

**To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.**

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## 1.0 Description of the Procedure, Product, or Service

Skin substitutes are used to treat chronic wounds, burns, rare skin conditions, trauma, immobility, ischemia, or other neurological impairments; over 90% of the lesions are related to venous stasis disease and diabetic neuropathy. These products promote the growth of new skin or serve as a temporary cover until other grafts can be placed.

The addition of Skin Substitutes, Cellular or Tissue Based Products (CTPs) to certain wounds may afford a healing advantage over dressings and conservative treatments when these options appear insufficient to affect complete healing. There are currently a wide variety of bioengineered products available for soft tissue coverage to affect closure. These products may be derived from human tissue (allogeneic or autologous), non-human tissue (xenogeneic), synthetic sources or a combination of any or all these types of materials. However, without the component of the recipient's own distinct epithelium and cellular skin elements, permanent skin replacement or coverage by the graft cannot be accomplished.

### 1.1 Definitions

**Diabetic Foot Ulcer (DFU)** – A non-healing or poorly healing full-thickness wound, through the dermis, below the ankle in a beneficiary with diabetes. DFUs are categorized as being purely neuropathic, purely ischemic or neuroischemic (mixed). The most common sites for DFUs are the plantar surface of foot (metatarsal heads and midfoot), and toes (dorsal interphalangeal joints or distal tip).

**Venous Stasis Ulcer (VSU)** - A venous ulcer is a shallow wound that develops on the lower leg when the leg veins fail to return blood back toward the heart normally - a condition known as venous insufficiency. They are also called varicose ulcer or stasis leg ulcer.

**Conservative Management** – This is the standard treatment of chronic lower extremity ulcers or skin loss. This primarily includes infection and edema control, mechanical offloading, mechanical compression or limb elevation, debridement of necrotic or infected tissue, and management of existing medical issues. Maintenance of a therapeutic environment with appropriate dressings to prevent further trauma facilitates the development of healthy granulation tissue and encourages re-epithelization.

**Chronic Wound** – a wound that does not respond to standard wound treatment for at least a 30-day period during organized comprehensive conservative therapy.

**Failed Response** – This is an ulcer or skin deficit that has failed to respond to documented appropriate wound-care measures, has increased in size or depth, or has not changed in baseline size or depth and has no indication that improvement is likely (such as granulation, epithelialization or progress towards closing).

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

#### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
None Apply.

### 2.2 Special Provisions

#### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**b. EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

NC Medicaid shall deny the claim for coverage for a NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for a NCHC beneficiary.

### 3.0 When the Procedure, Product, or Service Is Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

#### 3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

#### 3.2 Specific Criteria Covered

##### 3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover the following skin substitutes:

###### 3.2.1.1 Apligraf®

###### a. Apligraf® for Venous Stasis Ulcers (VSU)

Apligraf is covered when ALL of the following conditions are met in the treatment of partial or full thickness venous stasis ulcers and documented in the beneficiary's health record:

1. Ulcers are of more than one (1) months' duration;
2. Measurement of the initial ulcer size, the ulcer size following cessation of conservative management, and the size at the beginning of skin substitute treatment;
3. Ulcers have failed to respond to documented conservative measures used for more than four (4) weeks duration (failed to decrease the ulcer by 50%);
4. The ulcer must be free of infection (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge) and underlying osteomyelitis, and treatment of the underlying disease must be provided and documented in conjunction with the skin substitute treatment; and
5. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70.

###### b. Apligraf® for Neuropathic Diabetic Ulcers (DFU)

Apligraf is covered when ALL the following conditions are met in the treatment of neuropathic diabetic foot ulcers and documented in the beneficiary's health record:

1. The beneficiary has a primary diagnosis of foot ulcer and a secondary diagnosis of Type 1 or 2 diabetes mellitus with a glycated hemoglobin (HbA1c) of less than 12%;

