

# **Matrion**®

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 Matrion Placental Membrane is applied. Do not select the application code based upon the size of the product purchased.

CPT¹ 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 cm² 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 <sup>2</sup> 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 cm² 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 <sup>2</sup> 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 Matrion 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 Matrion 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 <sup>2</sup>	HCPCS Code Description
Q4201	Matrion, per square centimeter

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

- If the payer bases payment for Matrion 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 Matrion 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.						



### LifeNet Health® Coverage Access Intake Form

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



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.

			_					
			e Status					
Pro	e-Service	Post-Service Include copy of denial letter and EOB		Medicare Appeal Include copy of denial letter and EOB				
☐ New Pre-authorization	☐ New Pre-determination	□ 1 <sup>st</sup> Level appeal –			•			
Peer to Peer	☐ 1 <sup>st</sup> Level appeal		•	☐ 1 <sup>st</sup> Level appeal				
☐ 2 <sup>nd</sup> Level appeal	- post claim denial ☐ 2 <sup>nd</sup> Level appeal							
		☐ IRO – post claim	denial					
Physician Information	on		T					
Physician Name:			NPI:		Tax	Tax ID:		
Practice Name:			Phone:					
Address/City/State/ZIP								
Office Contact Name:			Preferred Method of Contact to	Receive R	espon	se Form:		
			☐ Fax ☐ Email					
Office Contact Email:								
Facility Information								
Facility Name:			NPI:		Tax	ID:		
Address/City/State/Zip:			Phone:		Fax:			
<b>Patient Information</b>								
Patient Name:			Date of Birth					
Address/City/State/Zip:			Phone: Em			ail:		
Insurance Informati	on			l				
Primary Insurance:			Member ID:		Phor	ne:		
Secondary Insurance:			Member ID:		Phor	Phone:		
Please provide a copy of th	e front and back of the patient's in	isurance card.		•				
Procedure								
Product Use: DermACELL (Q4122)□# of Applications requested for entire treatment			Place of Service: ☐ Inpatient ☐ Outpatient ☐ ASC ☐ Office ☐ WCC ☐ Other					
Matrion (Q4201)□#	of Applications requested for en	ntire treatment						
Size of Wound	Duration of Wound							
Procedure Code(s):			Primary & Secondary Diagr	Procedure Date:				
HIPAA Authorization	- This form may be signed by any	one with authority with	nin the requesting office/facility	<i>).</i>				
	CRA, LLC are hereby authorized to release inf vices relating to LifeNet Health®. This auth					s named above for the express and limited purpose of Met Health and/or MCRA.		
Authorized Representative	Signature:			Date:				

## SAMPLE CMS 1500 Paper Claim Form

THIS IS A MATRION WOUND APPLICATION FOR NORDIAN, COS, AND NGS ONLY    PREAT HI NUSURANCE CLAIM FORM   PRODUCT   PROD	THIS IS A MATRICI					RRIER
THE		N WOUND APPLICATION	•	•		<b>ŏ</b> -
SPACE   SPAC		AID CHAMPUS CHAMPVA	GROUP FECA	OTHER 1a. INSURE		
A PATIENT'S ACCIDENCY ON SURVEY STATES OF SERVICE ON SURVE	(Medicare #) (Medicai	id #) (Sponsor's SSN) (VA File	#) HEALTH PLAN BLK LU (SSN or ID) (SSN)	NG (ID)		
SAPE	2. PATIENT'S NAME (Last Nam	ne, First Name, Middle Initial)		<sup>3</sup> -^ — I	D'S NAME (Last Name, First N	ame, Middle Initial)
STATE   STAT	F DATIENTIO ADDDEGO (No.	Oterati			NO 4555550 (4) 0/ 1/	
THE PROCES   TRUE PROCES (Noted a Near Cook)   TRUE PROCES (Noted a Noted a No	5. PATIENT'S ADDRESS (No.,	Street)			O'S ADDRESS (No., Street)	
The repropriate of the party and some of service was proportiate of the party and society and the party an	CITY	STATE				STATE
The repropriate of the party and some of service was proportiate of the party and society and the party an			Single Married	Other		
The repropriate of the party and some of service was proportiate of the party and society and the party an	ZIP CODE	TELEPHONE (Include Area Code)	Employed — Full Time — I		TELEP	HONE (INCLUDE AREA CODE)
Light 21  WE OR Field 19  The appropriate or the party after coopie sessignment. Invoice information.  DATE or properties of the party after coopie sessignment. Invoice information.  DATE of PATE(S) OF SERVICE, or properties of the party of the party after coopie sessignment. In the party of the party of the party after coopie sessignment. In the party of the party after coopie sessignment. In the party of the party o	0.071150.1101105010.11115	( )	Student	Student	(	<u>)</u>
Lid 21  WE OP Field 19  Enter appropriate on the property of the purply with account information accounts on the property of the purply with accounts on the property of the purply of	9. OTHER INSURED 5 NAME (	(Last Name, First Name, Middle Initial)	10. IS PATIENT S CONDITION REI	ATED TO: 11. INSURE	D'S POLICY GROUP OR FEG	A NUMBER
The particular of the purpose of the	a. OTHER INSURED'S POLICY	Y OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR		S DATE OF BIRTH	SEX SEX
The particular of the purpose of the			YES NO		IM   DD   YY	M F
Commonweight   Comm		OF BIRTH SEX		, ,	ER'S NAME OR SCHOOL NA	ME 9
Id 21  PRAD COLOR DOTATION IN JUNE OF COLOR USE  PRODUCTION OF REFERENCE PROPERTY OF COAL USE  O-10  PROJECT STORY OF SERVICE TO JUNE OF COLOR USE  IN JUNE OF COLOR OF THE PATIENT IN JUNE OF					ICE DI ANI NAME OD DOGO	AM NAME
Field 24  Terra appropriate provided information.  Date  Inter appropriate  Inter appropr	C. LIVII LOTER 3 NAIVIE OR SC	A TOOL NAIVIL			NOL FLAIN INAIVIE UR PRUGR	Z Z
Enter appropriate on the property of the prope	ME C	OR Field 10		d	I4 24E	PLAN?
