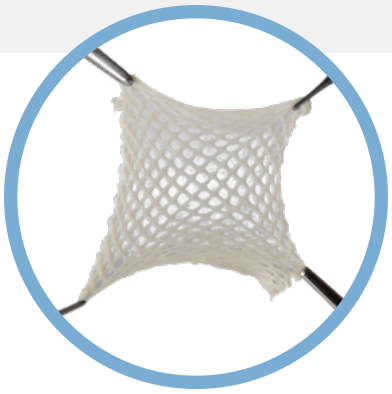
LifeNet Health®
Saving Lives. Restoring Health. Giving Hope.

DermACELL AWM®

Applied by Physicians and Other Qualified Healthcare Professionals (QHPs)



2022 CODING AND PAYMENT INFORMATION

Applications Codes:

Physicians and other QHPs should select the application codes based on the anatomic location and the wound surface area to which Dermacell AWM Placental Membrane is applied. Do not select the application code based upon the size of the product purchased.

CPT[1] Code	Wound Surface Area Less Than 100 Sq. CM
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	Each additional 25 cm^2 wound surface area or part thereof
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq. cm; first 100 sq. cm wound surface area, or 1% of body area of infants and children
+15274	Each additional 100 cm^2 wound surface area, or part thereof, or each additional 1% of body area of infants and children

CPT Code	Wound Surface Area Equal to or Greater Than 100 Sq.
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	Each additional 25 cm^2 wound surface area or part thereof
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq. cm; first 100 sq. cm wound surface area, or 1% of body area of infants and children
+15278	Each additional 100 cm^2 wound surface area, or part thereof, or each additional 1% of body area of infants and children)

The above table illustrates potential CPT codes that can be used to denote surgical skin procedures and the application of Dermacell AWM for the management of wounds.

- When applying the product, during the same encounter, to multiple wounds represented by the same application code, sum the surface areas of the wounds together.

  Examples:

  1. If the product is applied to a 5 sq. cm wound on the left foot and to a 10 sq. cm wound on the right foot, report 1 unit of 15275.
  2. If the product is applied to a 15 sq. cm wound on the right leg and to a 20 sq. cm on the left leg, report 1 unit of 15277 and 1 unit of 15278.

- When applying the product, during the same encounter, to multiple wounds represented by different application codes, separately sum the surface areas of the wounds represented by each application code.

  Examples:

  1. If the product is applied to a 20 sq. cm wound on the right leg, a 15 sq. cm wound on the left leg, and a 10 sq. cm on the right foot, report 1 unit of 15271, 1 unit of 15272, and 1 unit of 15275.
  2. If the product is applied to one large wound that is on the heel (30 sq. cm) and extends into the ankle (40 sq. cm), report 1 unit of 15275 and 1 unit of 15276 for the application to the heel and 1 unit of 15271 and 1 unit of 15272 for the application to the ankle.

     CAUTION: For coding purposes, the wrists are part of the arms and the ankles are part of the legs.

     NOTE: For wound surface areas less than 100 sq. cm, the maximum number of add-on codes that can be reported is 3.

     NOTE: If the wound surface area is exactly 100 sq. cm, 15273 or 15277 should be reported.

     NOTE: For wound surface areas greater than 100 sq. cm, report either 1 unit of 15273 with the appropriate number of units of 15274, or 1 unit of 15277 with the appropriate number of units of 15278.

Product Code:

When physicians and other QHPs purchase Dermacell AWM Placental Membrane and apply it in their offices, when it is covered, they should also report the appropriate HCPCS code for product, along with the appropriate modifiers.

HCPCS Coding Pathway Options	
HCPCS Code[2]	**HCPCS Code Description**
Q4122	Dermacell®, Dermacell AWM® and Dermacell AWM Porous, per square centimeter

NOTE: Physician/QHP offices should verify if the payer covers Dermacell AWM and whether they pay for it based on wholesale acquisition cost (WAC) or invoice price.

- If the payer bases payment for Dermacell AWM on WAC, the following information should be included in field 19 of a paper claim or in the narrative field of an electronic claim:
  - Product name
  - NDC or UPC code
  - WAC of product
  - WAC per sq. cm
  - Source of the WAC (e.g. Red Book)

- If the payer bases payment for Dermacell AWM on invoice price, the following information should be included in field 19 of a paper claim or in the narrative field of an electronic claim:
  - Product name
  - Product size (in sq.cn)
  - Product number
  - Invoice price per piece
  - Shipping cost

    CAUTION: Some payers only require the total product invoice cost for a specific patient in the following format (including cents): **INV. $00.00.**

Product Code Modifiers:

- If the physician/QHP applies (as a graft, not an implant) the entire piece to a patient, for whom the product was purchased by the office, the physician/QHP should report Q4201JC and the total number of sq. cm purchased.
- If the physician/QHP discards a portion of the product purchased by the office for the patient, the physician/QHP should append the JW modifier to the portion of the product code that was discarded.

