

Surgical Application in Outpatient Places of Service (POS) 22 and 24

Matrion



2023 CODING AND PAYMENT INFORMATION

Information on Matrion

The Centers for Medicare & Medicaid Services (CMS) payment systems are different for outpatients in provider-based hospital outpatient departments/provider-based hospital outpatient surgery departments (POS 22) and ambulatory surgical centers (POS 24).

Places of Service 22:

- **Provider-Based Hospital Outpatient Department:** *an on- or off-campus outpatient department that is 1) an integral part of the hospital, subject to the hospital conditions of participation, and 2) is not separately enrolled and certified in Medicare.*

The CMS pays these provider-based hospital outpatient departments an Outpatient Prospective Payment System (OPPS) packaged allowable rate for the appropriate Matrion application code. The packaged allowable rate also includes the cost of Matrion and is determined by the Ambulatory Payment Classification (APC) Group to which each application code is assigned. Each provider-based hospital outpatient department has a unique allowable APC payment rate.

- **Provider-Based Hospital Outpatient Surgery Department:** *an on- or off-campus outpatient surgery department that is 1) an integral part of the hospital, subject to the hospital conditions of participation, and 2) is not separately enrolled and certified in Medicare or subject to ASC conditions for coverage.*

The CMS pays these provider-based hospital outpatient surgery departments the same as provider-based hospital outpatient departments: the OPPS packaged allowable rate for the appropriate Matrion application code. The packaged allowable rate includes the cost of Matrion and is determined by the APC Group to which each application code is assigned. Each provider-based hospital outpatient surgery department has a unique allowable APC payment rate.

Place of Service 24:

- **Ambulatory Surgical Center (ASCs):** *a distinct ASC that operates exclusively for the purpose of furnishing surgical services to patients who do not require hospitalization and in which the expected duration of service does not exceed 24 hours following admission.*

The ASC can be either: 1) independent (not part of a provider of services or any other facility), or 2) operated by a hospital (under the common ownership, licensure, or control of a hospital).

An ASC Operated by a Hospital Must:

- Be a separately identifiable entity separately enrolled in Medicare with a supplier approval that is distinct from the hospital's Medicare provider agreement
- Be physically, administratively, and financially independent and distinct from other operations of the hospital
- Treat costs for the ASC as a non-reimbursable cost center on the hospital's cost report
- Agree to the same assignment, coverage, and payment rules applied to independent ASCs
- Comply with the conditions for coverage for ASCs

The CMS pays these ASCs an ASC Payment System single allowable rate for the application of Matrion which includes the cost of the product. Each ASC has a unique allowable ASC Payment System rate.

2023 Coding and Medicare Payment for Application of Matrion

Place of Service 22			Code	Code Description	Place of Service 24	
APC Group	Status Indicator*	2023 Medicare Payment Rate**			Payment Indicator***	2023 Medicare Payment Rate**
5054	T	\$1,725.86	15271	Application of Skin Substitute Graft	G2	\$898.64
N/A	N	Packaged	+15272	Each Additional Area	NI	Packaged
5055	T	\$3,253.04	15273	Application of Skin Substitute Graft	G2	\$1,693.83
N/A	N	Packaged	+15274	Each Additional Area	NI	Packaged
5054	T	\$1,725.86	15275	Application of Skin Substitute Graft	P3	\$89.93
N/A	N	Packaged	+15276	Each Additional Area	NI	Packaged
5054	T	\$1,725.86	15277	Application of Skin Substitute Graft	G2	\$898.64
N/A	N	Packaged	+15278	Each Additional Area	NI	Packaged

Status/Payment Indicators

- A2 = Payment based on OPPS relative payment rate
- G2 = Payment based on OPPS relative payment rate
- N = Payment packaged, not separately payable
- NI = Payment included in APC rate
- P3 – payment based on MPFS non-facility practice expense RVUs
- T = Multiple procedure reductions apply

***Payments are national unadjusted average amounts and do not account for differences in payment due to geographic variation.

2023 Coding for Matrion

Code ¹	Code Description
Q4201	Matrion™, per square centimeter

Medicare requires that when Matrion is applied as a skin substitute, both the application procedure code (1527X) and the Matrion HCPCS code (Q4201) be reported on the same claim. In addition, the appropriate modifier(s), and number of sq. cm of Matrion used must be reported on the claim with the application code(s).

- The -JC modifier was established to report use of a skin substitutes as a graft (not an implant). Each Medicare contractor may issue its own directions for the use of the -JC modifier and providers should check with their local MAC to determine reporting requirements.
- Providers and suppliers are required to report the -JW modifier on all claims that bill for drugs and biologicals separately payable under Medicare Part B with unused and discarded amounts from single-dose containers or single- use packages. As skin substitutes are not paid separately in the hospital outpatient or ASC setting, this is not required for Matrion.

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

Reference:

1. 2023 HCPCS, www.cms.gov
2. CY 2023 OPps and ASC Addendum B and ASC Addenda (CMS-1772-FC);

Disclaimer:

Disclaimer: This information is for educational/informational purposes only and should not be construed as authoritative. The information presented here is current as of December 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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