policy invoice information.    Charges for each   Invoice   Invoice   Invoice   Invoice   Invoice   Invoice   Invoice   Information.						n to and
DATE of concepts assignment. In formation in formation in formation.  DATE of the party who accepts assignment. In formation in formation.  DATE of the party who accepts assignment. In formation.  DATE of the party who accepts assignment. In formation in formation.  DATE of the party who accepts assignment. In formation in formation.  DATE of the party who accepts assignment. In formation in formation.  DATE of the party who accepts assignment. In formation in formation in formation.  DATE of the party who accepts assignment. In formation in formation in formation.  DATE of the party who accepts assignment. In formation in formation in formation.  DATE of the party who accepts assignment. In formation in formation.  DATE of the party who accepts assignment. In formation in formation in formation.  DATE of the party who accepts assignment. In formation in formation in formation in formation. DATE of the party who accepts assignment. In formation in formation in formation in formation in formation in formation in formation.  DATE of the party in the party who accepts assignment. In formation in formation in formation in formation in formation. DATE of the party in the party who accepts assignment. In formation in formation in formation in formation in formation in formation in formation. DATE of the party in the	· · · · HORIZ	ZE ' ' '				signed n
Interest		invoice	to myself or to the party who accepts a		0	authorization is
Faring true to convert   Number of the sum symbol   Supering true and Same of Samuar ILLNESS   Supering true and Samuar ILLNESS   Supering t	gnosis code(s).	information.	DATE	line	e item.	required.
The reinbursment information of the source o	14. DATE OF CURRENT:	ILLINESS (FIISL SYMPTOM) OK 15.	IF PATIENT HAS HAD SAME OR SIM	ILAR ILLNESS. 16. DA ES	PATIENT UNABLE TO WORK	IN CURRENT OCCUPATION
The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements.  The reimbursement information or white the marker of the requirements of the requirements.  The reimbursement information or white the marker of the marker of the requirements.  The reimbursement information or white the marker of the marker		PREGNANCY(LMP)		FROM		ТО
19. RESERVED FOR LOCAL USE  Matrion # units, Invoice total \$XXX.XX  21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1.2.3 OR 4 TO ITEM 24E BY LINE)  22. MEDICAD RESUBMISSION ORIGINAL REF. NO.  23. PROR AUTHORIZATION NUMBER  24. A L L L L L L L L L L L L L L L L L L	17. NAME OF REFERRING PH	1YSICIAN OR OTHER SOURCE 17a	I. I.D. NUMBER OF REFERRING PHY	N	ALIZATION DATES RELATED MM   DD   YY	D TO CURRENT SERVICES  MM   DD   YY
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 12.3 OR 4 TO ITEM 24E BY LINE)  22	19. RESERVED FOR LOCAL U	JSE			E LAB? \$	CHARGES
2	Matrion #	units, Invoice total \$X	XX.XX		s No	
2. L	21. DIAGNOSIS OR NATURE (	OF ILLNESS OR INJURY. (RELATE ITEMS	1,2,3 OR 4 TO ITEM 24E BY LINE) —	22. MEDICA CODE	AID RESUBMISSION ORIGIN	AL REF. NO.
2	1	3	3	<b>Y</b>	ALITHOPIZATION AND INCOME.	