Example:

1. If 20 sq. cm of the product were purchased by the office for the patient and 15 sq. cm were applied as a graft and 5 sq. cm were discarded, the physician/QHP should report the product code on two claim lines: Q4201JC with 15 units on the first claim line, and Q4201JW with 5 units on the second claim line.

CPT/HCPCS Modifier Options	
Modifier	**Description**
-JC	Skin Substitute Used as Graft.
-JW	Drug Amount Discarded/Not Administered to Any Patient. Used to report wastage when payor guidelines require separate reporting.

THE PINNACLE HEALTH GROUP

LifeNet Health® Coverage Access Intake Form

Fax this form to: (240) 238-9836 or (860) 645-3988

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Do you have a Business Associate Agreement in Place? ☐ YES ☐ NO
If NO, do not proceed until a Business Associate Agreement is in Place. Call (866) 562-6349 to have one emailed/faxed.

Case Status		
Pre-Service	**Post-Service**	**Medicare Appeal**
☐ New Pre-authorization ☐ New Pre-determination ☐ Peer to Peer ☐ 1st Level appeal ☐ 2nd Level appeal ☐ IRO (External appeal)	Include copy of denial letter and EOB ☐ 1st Level appeal – post claim denial ☐ 2nd Level appeal – post claim denial ☐ IRO – post claim denial	Include copy of denial letter and EOB ☐ 1st Level appeal ☐ 2nd Level appeal

Physician Information		
Physician Name:	NPI:	Tax ID:
Practice Name:	Phone:	Fax:
Address/City/State/ZIP		
Office Contact Name:	Preferred Method of Contact to Receive Response Form: ☐ Fax ☐ Email	
Office Contact Email:		

Facility Information		
Facility Name:	NPI:	Tax ID:
Address/City/State/Zip:	Phone:	Fax:

Patient Information		
Patient Name:	Date of Birth	
Address/City/State/Zip:	Phone:	Email:

Insurance Information		
Primary Insurance:	Member ID:	Phone:
Secondary Insurance:	Member ID:	Phone:
Please provide a copy of the front and back of the patient's insurance card.		

Procedure		
Product Use: DermACELL (Q4122) ☐ # of Applications requested for entire treatment Matrion (Q4201) ☐ # of Applications requested for entire treatment	**Place of Service:** ☐ Inpatient ☐ Outpatient ☐ ASC ☐ Office ☐ WCC ☐ Other	
Size of Wound	**Duration of Wound**	
Procedure Code(s):	**Primary & Secondary Diagnosis Code(s):**	**Procedure Date:**

