National Government Services Policy Primer[1,2]

Part A: IN, IL,CT, NY, WI, MI | Part B: CT, IN, & NY | Rev. Effective Date: 4/1/12

Indications

- VSU[3] ulcers that have failed to respond to documented conservative measures of greater than 4 weeks in duration.
- DFU[4] ulcers of greater than 3 weeks in duration which extend through the dermis but without tendon, muscle, capsule or bone exposure.

Limitations

- Application is limited to physicians (M.D, D.O., D.P.M., and NNP (non-physician practitioner) who are skilled in wound care management.
- The patient must have adequate circulation/oxygenation to support tissue growth/wound healing as evidenced by physical examination (presence of acceptable peripheral pulses and/or Doppler toe signals and/or ankle-brachial index (ABI) of no less than 0.65 in the limb undergoing the procedure).
- 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 five Apligraf® applications for any ulcer that initially qualifies for treatment. The use of more than five applications for the same ulcer is not considered reasonable and necessary and will not be reimbursed.
- Re-application of Apligraf® more frequently than once per week 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.

Documentation

- 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.

Continued on next page >

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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/HCPCS[5]

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

Continued on next page >

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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.

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2012 National Government Services Medicare Apligraf® Sample UB-04 Claim Form

1 Anytown Hospital
123 Medical Drive
Anytown, NJ 00000

2

3a PAT. CNTL # HIC 012345678A
b. MED. REC. #

4 TYPE OF BILL 131

5 FED. TAX NO. 01-2345678

6 STATEMENT COVERS PERIOD FROM 01012012 THROUGH 01012012

7

8 PATIENT NAME a
b Smith, Jane

9 PATIENT ADDRESS a 111 Maple Avenue
b Anytown c NJ d 00000 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
01011935	F																			

31 OCCURRENCE CODE / DATE — 32 OCCURRENCE CODE / DATE — 33 OCCURRENCE CODE / DATE — 34 OCCURRENCE CODE / DATE — 35 OCCURRENCE SPAN CODE / FROM / THROUGH — 36 OCCURRENCE SPAN CODE / FROM / THROUGH — 37

> All dates should be in eight digit format.

38
Jane Smith
111 Maple Avenue
Anytown, NJ 00000

39 VALUE CODES CODE / AMOUNT — 40 VALUE CODES CODE / AMOUNT — 41 VALUE CODES CODE / 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
636	Apligraf	Q4101 JC RT or LT	01012012	44	XXX XX		
360	Application, first 25 sq cm	15271 RT or LT	01012012	1	XXX XX		
360	Application, each additional 25 sq cm	15272 RT or LT	01012012	1	XXX XX		
	PAGE ____ OF ____	**CREATION DATE**		**TOTALS**			

> 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.

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
Medicare	A987654X				

56 NPI — 57 OTHER PRV ID

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

63 TREATMENT AUTHORIZATION — 65 EMPLOYER NAME

66 DX XXX.XX — 68

> **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.

69 ADMIT DX — 70 PATIENT REASON DX — 71 PPS CODE — 72 ECI — 73

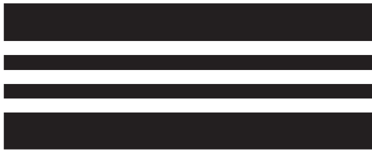
74 PRINCIPAL PROCEDURE CODE / DATE — a. OTHER PROCEDURE CODE / DATE — b. OTHER PROCEDURE CODE / DATE — 75
c. OTHER PROCEDURE CODE / DATE — d. OTHER PROCEDURE CODE / DATE — e. OTHER PROCEDURE CODE / DATE

76 ATTENDING NPI QUAL — LAST FIRST
77 OPERATING NPI QUAL — LAST FIRST
78 OTHER NPI QUAL — LAST FIRST
79 OTHER NPI QUAL — LAST FIRST

80 REMARKS — 81CC a, b, c, d

2012 National Government Services 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

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 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 [ ] F [X]

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 [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Any Street

CITY: ANYTOWN STATE: NJ

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: ANYTOWN STATE: NJ

ZIP CODE: 00000 TELEPHONE (Include Area Code): (973) 555-1234

ZIP CODE: 00000 TELEPHONE (INCLUDE AREA CODE): (973) 555-1234

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

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

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

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any 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: SIGNATURE ON FILE 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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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 U…

$ CHARGES

…NO

…MISSION ORIGINAL REF. NO.

…ATION NUMBER

21. DIAGNOSIS OR NATURE …

1. XXX . XX

2. XXX . XX

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.

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

25. FEDERAL TAX I.D. NUMBER SSN EIN: 01-2345678

26. PATIENT'S ACCOUNT NO.: 012345678

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

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#

PHYSICIAN OR SUPPLIER INFORMATION

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

2012 National Government Services Medicare

PLEASE
DO NOT
STAPLE
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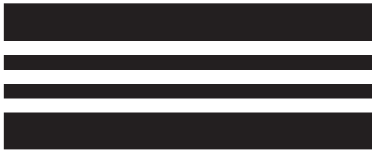
AREA



Apligraf®

Sample CMS-1500 Claim Form

Physician Services in an Office Setting

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

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3. PATIENT'S BIRTH DATE MM DD YY: 12 13 35 SEX M [ ] F [X]

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 [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Any Street

CITY: ANYTOWN STATE: NJ

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: ANYTOWN STATE: NJ

ZIP CODE: 00000 TELEPHONE (Include Area Code): (973) 555-1234

ZIP CODE: 00000 TELEPHONE (INCLUDE AREA CODE): (973) 555-1234

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

c. OTHER ACCIDENT? YES [ ] NO [X]

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any 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 SIGNATURE ON FILE 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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? NO $ CHARGES

21. DIAGNOSIS OR NATURE

1. XXX . XX

2. XXX . XX

...UBMISSION ORIGINAL REF. NO.

...IZATION NUMBER

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.

24.	A 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 CODE	$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01	01	12	01	01	12	11		Q4101	JC RT or LT			44				
2	01	01	12	01	01	12	11		15271	RT or LT							
3	01	01	12	01	01	12	11		15272	RT or LT							
4																	
5																	
6																	

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).

25. FEDERAL TAX I.D. NUMBER SSN EIN: 01-2345678 [ ] [ ]

26. PATIENT'S ACCOUNT NO.: 012345678

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

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#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Apligraf

Model Documentation Form for National Government Services

Pretreatment:

1. Duration of ulcer

   ______________________________________ weeks

2. Document failure to respond to conservative measures (VSU for at least 4 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

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%)

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.

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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

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.

14. For Apligraf reapplications document that applications have been successful (e.g. decrease in size or depth, increase in granulation tissue).

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

Continued on next page >

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Modifiers:

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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Apligraf

ICD-9 CM Codes commonly used when billing for Apligraf[1]

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 Postphlebitic syndrome with ulcer
459.13 Postphlebitic 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.

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