Pield 24D  Ter appropriate de indicating lere service was brided.  Field 24D  Enter applicable HCPCS/CPT codes and modifiers. Check directly with the payer to determine specific modifier requirements.  The reimbursement information or requirements.  Field 21.  Field 24B  Field 24D  Field 24B  Field 24B  Field 24D  Field 24B  Enter diagnosis code(s) in Field 21.  Field 21.  Field 24B  Field 24B  Field 24B  Enter diagnosis code(s) in Field 21.  Field 21.  Field 24B  Field 24B  Enter diagnosis code(s) in Field 21.  Field 21.  Field 24B  Enter appropriate number of units billed per sq. cm. (this is an example, sizes vary) 20mm = 3 units 2x3cm = 6 units 3x4cm = 12 units 5x5cm = 25 units 2x5cm = 25 u				23. PRIDR.	AUTHORIZATION NUMBER	
Field 24B  ter appropriate de indicating lere service was byided.  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. Artacen Wound is billed per sq. cm. (this is an example, sizes vary) 20mm = 3 units 2x3cm = 6 units 3x4cm = 12 units	24. A	ВС	D	E F		I J K Z
Field 24B  ter appropriate de indicating lere service was byided.  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. Artacen Wound is billed per sq. cm. (this is an example, sizes vary) 20mm = 3 units 2x3cm = 6 units 3x4cm = 12 units		To of of (Expla	ain Unusual Circumstances)		OR Family 5	RESERVED FOR COB LOCAL USE
Field 24B  ter appropriate de indicating ere service was producted.  SICIAN OF SO R CRED  TOTAL CH  TO	MM DD YY MM			JOBE TO THE STATE OF THE STATE	UNITS Plan	MA MA
Field 24B  ter appropriate de indicating lere service was brided.  SICIAN OF EACH and modifiers. Check directly with the payer to determine specific modifier requirements.  The reimbursement information of the remarks of the remark	1	Q42	.01	<u> </u>		
Field 24B  ter appropriate de indicating lere service was brided.  SICIAN OF EACH and modifiers. Check directly with the payer to determine specific modifier requirements.  The reimbursement information of the remarks of the remark						
Field 24B  ter appropriate de indicating lere service was brided.  SICIAN OF EACH and modifiers. Check directly with the payer to determine specific modifier requirements.  The reimbursement information of the remarks of the remark	2   1   1					<del>                                     </del>
Field 24B  ter appropriate de indicating lere service was brided.  SICIAN OF FACIL CHAP (and home of the payer to determine specific modifier requirements.)  The reimbursement information of the remarks of the remarks of the remarks of the requirement information of the remarks of the remar	3					
Field 24B  ter appropriate de indicating UMBER der service was pere service was povided.  SICIAN OF SOR CRE ments on it payer to determine specific modifier requirements.  Field 24E  Enter diagnosis code(s)  corresponding with code(s) in Field 21.  Field 24E  Enter appropriate number of units for each service provided. Artacen Wound is billed per sq. cm. (this is an example, sizes vary)  20mm = 3 units  2x3cm = 6 units  3x4cm = 12 units						
Enter appropriate de indicating where service was ere service was evided.  SICIAN OF SOR CRE ments on the made a requirements.  Enter applicable HCPCS/CPT codes and modifiers. Check directly with the payer to determine specific modifier requirements.  Enter diagnosis code(s) corresponding with code(s) in Field 21.  Enter appropriate number of units for each service provided. Artacen Wound is billed per sq. cm. (this is an example, sizes vary) 20mm = 3 units 2x3cm = 6 units 3x4cm = 12 units				1	<u> </u>	\
Enter appropriate de indicating where service was ere service was evided.  SICIAN OF SOR CRE ments on the made a requirements.  Enter applicable HCPCS/CPT codes and modifiers. Check directly with the payer to determine specific modifier requirements.  Enter diagnosis code(s) corresponding with code(s) in Field 21.  Enter appropriate number of units for each service provided. Artacen Wound is billed per sq. cm. (this is an example, sizes vary) 20mm = 3 units 2x3cm = 6 units 3x4cm = 12 units	ld 24B	Field 24D	Field 24	LF.	Field 24G	
de indicating with the payer to determine specific modifier requirements.  HCPCS/CPT codes and modifiers. Check directly with the payer to determine specific modifier requirements.  HCPCS/CPT codes and modifiers. Check directly with the payer to determine specific modifier requirements.  HCPCS/CPT codes and modifiers. Check directly with the payer to determine specific modifier requirements.  HCPCS/CPT codes and modifiers. Code(s) to corresponding with code(s) in Field 21.  Field 22.  Field 23.  Field 24.  Field 25.  Field 26.  Field 27.  Field 27.  Field 28.  Field 29.  Field	er appropriate				!	- wi-4
and modifiers. Check directly with the payer to determine specific modifier specific modifier requirements.  The reimbursement information process of the control of the co			i i	Ü		
Divided.  SICIAN OF SOR CRE ments on the ments of the ments on the ments of the ments on the ments of the men	ie iudicatiua		(-)			•
payer to determine specific modifier requirements.  The reimbursement information of the specific modifier requirements.  So or or annowed with code(s) in an home with code(s	O O		OF FACIL	DUMOIO	LANI	
payer to determine specific modifier specific modifier requirements.  The reimbursement information process of the process of	ere service was	AN OH directly LL LL -	an home WITH CO	de(s) in & Phon	E# (this is an ex	ample, sizes vary)
signed requirements.  The reimbursement information or the second property of the second pr	ere service was sicial sicial sicial ments	R CRE DIRECTLY WITH THE	_, , , ,			
The reimbursement information produced in the second in th	ere service was sicial sicial sicial ments	RCRE directly with the sonth payer to determine	Field 21.		20mm = 3 ui	nits
The reimbursement information promote the reimbursement information in the reimbursement information in the reimbursement information in the reimbursement in the reimburseme	ere service was sicial sicial sicial ments	payer to determine specific modifier	Field 21.			