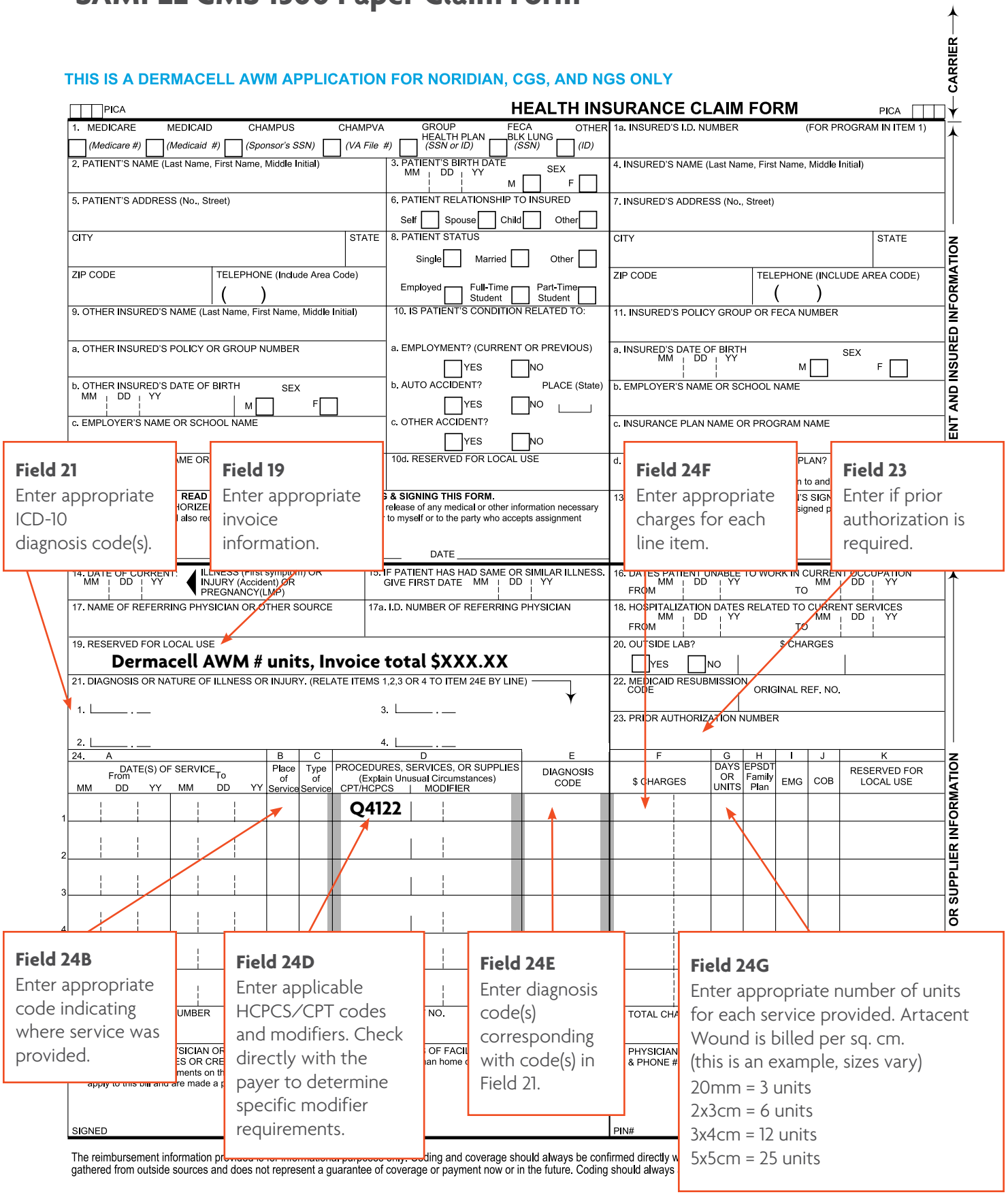
HIPAA Authorization- ***This form may be signed by anyone with authority within the requesting office/facility.***

LifeNet Health® and its agent MCRA, LLC are hereby authorized to release information regarding the above named patient to the Primary and Secondary insurance carriers named above for the express and limited purpose of validating coverage for clinical services relating to LifeNet Health®. This authorization may be revoked or modified at any time, upon delivery of my written request to LifeNet Health® and/or MCRA.

Authorized Representative Signature: Date:

SAMPLE CMS 1500 Paper Claim Form

THIS IS A DERMACELL AWM APPLICATION FOR NORIDIAN, CGS, AND NGS ONLY



Field 21
Enter appropriate ICD-10 diagnosis code(s).

Field 19
Enter appropriate invoice information.

Field 24F
Enter appropriate charges for each line item.

Field 23
Enter if prior authorization is required.

Field 24B
Enter appropriate code indicating where service was provided.

Field 24D
Enter applicable HCPCS/CPT codes and modifiers. Check directly with the payer to determine specific modifier requirements.

Field 24E
Enter diagnosis code(s) corresponding with code(s) in Field 21.