2. Full thickness ulcers of greater than three (3) weeks' in duration, which extend through the dermis but without tendon, muscle, capsule or bone exposure;
3. Measurement of the initial ulcer size, the ulcer size following cessation of conservative management, and the size at the beginning of skin substitute treatment;
4. Ulcers have failed to respond to documented conservative measures used for more than four (4) weeks' duration (failed to decrease the ulcer by 50%);
5. Appropriate steps to off-load pressure during treatment are being taken;
6. The ulcer must be free of infection (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge) and underlying osteomyelitis, and treatment of the underlying disease must be provided and documented in conjunction with skin substitute treatment; and
7. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70;

#### **3.2.1.2 Dermagraft®**

Dermagraft® is covered for the treatment of full-thickness diabetic foot ulcers when ALL the following conditions are met:

- a. The ulcer has persisted for six (6) weeks or longer;
- b. The ulcer extends through the dermis, but without tendon, muscle, joint capsule, or bone exposure;
- c. The beneficiary has a primary diagnosis of foot ulcer and a secondary diagnosis of Type 1 or 2 diabetes mellitus with a current HbA1C that does not exceed 12%.
- d. Ulcers are located on foot or toes and are free of infection, (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge), underlying osteomyelitis, surrounding cellulitis, sinus tracts, eschar, or any necrotic material that would interfere with adherence of a living skin equivalent and wound healing;
- e. Appropriate steps to off-load pressure during treatment are being taken;
- f. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70; and
- g. Dermagraft® is used in conjunction with standard wound care regimens.

### 3.2.1.3 Integra®

The application of Integra is covered when indicated for either of the following:

- a. Post-excisional treatment of life-threatening full-thickness or deep partial-thickness thermal injuries where sufficient autograft is not available at the time of excision or not desirable due to the physiological condition of the beneficiary; or
- b. Repair of scar contractures when other therapies have failed or when donor sites for repair are not sufficient or desirable due to the physiological condition of the beneficiary.

### 3.2.1.4 AlloDerm®

The application of AlloDerm® is covered when indicated for either of the following:

- a. Skin grafting: AlloDerm® is often used in conjunction with a split-thickness skin graft. AlloDerm® is laid down first and is then covered by a thin split-thickness autograft. Both the application of AlloDerm® and the split-thickness autograft are coded separately; or
- b. Plastic surgeries on various soft tissue defects, such as abdominal wall reconstruction, breast reconstruction post-mastectomy, and tympanoplasty. Although reconstructive procedures require prior approval, the application of AlloDerm does not.

### 3.2.1.5 TheraSkin®

#### a. TheraSkin® for Venous Stasis Ulcers

TheraSkin® is covered in the treatment of partial or full-thickness lower extremity ulcers which extend through the dermis with or without tendon, muscle, joint capsule or bone exposure, when ALL the following conditions are met:

1. Ulcers have demonstrated a failed or insufficient response to no fewer than four (4) weeks of conservative wound-care measures consisting of, at minimum, regular dressing changes, debridement of necrotic tissue and standard therapeutic compression;
2. Documentation of response, or lack thereof, requires measurement of the initial ulcer at baseline, following cessation of conservative or conventional management. Documentation must also contain a measurement of the ulcer immediately prior to the placement of TheraSkin®;
3. Ulcers are free of infection, (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge), underlying osteomyelitis, surrounding cellulitis, sinus tracts, eschar, or any necrotic material that would interfere with adherence of a living skin equivalent and wound healing; and
4. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70.



**b. TheraSkin® for Diabetic Foot Ulcers**

TheraSkin® is covered for the treatment of full-thickness diabetic foot ulcers when ALL the following conditions are met:

1. The ulcer has persisted for greater than three (3) weeks duration;
2. The ulcer extends through the dermis, with or without tendon, muscle, joint capsule, or bone exposure;
3. The beneficiary has a primary diagnosis of foot ulcer and a secondary diagnosis of Type 1 or 2 diabetes mellitus with a current HbA1C that does not exceed 12%;
4. Ulcers are located on foot or toes and are free of infection, (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge), underlying osteomyelitis, surrounding cellulitis, sinus tracts, eschar, or any necrotic material that would interfere with adherence of a living skin equivalent and wound healing;
5. Appropriate steps to off-load pressure during treatment are being taken;
6. The beneficiary has adequate arterial blood supply to the foot; as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70; and
7. TheraSkin® is used in conjunction with standard wound care regimens.