	ere service was sicial solution of the service was sicial solution of the service was apply to this bilitario are made	payer to determine specific modifier	Field 21.	PIN#	2x3cm = 6 u	nits

## SAMPLE CMS 1500 Paper Claim Form

THIS IS A MAT	RION WOUR			r ok r iko r		ALTH IN					•	PICA		← CARRIER
	MEDICAID CH	HAMPUS	CHAMPVA	GROUP HEALTH DI	FECA			D'S I.D. NUMBI			OR PR	OGRAM IN I		忕
		oonsor's SSN)	(VA File #	· 🗀 ·		N) (ID)								
2. PATIENT'S NAME (L	ast Name, First Name.	e, Middle Initial)		3. PATIENT'S BIRT	M L	□ SEX F □	4. INSURE	o'S NAME (Last	Name, Firs	t Name, M	lidd <b>l</b> e In	nitia <b>l</b> )		
5. PATIENT'S ADDRES	SS (No., Street)			6. PATIENT RELA			7. INSURE	)'S ADDRESS (	No., Street)	ı				-
				Self Spous		Other								
CITY			STATE	8. PATIENT STATU	us		CITY					STA	E	8
ZIP CODE	TELEPHO	NE (Include Are	ea Code)	Single	Married	Other	ZIP CODE		TEI	EDHONE I	(INCLL)	JDE AREA C	DDE)	Ĭ
	(	)			Full-Time Student	Part-Time Student	2 0052		1.22	(	)	DE TINETO	<i>,</i>	SRI
9. OTHER INSURED'S	NAME (Last Name, F	irst Name, Middl	le Initial)	10. IS PATIENT'S			11. INSURE	D'S POLICY GE	ROUP OR F	ECA NUM	/ //BER			N N
				- EMPLOYMENTO	OUDDENT O	D DDE (4010)								AND INSURED INFORMATION
a. OTHER INSURED'S	POLICY OR GROUP	NUMBER		a. EMPLOYMENT?		NO	a. INSUREI	O'S DATE OF BI	RTH Y	мГ	່ ່	SEX F [	٦	SUF
b. OTHER INSURED'S	DATE OF BIRTH	SEX		b. AUTO ACCIDEN		PLACE (State)	b. EMPLOY	i I ER'S NAME OR	SCHOOL	NAME				Z O
MM DD YY	м[	F				NO								A
c. EMPLOYER'S NAME	OR SCHOOL NAME			c. OTHER ACCIDE		NO.	c. INSURAN	ICE PLAN NAM	E OR PRO	GRAM NA	ME			EN
100	ME OR PROGRAM	I NAME		10d. RESERVED F		NO BE	d			PLAI	N?		_	
d 21							Fie	ld 24F		n to a	and	Field 2		
er appropriate				& SIGNING THIS F		mation necessary		er appro		l'S S signe	ad n	Enter if		
-10				to myself or to the pa			1 1	rges for	each	Jigino	,	authori	zatio	n is
nosis code(s).							line	item.			1	require	d.	
14. DATE OF CURREN	ILLNESS (Firs	st symptom) OR	15. IF	DATE	AD SAME OR SI		16. DA ES	PATIENT UNAE	LE TO WO	IKK IN CU	RRENI	I DCCUPATI	ON	<b></b>
14. DATE OF CURREN MM   DD   YY 10   TY 17. NAME OF REFERR	INJURY (Ácci PREGNANCY RING PHYSICIAN OR	dent) OR (LMP)	G		MM   DD	I YY	18. HOSPIT	E LAB?		TED TO C	URREN MM		3	
17. NAME OF REFERR	INJURY (Acci PREGNANCY RING PHYSICIAN OR OCAL USE	dent) OR (LMP) OTHER SOURC	DE 17a.	F PATIENT HAS HA BIVE FIRST DATE I.D. NUMBER OF R	MM   DD   	I YY	18. HOSPIT FROM 20. OU SIC	ALIZATION DA'	TES RELAT	TED TO C	URREN MM	NT SERVICE:	3	
19. RESERVED FOR L	INJURY (Acci PREGNANCY RING PHYSICIAN OR OCAL USE	dent) OR (LMP) OTHER SOURC	DE 17a.	F PATIENT HAS HA SIVE FIRST DATE I.D. NUMBER OF R 2,3 OR 4 TO ITEM	MM   DD   	I YY	18. HOSPIT FROM 20. OU SID YE 22. MEDIC/ CODE	ALIZATION DA'	FES RELATIVY	TED TO CI	URREN MM	NT SERVICE:	3	
19. RESERVED FOR L	INJURY (Acci PREGNANCY RING PHYSICIAN OR OCAL USE	dent) OR (LMP) OTHER SOURC	CE 17a.	F PATIENT HAS HA SIVE FIRST DATE I.D. NUMBER OF R 2,3 OR 4 TO ITEM	MM   DD   	I YY	18. HOSPIT FROM 20. OU SID YE 22. MEDIC/ CODE	ALIZATION DA' IM DD E LAB? S NO	FES RELATIVY	TED TO CI	URREN MM	NT SERVICE:	3	