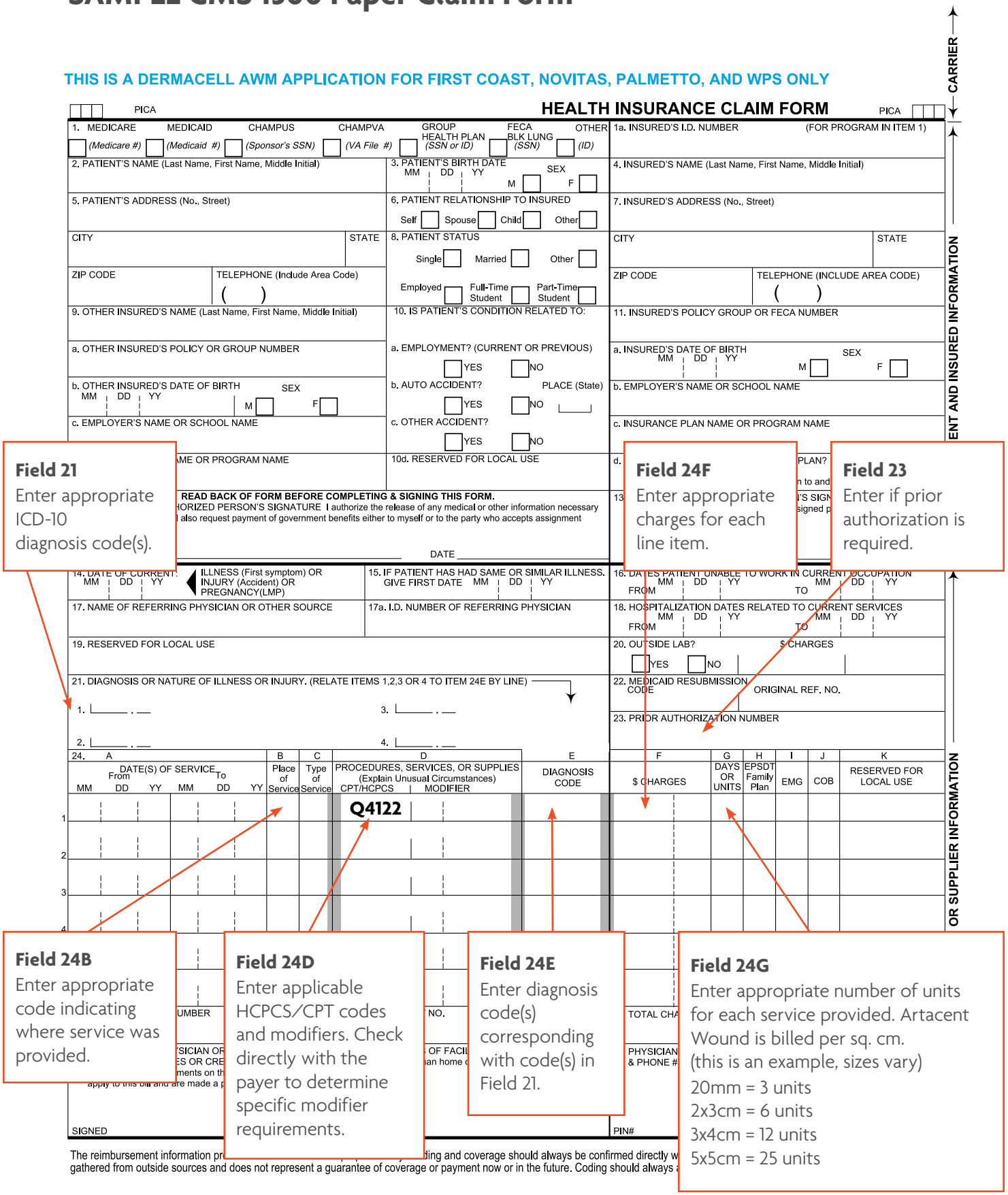
Field 24G
Enter appropriate number of units for each service provided. Artacent Wound is billed per sq. cm. (this is an example, sizes vary)

20mm = 3 units
2x3cm = 6 units
3x4cm = 12 units
5x5cm = 25 units

The reimbursement information provided is for informational purposes only. Coding and coverage should always be confirmed directly with the payer. The information gathered from outside sources and does not represent a guarantee of coverage or payment now or in the future. Coding should always

SAMPLE CMS 1500 Paper Claim Form

THIS IS A DERMACELL AWM APPLICATION FOR FIRST COAST, NOVITAS, PALMETTO, AND WPS ONLY



PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

1. MEDICARE (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)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS — Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

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 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 NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

ME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. PLAN?

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
HORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary
I also request payment of government benefits either to myself or to the party who accepts assignment

DATE

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 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 MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1			Q4122							
2										
3										
4										

UMBER — NO. — TOTAL CHA

SICIAN OR — OF FACIL — PHYSICIAN & PHONE #

apply to this bill and are made a p

SIGNED — PIN#

The reimbursement information pr ding and coverage should always be confirmed directly w
gathered from outside sources and does not represent a guarantee of coverage or payment now or in the future. Coding should always

CARRIER

ENT AND INSURED INFORMATION

OR SUPPLIER INFORMATION

Field 21
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Field 24F
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Field 23
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Field 24B
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3x4cm = 12 units
5x5cm = 25 units

If you have any questions, please contact the Dermacell Benefits Verification/Pre-Authorization & Coding Hotline: 1-866-562-6349 or LifeNet@thepinnaclehealthgroup.com

References:

1. CPT 2022 Professional Edition, 2019 American Medical Association (AMA); CPT is a trademark of the AMA.
2. MS 2022 PFS Final Rule, www.cms.gov.

Disclaimer:

This information is for educational/informational purposes only and should not be construed as authoritative. The information presented here is current as of January 2020 and is based upon publicly available source information. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third-party payers is solely responsible for the accuracy of the codes assigned to the services or items in the medical record. When making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor, and other health plans to which you submit claims. Items and services that are billed to payors must be medically necessary and supported by appropriate documentation. It is important to remember that while a code may exist describing certain procedures and/or technologies, it does not guarantee coverage and payment by payers.

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EX-22-168

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