**3.2.1.6 EpiFix®**

**a. EpiFix® for Venous Stasis Ulcers**

EpiFix® is covered in the treatment of partial or full-thickness lower extremity ulcers which extend through the dermis, with or without tendon, muscle, joint capsule or bone exposure, when the following conditions are met:

1. Ulcers have demonstrated a failed or insufficient response to no fewer than four (4) weeks of conservative wound-care measures consisting of, at minimum, regular dressing changes, debridement of necrotic tissue and standard therapeutic compression;
2. Documentation of a response, or lack thereof, requires measurement of the initial ulcer at baseline, following cessation of conservative or conventional management. Documentation must also consist of measurement of the ulcer immediately prior to the placement of EpiFix®;
3. Ulcers are free of infection, (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge), underlying osteomyelitis, surrounding cellulitis, sinus tracts, eschar, or any necrotic material that would interfere with adherence of a living skin equivalent and wound healing; and
4. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70.

**b. EpiFix® for Diabetic Foot Ulcers**

EpiFix® is covered for the treatment of full-thickness diabetic foot ulcers when ALL the following conditions are met:

1. The ulcer has persisted for greater than three (3) weeks duration;
2. The ulcer extends through the dermis, with or without tendon, muscle, joint capsule, or bone exposure;
3. The beneficiary has a primary diagnosis of foot ulcer and a secondary diagnosis of Type 1 or 2 diabetes mellitus with a current HbA1C that does not exceed 12%;
4. Ulcers are located on a foot or toes and are free of infection, (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge), underlying osteomyelitis, surrounding cellulitis, sinus tracts, eschar, or any necrotic material that would interfere with adherence of a living skin equivalent and wound healing;
5. Appropriate steps to off-load pressure during treatment are being taken;
6. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70; and
7. EpiFix® is used in conjunction with conservative wound care regimens.

**3.2.2 Medicaid Additional Criteria Covered**

None Apply.

**3.2.3 NCHC Additional Criteria Covered**

None Apply.

**4.0 When the Procedure, Product, or Service Is Not Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

**4.1 General Criteria Not Covered**

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

## 4.2 Specific Criteria Not Covered

### 4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover skin substitutes for any ONE of the following diagnoses and conditions:

- a. Infected ulcers;
- b. Wounds or ulcers that are progressing toward closure with traditional wound care dressings and treatment;
- c. Eschar, or any necrotic material;
- d. Ulcers with sinus tracts or tunnels;
- e. Underlying osteomyelitis;
- f. Surrounding cellulitis;
- g. A beneficiary with known hypersensitivity to bovine products, bovine collagen and chondroitin materials;
- h. Arterial disease with an ankle brachial index (ABI) (systolic ankle blood pressure over the systolic brachial blood pressure) of less than 0.70 or a lack of pedal pulses;
- i. Uncontrolled diabetes (for purposes of this policy, controlled diabetes is based on documentation in the health record);
- j. Active Charcot's arthropathy of the ulcer extremity;
- k. Vasculitis;
- l. Uncontrolled rheumatoid arthritis, rheumatoid ulcers, or both;
- m. Other uncontrolled collagen vascular diseases;
- n. A beneficiary who is under treatment with high-dose corticosteroids or immunosuppressants;
- o. A beneficiary who has undergone radiation, chemotherapy, or both within the month immediately preceding proposed skin substitute treatment.
- p. EpiFix® for wounds that probe to the bone or are infected.
- q. Dermagraft® for the treatment of dystrophic epidermolysis bullosa.

### 4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

### 4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

## 5.0 Requirements for and Limitations on Coverage

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 5.1 Prior Approval

Medicaid and NCHC shall not require prior approval for Skin Substitutes.

### 5.2 Prior Approval Requirements

#### 5.2.1 General

None Apply.

#### 5.2.2 Specific

None Apply.