19. RESERVED FOR L  21. DIAGNOSIS OR NA  1. L  2. L  24. A	INJURY (Ácci PREGNANCY PREGNANCY SING PHYSICIAN OR OCAL USE	dent) OR ((LMP) OTHER SOURC	ELATE ITEMS 1, 3.	PATIENT HAS	MM   DD	LYSICIAN  E	18. HOSPIT FROM 20. OU SID YE 22. MEDIC/ CODE	ALIZATION DA' MIN DD   E LAB? S NO MID RESUBMISS AUTHORIZATIO	SION ORIGIN NUMBER	FED TO CI	URREN MM	NT SERVICE DD   YY	5	NO NO
17. NAME OF REFERS  19. RESERVED FOR L  21. DIAGNOSIS OR NA  1	INJURY (Ácci PREGNANCY PREGNANCY OCAL USE  ATURE OF ILLNESS OF ILL	dent) OR ((LMP) OTHER SOURC  OR INJURY. (RE  B C Place Type of of	ELATE ITEMS 1, 3. 4. 9 PROCEDUR (Explain	PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2,3 OR 4 TO ITEM  D  ES, SERVICES, OF	MM   DD   REFERRING PH  24E BY LINE)	HYSICIAN	18. HOSPIT FROM  20. OUTSIE YE  22. MEDIC/CODE  23. PRIOR	ALIZATION DA' ALIZATION DA' MM	SION ORIG	TO TO CI	GES . NO.	NT SERVICE DD   YY	S FOR	ATION —————
19. RESERVED FOR L  21. DIAGNOSIS OR NA  1	INJURY (Ácci PREGNANCY PREGNANCY OCAL USE  ATURE OF ILLNESS OF ILL	dent) OR ((LMP) OTHER SOURC	ELATE ITEMS 1, 3. 4. 9 PROCEDUR (Explain	F PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2,3 OR 4 TO ITEM  D  ES, SERVICES, OF 1 Unusual Circumsts  MODIFIER	MM   DD   REFERRING PH  24E BY LINE)	HYSICIAN  E DIAGNOSIS	18. HOSPIT FROM  20. OUTSIE  YE  22. MEDICACODE  23. PRIOR	ALIZATION DA' ALIZATION DA' MM	TES RELATYYY  SION ORIGINAL OR	TO TO CI	GES J	NT SERVICE: DD   YY	S FOR	ORMATION →
19. RESERVED FOR L  21. DIAGNOSIS OR NA  1	INJURY (Ácci PREGNANCY PREGNANCY OCAL USE  ATURE OF ILLNESS OF ILL	dent) OR ((LMP) OTHER SOURC  OR INJURY. (RE  B C Place Type of of	ELATE ITEMS 1, 3. 4. PROCEDUR (Explain CPT/HCPC)	F PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2,3 OR 4 TO ITEM  D  ES, SERVICES, OF 1 Unusual Circumsts  MODIFIER	MM   DD   REFERRING PH  24E BY LINE)	HYSICIAN  E DIAGNOSIS	18. HOSPIT FROM  20. OUTSIE  YE  22. MEDICACODE  23. PRIOR	ALIZATION DA' ALIZATION DA' MM	TES RELATYYY  SION ORIGINAL OR	TO TO CI	GES J	NT SERVICE: DD   YY	S FOR	INFORMATION
19. RESERVED FOR L  21. DIAGNOSIS OR NA  1	INJURY (Ácci PREGNANCY PREGNANCY OCAL USE  ATURE OF ILLNESS OF ILL	dent) OR ((LMP) OTHER SOURC  OR INJURY. (RE  B C Place Type of of	ELATE ITEMS 1, 3. 4. PROCEDUR (Explain CPT/HCPC)	F PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2,3 OR 4 TO ITEM  D  ES, SERVICES, OF 1 Unusual Circumsts  MODIFIER	MM   DD   REFERRING PH  24E BY LINE)	HYSICIAN  E DIAGNOSIS	18. HOSPIT FROM  20. OUTSIE  YE  22. MEDICACODE  23. PRIOR	ALIZATION DA' ALIZATION DA' MM	TES RELATYYY  SION ORIGINAL OR	TO TO CI	GES J	NT SERVICE: DD   YY	S FOR	
19. RESERVED FOR L  21. DIAGNOSIS OR NA  1	INJURY (Ácci PREGNANCY PREGNANCY OCAL USE  ATURE OF ILLNESS OF ILL	dent) OR ((LMP) OTHER SOURC  OR INJURY. (RE  B C Place Type of of	ELATE ITEMS 1, 3. 4. PROCEDUR (Explain CPT/HCPC)	F PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2,3 OR 4 TO ITEM  D  ES, SERVICES, OF 1 Unusual Circumsts  MODIFIER	MM   DD   REFERRING PH  24E BY LINE)	HYSICIAN  E DIAGNOSIS	18. HOSPIT FROM  20. OUTSIE  YE  22. MEDICACODE  23. PRIOR	ALIZATION DA' ALIZATION DA' MM	TES RELATYYY  SION ORIGINAL OR	TO TO CI	GES J	NT SERVICE: DD   YY	S FOR	
