

Cigna MAC A& B Policy Primer^{1,2}

Part A & B: KY & OH | Effective Date: 1/1/12

| | |
|-----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Indications</p> | <ul style="list-style-type: none"> ■ VSU³ ulcers that have failed to respond to documented conservative measures of greater than 6 weeks in duration. ■ DFU⁴ ulcers of greater than 3 weeks in duration which extend through the dermis but without tendon, muscle, capsule or bone exposure. |
| <p>Limitations</p> | <ul style="list-style-type: none"> ■ Application is limited to physicians (M.D, D.O., D.P.M., and NNP (non-physician practitioner) who are skilled in wound care management. ■ Managed wounds should be free of infection, and are of reasonable size (at least 1.0 sq cm), with adequate circulation/oxygenation to support tissue growth as evidenced by physical examination (presence of ABI of no less than 0.65). ■ A single application of DET for any particular ulcer is usually all that is required to affect wound healing in those wounds that are likely to be helped by this therapy. Treatment with Apligraf[®] is usually expected to last no more than twelve (12) weeks and to involve a maximum of four Apligraf[®] applications for any ulcer that initially qualifies for treatment. The use of more than four applications for the same ulcer is not considered reasonable and necessary and will not be reimbursed. ■ Re-application of Apligraf[®] within three weeks for the same ulcer is not considered reasonable and necessary and will not be reimbursed. ■ Re-application of Apligraf[®] where initial application has resulted in no decrease in size or depth or increase in granulation tissue, epithelialization, or progress towards closing, will be denied as not reasonable and necessary and will not be reimbursed. ■ Re-treatment within one year following the last successful application with DET is not considered reasonable and necessary, and will not be reimbursed. ■ Re-treatment of an ulcer following the unsuccessful treatment where it consisted of two failed Apligraf[®] applications is not considered reasonable and necessary, and will not be reimbursed. |
| <p>Documentation</p> | <ul style="list-style-type: none"> ■ The medical record documentation supporting medical necessity should be legible, maintained in the patient's medical record, and made available to Medicare upon request. ■ The medical record documentation must confirm and support that all requirements set forth in the "Indications" section of this policy (and applicable article) have been satisfied with regards to the clinical characteristics of the ulcer, the presence of qualifying or disqualifying conditions, and the duration and intensity of pre-treatment conservative/conventional management. ■ Documentation of response or lack thereof, requires measurement of the ulcer at baseline and following cessation of conservative or conventional management and must be included in the medical record. Documentation should also include measurement of the ulcer immediately prior to the placement of skin substitutes/replacements. A "failed response" is defined as an ulcer that has increased in size or depth, or for which there has been no change in baseline size or depth and no sign of improvement or indication that improvement is likely, such as granulation, epithelialization or progress toward closing. |

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Documentation

- The medical record must document that wound treatments with skin substitutes/replacements are accompanied by appropriate wound dressing changes during the healing period and by appropriate compressive dressings during follow-up, including, for neuropathic diabetic foot ulcers, appropriate steps to off-load wound pressure during the follow-up.
- Rationale for the selection of a biological product for surgical interventions in repair of anatomic defects or reconstruction work must be documented in the medical record and submitted to Medicare upon request.
- The patient's medical record must contain documentation that fully supports the medical necessity for services included within this coverage article. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Product Wastage Documentation Requirements

Although a reasonable amount of product wastage is permitted, an exact amount of the tissue used per application should be documented in the patient's medical record with:

- Date and time.
- Amount of product used.
- Amount of product wasted.
- The reason for the wastage.

Coding

CPT/HCPCS⁵

- **Q4101:** Apligraf, per square centimeter (when Apligraf is used in accordance with the below definition it should be billed with the JC modifier, as well as site modifier RT or LT.)

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)

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Cigna MAC A & B Policy Primer^{1,2} (continued)

Coding

Modifiers effective 01/01/2009 (as per CMS Change Request #6315)

- **JC:** Skin substitute used as a graft.
- **JD:** Skin substitute not used as a graft.

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.

ICD-9-CM

- **VSU:** (one of the following) 454.0, 454.2, 459.11, 459.13, 459.31, 459.33

Or you may bill:

- **VSU:** 459.81 along with an ulcer code 707.12-707.15, 707.19
- **DFU (Primary):** 249.60-249.61, 249.70-249.71, 249.80-249.81, 250.60-250.63, 250.70-250.73, 250.80-250.83
- **DFU (Secondary):** 707.13-707.15
- Record the site of service where the procedure was performed.

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 Cigna MAC B Apligraf® Sample UB-04 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 THROUGH 01012012 01012012 | |

| | | | | | | | | | | | |
|---------------------------------|--|-----------------------------------------|--|--|--|------|--|---------|--|---|--|
| 8 PATIENT NAME a Smith, Jane | | 9 PATIENT ADDRESS a 111 Maple Avenue | | | | | | | | | |
| b Smith, Jane | | 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 | | CONDITION CODES 22 23 24 25 26 27 28 | | 29 ACDT STATE 30 | |
|--------------------------|--|-------------|--|---------|--|--------------------------------|--|--------|--|---------|--|-------------|--|--------------------------------------|--|---------------------|--|

| | | | | | | | | | | | | | |
|--------------------|--|--------------------|--|--------------------|--|--------------------|--|---------------------------------|--|---------------------------------|--|----|--|
| 31 OCCURRENCE DATE | | 32 OCCURRENCE DATE | | 33 OCCURRENCE DATE | | 34 OCCURRENCE DATE | | 35 OCCURRENCE SPAN FROM THROUGH | | 36 OCCURRENCE SPAN FROM THROUGH | | 37 | |
|--------------------|--|--------------------|--|--------------------|--|--------------------|--|---------------------------------|--|---------------------------------|--|----|--|