### 5.3 Limitations or Requirements

- a. Apligraf<sup>®</sup> is limited to 88 units within 365 calendar days with no more than five (5) applications per ulcer.
- b. Dermagraft<sup>®</sup> is limited 304 units every 12 weeks. When reasonable healing progress is noted, re-application may continue to a maximum of eight (8) applications in 12 weeks.
- c. TheraSkin<sup>®</sup> is limited to eight (8) applications per ulcer. Each application is limited to 80 units per day, to a maximum of 640 units every 12 weeks. Re-application of TheraSkin<sup>®</sup> within one (1) week for the same ulcer is not allowed. Re-application of TheraSkin<sup>®</sup> is not allowed for the same ulcer if satisfactory and reasonable healing progress is not noted after 12 weeks of therapy.
- d. Integra<sup>®</sup> coverage is limited to the application of a quantity of material that closely approximates the size of the wound. The number of units billed must closely correlate with the wound size. The maximum daily allowable units are 60.
- e. EpiFix<sup>®</sup> is limited to five (5) applications per ulcer; the initial application, then additional applications may be applied at a minimum of one (1) week intervals, for up to a maximum of four (4) applications in 12 weeks, when there is evidence of wound healing.

## 6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid or NCHC qualifications for participation;
- b. be currently Medicaid - enrolled; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### 6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

### 6.2 Provider Certifications

None Apply.

## 7.0 Additional Requirements

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

### 7.2 US Food and Drug Administration (FDA) Approvals

- a. The safety and effectiveness of specific skin substitutes approved by the US Food and Drug Administration (FDA) have been established. Provider(s) shall use FDA approved Skin Products when used within the scope of the FDA intended use and indications; and
- b. Human tissue products are subject to the rules and regulations of banked human tissue by the American Association of Tissue Banks (AATB). The FDA has classified TheraSkin<sup>®</sup> as banked human tissue and is therefore subject to the rules and regulations of banked human tissue by the American Association of Tissue Banks (AATB). The Center for Biologics Evaluation and Research (CBER) regulates Human Cell & Tissue Products (HCT/Ps) in accordance with 21 CFR Part 1270 and 1271—Human cells, tissues, and cellular and tissue-based products at: <http://www.ecfr.gov/>

### 7.3 Documentation

The health record must show that criteria described in **Section 3.0** and the limitations set forth in **Section 5.0** have been met and must document that wound treatment by this method is accompanied by appropriate:

- a. date, time and location of ulcer treated;
- b. name of skin substitute and how product supplied;
- c. amount of product used;
- d. wound dressing during the healing period;
- e. compressive dressings during follow-up; and
- f. steps to off-load wound pressure during follow-up (for neuropathic diabetic foot ulcers).

## 8.0 Policy Implementation/Revision Information

Original Effective Date: November 1, 2000

### Revision Information:

Date	Section Revised	Change
04/01/2007	All sections and attachment(s)	Implementation of coverage for the application of Integra
05/01/2007	Attachment A	Added UB-04 as an accepted claim form
05/01/2009	All sections and attachment(s)	Updated to DMA's current standard language.
05/01/2009 (eff. 01/01/2009)	Attachment A	HCPCS code update: Q4101 replaced J7340 and Q4106 replaced J7342.
07/01/2010	All sections and attachment(s)	Policy Conversion: Implementation of Session Law 2009-451, <b>Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."</b>
03/01/2012	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1S-4 under Session Law 2011-145, § 10.41.(b)
03/12/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
01/04/2013	Subsection 3.3	Item "e." deleted word "redness"
01/04/2013	Attachment A	Code changes for 2012 CPT update
01/04/2013	Subsection 3.3 and Attachment A	Incorrect policy was posted. Policy amended to incorporate the changes listed above in Subsections 3.3 and Attachment A.
01/04/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
07/01/2013	Section 1.0, Subsections 3.4 and 5.2, Attachment A	Implementation of coverage for Theraskin Updated code descriptions.
07/01/2013	Section 1.0, and throughout	Changed title from Bioengineered Skin to Skin Substitutes.
07/01/2013	Sections 3.0 through 5.2	Changed formatting of sections 3 through 5.
07/01/2013	Subsections 3.2.6 & 3.2.7	Added <b>TheraSkin</b> <sup>®</sup> criteria
07/01/2013	Subsection 4.2	Updated
07/01/2013	Subsection 5.3 a b & c	Added limitations
07/01/2013	Subsections 5.3 & 5.4	Deleted
07/01/2013	Subsection 7.1	Updated to reflect <b>TheraSkin</b> <sup>®</sup> compliance.