19. RESERVED FOR L  21. DIAGNOSIS OR NA  1	INJURY (Ácci PREGNANCY PREGNANCY OCAL USE  ATURE OF ILLNESS OF ILL	dent) OR ((LMP) OTHER SOURC  OR INJURY. (RE  B C Place Type of of	ELATE ITEMS 1, 3. 4. PROCEDUR (Explain CPT/HCPC)	F PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2,3 OR 4 TO ITEM  D  ES, SERVICES, OF 1 Unusual Circumsts  MODIFIER	MM   DD   REFERRING PH  24E BY LINE)	HYSICIAN  E DIAGNOSIS	18. HOSPIT FROM  20. OUTSIE  YE  22. MEDICACODE  23. PRIOR	ALIZATION DA' ALIZATION DA' MM	TES RELATYYY  SION ORIGINAL OR	TO TO CI	GES J	NT SERVICE: DD   YY	S FOR	
19. RESERVED FOR L  21. DIAGNOSIS OR NA  1	INJURY (Ácci PREGNANCY PREGNANCY OCAL USE  ATURE OF ILLNESS OF ILL	dent) OR ((LMP) OTHER SOURC  OR INJURY. (RE  B C Place Type of of	ELATE ITEMS 1, 3. 4. PROCEDUR (Explain CPT/HCPC)	F PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2,3 OR 4 TO ITEM  D  ES, SERVICES, OF 1 Unusual Circumsts  MODIFIER	MM   DD   REFERRING PH  24E BY LINE)	HYSICIAN  E DIAGNOSIS	18. HOSPIT FROM  20. OUTSIE  YE  22. MEDICACODE  23. PRIOR	ALIZATION DA' ALIZATION DA' MM	TES RELATYYY  SION ORIGINAL OR	TO TO CI	GES J	NT SERVICE: DD   YY	S FOR	OR SUPPLIER INFORMATION →
17. NAME OF REFERS  19. RESERVED FOR L  21. DIAGNOSIS OR NA  1	INJURY (Accident of the pregnancy pr	dent) OR ((LMP) OTHER SOURC  OR INJURY. (RE  B C Place Type of of y Service Service	ELATE ITEMS 1, 3. 4. PROCEDUR (Explain CPT/HCPC)	F PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2,3 OR 4 TO ITEM  D  ES, SERVICES, OF 1 Unusual Circumsts  MODIFIER	MM   DD   REFERRING PH  24E BY LINE)	HYSICIAN  E DIAGNOSIS CODE	18. HOSPIT FROM  20. OUTSIE  YE  22. MEDICACODE  23. PRIOR	ALIZATION DA' MIN DD   E LAB? S NO MID RESUBMISS AUTHORIZATIC DA O O O O O O O O O O O O O O O O O O	FES RELATIVY  N NUMBER  H YS EPSDT R Family TIS Plan	TO TO CI	GES J	NT SERVICE: DD   YY	S FOR	
17. NAME OF REFERS  19. RESERVED FOR L  21. DIAGNOSIS OR NA  1	INJURY (Accident of the pregnancy pr	dent) OR ((LMP) OTHER SOURCE OF INJURY. (RE	ELATE ITEMS 1, 3. 4. PROCEDUR (Explain CPT/HCPC) Q420	F PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2,3 OR 4 TO ITEM  D  ES, SERVICES, OF 1 Unusual Circumsts  MODIFIER	REFERRING PH  24E BY LINE)  R SUPPLIES ances)  Field 2	E DIAGNOSIS CODE	18. HOSPIT FROM  20. OUTSIE  YE  22. MEDICACODE  23. PRIOR	ALIZATION DA  ALIZATION DA  IM D  E LAB?  S NO  IID RESUBMISS  AUTHORIZATIO  C DA  O UN  RGES UN  Field	PES RELATIVY  N NUMBEI  I H YS EPSDT Family Plan	SCHARCE R	URREN MM J GES	NT SERVICE: DD   YY	) FOR	OR SUPPLIER IN
17. NAME OF REFERR  19. RESERVED FOR L  21. DIAGNOSIS OR NA  1. L  2. L  24. A  Prom DD YY  1	INJURY (Accident of the pregnancy of the	dent) OR ((LMP) OTHER SOURCE OF INJURY. (RE    B	ELATE ITEMS 1, 3. 4. PROCEDUR (Explain CPT/HCPC) Q420	PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2.3 OR 4 TO ITEM  D  ES, SERVICES, OF IN UNUSUAL Circumsts  MODIFIER  D1	REFERRING PH  24E BY LINE)  R SUPPLIES ances)  Field 2  Enter C	E DIAGNOSIS CODE	FROM  18. HOSPIT FROM  20. OUTSILE CODE  22. MEDICACODE  23. PRIDR.	ALIZATION DA  ALIZATION DA  IM DD  E LAB?  S NO  IID RESUBMISS  AUTHORIZATION  RGES ON  UN  Field  Entel	SION ORIGIN NUMBER  WS EPSDT Family Plan	SCHARGE REMEDIATE OPTICAL OPTICAL PROPERTY OF THE PROPERTY OF	URREN MM J. J. S. NO.	K RESERVEL LOCAL L	of un	OR SUPPLIER IN