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 RT or LT | 01012012 | 44 | XXX:XX | | |
| 2 360 | Application, first 25 sq cm | 15271 RT or LT | 01012012 | 1 | XXX:XX | | |
| 3 360 | Application, each additional 25 sq cm | 15272 RT or LT | 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 → | |
|-------------------|--|---------------|--|-----------------|--|

| | | | | | | | | | | | | | |
|-----------------------------|--|-------------------------------|--|--------------|--|--------------|--|-------------------|--|--------------------|--|-----------------|--|
| 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. | | |
|------------------------------------|--|--|------------|--|------------------------|--|---------------|--|------------------------|--|--|

VSU: (one of the following) 454.0, 454.2, 459.11, 459.13, 459.31, 459.33
 Or you may bill: **VSU:** 459.81 along with the ulcer code 707.12-707.15, 707.19
DFU (Primary): 249.60-249.61, 249.70-249.71, 249.80-249.81, 250.60-250.63, 250.70-250.73, 250.80-250.83
DFU (Secondary): 707.13-707.15
 Record the site of service where the procedure was performed.

| | | | | | | | |
|----------------------------|--|------------------|--|--|--|--|--|
| 63 TREATMENT AUTHORIZATION | | 65 EMPLOYER NAME | | | | | |
| 66 DX XXX.XX | | 68 | | | | | |

| | | | | | | | | | |
|----------------------------------|--|------------------------------|--|------------------------------|--|--------|--|-----------------------|--|
| 69 ADMIT DX | | 70 PATIENT REASON DX | | 71 PPS 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 | | | | | | 78 OTHER NPI QUAL | |
| | | b | | | | | | LAST FIRST | |
| | | c | | | | | | 79 OTHER NPI QUAL | |
| | | d | | | | | | LAST FIRST | |

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 | | 19. RESERVED FOR LOCAL USE | | 19. RESERVED FOR LOCAL USE | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS | | 21. DIAGNOSIS OR NATURE OF ILLNESS | | 21. DIAGNOSIS OR NATURE OF ILLNESS | |

VSU: (one of the following) 454.0, 454.2, 459.11, 459.13, 459.31, 459.33
 Or you may bill: **VSU: 459.81** along with the ulcer code **707.12-707.15, 707.19**
DFU (Primary): 249.60-249.61, 249.70-249.71, 249.80-249.81, 250.60-250.63, 250.70-250.73, 250.80-250.83
DFU (Secondary): 707.13-707.15
 Record the site of service where the procedure was performed.

| | A DATE(S) OF SERVICE From | | B DATE(S) OF SERVICE To | | C Place of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E DIAGNOSIS CODE | F CHARGES | G DAYS OR | H EPSDT Family | I FUM | J COB | K RESERVED FOR LOCAL USE |
|---|---------------------------|----|-------------------------|----|--------------------|----------------------------------------------------------------------------------------|------------------|-----------|-----------|----------------|-------|-------|--------------------------|
| | MM | DD | YY | MM | | | | | | | | | |
| 1 | 01 | 01 | 12 | 01 | 01 | 12 | 22 | 15271 | RT | or | LT | | |
| 2 | 01 | 01 | 12 | 01 | 01 | 12 | 22 | 15272 | RT | or | LT | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | |

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"/> | | 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 # PIN# _____ GRP# _____ | | | |

Model Documentation Form for Cigna MAC B

Pretreatment:

1. Duration of ulcer

_____ weeks
2. Document failure to respond to conservative measures (VSU for at least six (6) weeks). A failed response is defined as an ulcer that has increased in size or depth, no change in baseline size or depth, and no sign of improvement- such as granulation.
3. Document measurement of the ulcer at baseline, following cessation of conservative management.
4. Document adequate treatment of the underlying disease process contributing to the ulcer
5. Exact location of ulcer (site modifier RT or LT must be reported to indicate right-side or left-side)
6. Diagnosis of patient
VSU: 454.0, 454.2, 459.11, 459.13, 459.31, 459.33 or
VSU: 459.81 along with an ulcer code 707.12-707.15, 707.19
DFU: (Primary): 249.60-249.61, 249.70-249.71, 249.80-249.81, 250.60-250.63, 250.70-250.73, 250.80-250.83 : **(Secondary):** 707.13-707.15
7. Document that wound is free of infection, redness, drainage, underlying osteomyelitis, surrounding cellulitis, tunnels and tracts, eschar or any necrotic material
8. For DFU, document current HbA1C reading (HbA1C should not exceed 12%)

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9. For DFU, document ulcer extends through the dermis but without tendon, muscle, capsule or bone exposure.
10. Document adequate arterial blood supply as evidenced by ABI (ABI of 0.65 or greater)
11. Document rationale for the selection of Apligraf for surgical interventions in repair of anatomic defects or reconstruction work

Treatment:

12. Document measurement of ulcer (width and length or circumference and depth) immediately prior to application of Apligraf _____sq cm
13. Document whether this is an initial application of Apligraf or a reapplication. (LCD limits Apligraf to 4 applications per ulcer.)
14. For Apligraf reapplications document that applications have been successful (e.g. decrease in size or depth, increase in granulation tissue). Note: reapplication of Apligraf within 3 weeks for same ulcer is not covered.
15. Document the wound dressing changes and the standard conservative measures (i.e. use of pressure- reducing footwear, non-weight bearing regiment, debridement of necrotic and callused tissue, saline moistened dressings, dressing changes) accompanying the wound treatment with Apligraf.
16. Document how the wound site was prepared, and how Apligraf was fixated on the wound

Product Wastage Documentation Requirements:

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

Modifiers:

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- JC – Skin substitute used as a graft (use for Apligraf)
- JD – Skin substitute not used as a graft

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.

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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

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- 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.