INPATIENT FACILITY BILLING & CODING GUIDE

Hospital Inpatient MS-DRG		
MS-DRG	**MS-DRG Description**	**Medicare National Average Payment 2021[1]**
573	Skin Graft for Skin Ulcer or Cellulitis with MCC	$35,590.50
574	Skin Graft for Skin Ulcer or Cellulitis with CC	$20,878.16
575	Skin Graft for Skin Ulcer or Cellulitis without CC/MCC	$11,321.88
576	Skin Graft Except for Skin Ulcer or Cellulitis with MCC	$32,464.21
577	Skin Graft Except for Skin Ulcer or Cellulitis with CC	$16,414.32
578	Skin Graft Except for Skin Ulcer or Cellulitis without CC/MCC	$10,481.18
622	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders with MCC	$23,220.95
623	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders with CC	$12,037.90
624	Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders without CC/MCC	$7,033.51

The table above provides potential MS-DRGs assignments for hospitals when applying cellular and/or tissue based products (CTP's) for the management of skin wounds in the inpatient setting of care (formerly skin substitutes). These are 2021 Medicare average rates and are provided as a benchmark. Rates nationwide can vary widely.

Medicare reimburses hospital inpatient stays based on the Medicare Severity Diagnosis Related Group (MS-DRG) system. MS-DRGs represent a consolidated prospective payment for all services provided by the hospital during the patient's hospitalization, based on submitted claims data. With limited exceptions, the MS-DRG payment is inclusive of all services, products, and resources, regardless of the final cost to the hospital. Medicare and many private payors use the MS-DRG based system to reimburse facilities for inpatient services.

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 payors 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 payment by payors.*

Benefits Verification/Pre-Authorization & Coding Hotline

1-866-562-6349

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[1] 2021 MS-DRG relative weight multiplied by 2021 rate per IPPS Final Rule CMS-1677, as calculated by MCRA, payment rates will vary by facility. Calculation includes labor related, non-labor related and capital payment rates. EX-21-014