19. RESERVED FOR L  21. DIAGNOSIS OR NA  1. L  2. L  24. A  DATE(S) OF  MM DD YY  1  24. A  Prom  DATE(S) OF  MM DD YY  24. A  Prom  A  A  B  B  B  C  C  C  C  C  C  C  C  C  C	INJURY (Accident of the pregnancy pregnancy pregnancy pregnancy pregnancy ocal use the preg	dent) OR ((LMP) OTHER SOURCE OF INJURY. (RE    B	ELATE ITEMS 1, 3. 4. PROCEDUM (Explains CPT/HCPC Q420  Cable T codes	PATIENT HAS HAS HAS IVE FIRST DATE  I.D. NUMBER OF R  2,3 OR 4 TO ITEM  D  ES, SERVICES, OF IN UNUSUAL Circumsts  MODIFIER  D1	REFERRING PH  24E BY LINE)  R SUPPLIES ances)  Field 2  Enter code(s	E DIAGNOSIS CODE  24E diagnosis	18. HOSPIT FROM  20. OUTSIE  YE  22. MEDICACODE  23. PRIOR	ALIZATION DA'  MIN DD  E LAB?  S NO  NID RESUBMISS  AUTHORIZATIC  DA  O  O  O  O  C  C  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  O  D  D	N NUMBER HYS EPSDT Family TIS Plan	SCHARGE SCHARG	J COB	K RESERVEL LOCAL L	of un	OR SUPPLIER IN
17. NAME OF REFERS  19. RESERVED FOR L  21. DIAGNOSIS OR NA  1. L  24. A  From MM DD YY  24. A  A  From MM DD YY  24. A  From MM DD YY  25. C  26. A  From MM DD YY  26. C  27. A  A  A  A  A  A  B  A  B  A  B  A  B  A  B  A  B  A  B  A  B  A  B  A  B  A  B  B	INJURY (Acc) PREGNANCY PREGNANCY OCAL USE  STURE OF ILLNESS OF ILL	B C Place Type of of of of y Service Service Service CPCS/CP'd modified	ELATE ITEMS 1, 3. 4. PROCEDUR (Explain cPT/HCPC Q420	PATIENT HAS HAS HAS PATIENT HAS	REFERRING PH  24E BY LINE)  REFERRING PH  24E BY LINE)  REFERRING PH  24E BY LINE)  REFERRING PH  24E BY LINE)	E DIAGNOSIS CODE  24E diagnosis ) ponding	18. HOSPIT FROM 20. OUT SIE 22. MEDICA 23. PRIDR.  F \$ CHAIL  TOTAL  PHYSIC	ALIZATION DA  MIN DD  E LAB?  S NO  MID RESUBMISS  AUTHORIZATIC  CREES UN  Field  Enter  For e  Would  WOU  MAN  FOR EACH  FOR E  WOU  MAN  MORE  MORE	N NUMBER  H YS EPSDT Family Family Family Family A Plan  1 24G  appr ach se nd is l	SCHARGE OPTIAL PROPERTY OF THE	J cob te n pro	with services by the services of the services	of un Artac	OR SUPPLIER IN
19. RESERVED FOR L  21. DIAGNOSIS OR NA  1. L  2. L  24. A  PROMISE OF REFERS  19. RESERVED FOR L  21. DIAGNOSIS OR NA  1. L  2. L  24. A  PROMISE OF REFERS  21. DIAGNOSIS OR NA  2. L  24. A  PROMISE OF REFERS  21. DIAGNOSIS OR NA  2. L  24. A  PROMISE OF REFERS  22. L  24. A  DATE(S) OF MM DD YY  22. L  24. A  PROMISE OF REFERS  25. DIAGNOSIS OR NA  26. L  27. DIAGNOSIS OR NA  28. L  29. L  20. L  20. L  21. DIAGNOSIS OR NA  21. L  22. L  24. A  PROMISE OF REFERS  21. DIAGNOSIS OR NA  22. L  24. A  PROMISE OF REFERS  24. A  PROMISE OF REFERS  25. DIAGNOSIS OR NA  26. L  27. L  28. L  29. L  29. L  20. L  20. L  20. L  20. L  21. L  22. L  24. A  PROMISE OF REFERS  21. DIAGNOSIS OR NA  22. L  24. A  PROMISE OF REFERS  24. A  PROMISE OF REFERS  25. L  26. L  27. L  28. L  29. L  29. L  20.	INJURY (Accident of the property of the proper	B C Place Type of of Service Service  Eld 24D  ter applice certly with the cer	ELATE ITEMS 1, 3. 4. 9 PROCEDUR (Explain cPT/HCPC: Q420  Cable T codes ers. Check the	PATIENT HAS HABIVE FIRST DATE  I.D. NUMBER OF R  2.3 OR 4 TO ITEM  D  ES  S  S  NODIFIER  NO.  