postphlebotic syndrome with ulcer
- 459.13** Postphlebotic syndrome with ulcer and inflammation
- 459.31** Chronic venous hypertension with ulcer
- 459.33** Chronic venous hypertension with ulcer and inflammation
- 459.81** Other specified disorders of circulatory system, venous (peripheral) insufficiency, unspecified

- 707.10** Ulcer of lower limb, unspecified
- 707.11** Ulcer of thigh
- 707.12** Ulcer of calf
- 707.13** Ulcer of ankle
- 707.14** Ulcer of heel and midfoot (Plantar surface of midfoot)
- 707.15** Ulcer of other part of foot (Toes)
- 707.19** Ulcer of other part of lower limb
- 707.8** Chronic ulcer of other specified sites

- 249.00** Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified
- 249.01** Secondary diabetes mellitus without mention of complication, uncontrolled
- 249.10** Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified
- 249.11** Secondary diabetes mellitus with ketoacidosis, uncontrolled
- 249.20** Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified
- 249.21** Secondary diabetes mellitus with hyperosmolarity, uncontrolled
- 249.30** Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified
- 249.31** Secondary diabetes mellitus with other coma, uncontrolled

Continued on next page >

- 249.40** Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified
- 249.41** Secondary diabetes mellitus with renal manifestations, uncontrolled
- 249.50** Secondary diabetes mellitus with ophthalmic manifestations, not stated as uncontrolled, or unspecified
- 249.51** Secondary diabetes mellitus with ophthalmic manifestations, uncontrolled
- 249.60** Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified
- 249.61** Secondary diabetes mellitus with neurological manifestations, uncontrolled
- 249.70** Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled, or unspecified
- 249.71** Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled
- 249.80** Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified
- 249.81** Secondary diabetes mellitus with other specified manifestations, uncontrolled
- 249.90** Secondary diabetes mellitus with unspecified complication, not stated as uncontrolled, or unspecified
- 249.91** Secondary diabetes mellitus with unspecified complication, uncontrolled
- 250.60** Diabetes With Neurological Manifestations, Type II Or Unspecified Type, not stated as uncontrolled
- 250.61** Diabetes With Neurological Manifestations, Type I (Juvenile Type), not stated as uncontrolled
- 250.62** Diabetes With Neurological Manifestations, Type II Or Unspecified Type, uncontrolled
- 250.63** Diabetes With Neurological Manifestations, Type I (Juvenile Type), uncontrolled
- 250.70** Diabetes With Peripheral Circulatory Disorders, Type II Or Unspecified type, not stated as uncontrolled
- 250.71** Diabetes With Peripheral Circulatory Disorders, Type I (Juvenile Type), not stated as uncontrolled
- 250.72** Diabetes With Peripheral Circulatory Disorders, Type II Or Unspecified type, uncontrolled
- 250.73** Diabetes With Peripheral Circulatory Disorders, Type I (Juvenile Type), uncontrolled
- 250.80** Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled
- 250.81** Diabetes with other specified manifestations, type I, not stated as uncontrolled
- 250.82** Diabetes with other specified manifestations, type II or unspecified type, uncontrolled
- 250.83** Diabetes with other specified manifestations, type I, uncontrolled

¹ This brief summary is provided for consideration only. All codes provided herein are for information purposes only and shall not be construed as a statement, promise, or guarantee that these codes are accurate or reimbursement will be received. Coding requirements are subject to change at any time, therefore check with your local payer regularly to verify prior authorization requirements.