Date	Section Revised	Change
07/01/2013	Attachment A	Added ICD-9 codes for <b>TheraSkin</b> <sup>®</sup> updated HCPCS Procedure Codes and added <b>TheraSkin</b> <sup>®</sup> where applicable
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
11/01/2017	Section 1.1	Added definitions.
11/01/2017	Section 3.2.1.1	Updated coverage text to include an ABI of greater than or equal to 0.70.
11/01/2017	Section 3.2.1.2	Updated coverage text to include an ABI of greater than or equal to 0.70.
11/01/2017	Section 3.2.1.5	Updated coverage text to include an ABI of greater than or equal to 0.70.
11/01/2017	Section 3.2.1.6.a	Added EpiFix <sup>®</sup> coverage for venous stasis ulcers.
11/01/2017	Section 3.2.1.6.b	Added EpiFix <sup>®</sup> coverage for diabetic foot ulcers.
11/01/2017	Section 4.2.1	Added non-coverage text for ABI less than 0.70, non-coverage text for EpiFix <sup>®</sup> and Dermagraft <sup>®</sup> .
11/01/2017	Subsection 5.2.1	Removed Prior Approval: General text and replaced with None Apply.
11/01/2017	Subsection 5.3e	Added limitations for EpiFix <sup>®</sup> .
11/01/2017	Subsection 7.2	Subsection created from 7.1
11/01/2017	Subsection 7.3	Additional documentation requirements added.
11/01/2017	Attachment A Section B	Removed ICD 10 code tables for Apligraf <sup>®</sup> , Dermagraft <sup>®</sup> and TheraSkin <sup>®</sup> .
11/01/2017	Attachment A Section C.1.	Added CPT code for EpiFix <sup>®</sup> , AlloDerm <sup>®</sup> and Integra <sup>®</sup> .
11/01/2017	Attachment A Section C. 2.	Added codes 15271-15278 used to bill the applications.
11/01/2017	Attachment A Section E	Added CPT codes Q4104, Q4116, Q4131 to the table.
11/01/2017	Attachment A Section F	Added place of service for EpiFix <sup>®</sup> .
11/14/2017	All Sections and Attachments	Amended policy posted 11/14/2017 with an effective date of 11/01/2017
01/01/2019	Attachment A Section C. 1.	Deleted Q4131 EpiFix <sup>®</sup> and replaced with Q4186 - EpiFix <sup>®</sup> .
01/01/2019	Attachment A Section E	End dated Q4131 and replaced with Q4186 as per 2019 CPT update.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.

## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

### A. Claim Type

Professional (CMS-1500/837P transaction)

### B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

### C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Apligraf®, Dermagraft®, Integra®, AlloDerm®, EpiFix®, and TheraSkin® must be billed in conjunction with codes that describe application of the tissue and preparation of the site. For burn treatments, reimbursement for physician services is limited to the application of the product.

#### 1. HCPCS Procedure Code

- Q4101 - Apligraf®
- Q4104 - Integra®
- Q4106 - Dermagraft®
- Q4116 - AlloDerm®
- Q4121 - TheraSkin®
- Q4186 - EpiFix®

#### 2. CPT Procedure Codes

15002 through 15005 are used to bill for the site preparation and 15271 through 15278 are used to bill application. Bill on the CMS-1500 form using HCPCS procedure code listed above.



**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Provider(s) shall report the appropriate procedure code(s) used which determines the billing unit(s).

**One unit equals 1 square centimeter (sq cm).**

Code		
15002	15273	Q4101
15003	15274	Q4104
15004	15275	Q4106
15005	15276	Q4116
15271	15277	Q4121
15272	15278	Q4186

**F. Place of Service**

Place of service for Dermagraft® Apligraf®, EpiFix® and TheraSkin® is limited to inpatient, outpatient hospital, and office.

Place of service for Integra® and AlloDerm® is limited to inpatient and outpatient hospital.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

**H. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>