OF FACIL an home of	REFERRING PH  24E BY LINE)  R SUPPLIES ances)  Field 2  Enter code(s)  corresp with co	E DIAGNOSIS CODE  A DIAGNOSIS CODE  A DIAGNOSIS CODE  DIAGNOSI	18. HOSPIT FROM 20. OUT SILE CODE 22. MEDICA CODE 23. PRIDR.	ALIZATION DA  MIN DD  E LAB?  S NO  MID RESUBMISS  AUTHORIZATIC  CREES  ON  Field  Enter  For e  Would  IAN  E ## (this	N NUMBER  H YS EPSDT R TS Plan  1 24G  approach see  nd is b is an e	SCHARGE OPTICAL OPTICA	J cob te n pro	K RESERVEL LOCAL L	of un Artac	OR SUPPLIER IN
17. NAME OF REFERS  19. RESERVED FOR L  21. DIAGNOSIS OR NA  1. L  24. A  From MM DD YY  24. A  A  From MM DD YY  24. A  From MM DD YY  25. C  26. A  From MM DD YY  26. C  27. A  A  A  A  A  A  B  A  B  A  B  A  B  A  B  A  B  A  B  A  B  A  B  A  B  A  B  B	INJURY (Accident of the pregnancy pr	B C Place Type of of y Service Service  CPCS/CP d modifice ectly with yer to de	ELATE ITEMS 1.  3.  4.  PROCEDUR (Explain CPT/HCPC Q420  Cable T codes ers. Check the extermine	PATIENT HAS HABIVE FIRST DATE  I.D. NUMBER OF R  2.3 OR 4 TO ITEM  D  ES  S  S  NODIFIER  NO.  OF FACIL an home of	REFERRING PH  24E BY LINE)  REFERRING PH  24E BY LINE)  REFERRING PH  24E BY LINE)  REFERRING PH  24E BY LINE)	E DIAGNOSIS CODE  A DIAGNOSIS CODE  A DIAGNOSIS CODE  DIAGNOSI	18. HOSPIT FROM 20. OUT SIE 22. MEDICA 23. PRIDR.  F \$ CHAIL  TOTAL  PHYSIC	Field Enter  For e  Would  Wou	I 24G  Tapprach send is list an earm = 3	SCHARGE OPTION OF THE PROPERTY	J cob te n pro	with services by the services of the services	of un Artac	OR SUPPLIER IN
19. RESERVED FOR L  21. DIAGNOSIS OR NA  1. L  2. L  24. A  PROMISE OF REFERS  19. RESERVED FOR L  21. DIAGNOSIS OR NA  1. L  2. L  24. A  PROMISE OF REFERS  21. DIAGNOSIS OR NA  2. L  24. A  PROMISE OF REFERS  21. DIAGNOSIS OR NA  2. L  24. A  PROMISE OF REFERS  22. L  24. A  DATE(S) OF MM DD YY  22. L  24. A  PROMISE OF REFERS  25. DIAGNOSIS OR NA  26. L  27. DIAGNOSIS OR NA  28. L  29. L  20. L  20. L  21. DIAGNOSIS OR NA  21. L  22. L  24. A  PROMISE OF REFERS  21. DIAGNOSIS OR NA  22. L  24. A  PROMISE OF REFERS  24. A  PROMISE OF REFERS  25. DIAGNOSIS OR NA  26. L  27. L  28. L  29. L  29. L  20. L  20. L  20. L  20. L  21. L  22. L  24. A  PROMISE OF REFERS  21. DIAGNOSIS OR NA  22. L  24. A  PROMISE OF REFERS  24. A  PROMISE OF REFERS  25. L  26. L  27. L  28. L  29. L  29. L  20.	INJURY (Accident of the part o	B C Place Type of of Service Service  Eld 24D  ter applice certly with the cer	cable T codes ers. Checkholdier	PATIENT HAS HABIVE FIRST DATE  I.D. NUMBER OF R  2.3 OR 4 TO ITEM  D  ES  S  S  NODIFIER  NO.  OF FACIL an home of	REFERRING PH  24E BY LINE)  R SUPPLIES ances)  Field 2  Enter code(s)  corresp with co	E DIAGNOSIS CODE  A DIAGNOSIS CODE  A DIAGNOSIS CODE  DIAGNOSI	18. HOSPIT FROM 20. OUT SIE 22. MEDICA 23. PRIDR.  F \$ CHAIL  TOTAL  PHYSIC	Field  Field  CHE  CHE  CHE  CHE  CHE  CHE  CHE  CH	N NUMBER  H YS EPSDT R TS Plan  1 24G  approach see  nd is b is an e	Opriate ervice billed exampunits units	ges = No.	with services by the services of the services	of un Artac	OR SUPPLIER IN

If you have any questions, please contact the Matrion 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.



