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Matrion™
Placental Membrane

2021 Coding and Payment Information for Surgical Application of Matrion in Outpatient Places of Service (POS) 22 and 24

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).

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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.

2021 Coding and Medicare Payment for Application of Matrion

Place of Service 22			Code	Code Description	Place of Service 24	
APC Group	Status Indicator*	2021 Medicare Payment Rate**			Payment Indicator***	2021 Medicare Payment Rate**
5054	T	$1,715.36	**15271**	**Application of Skin Substitute Graft**	G2	$866.81
N/A	N	Packaged	**+15272**	**Each Additional Area**	N1	Packaged
5055	T	$3,522.15	**15273**	**Application of Skin Substitute Graft**	G2	$1,779.83
N/A	N	Packaged	**+15274**	**Each Additional Area**	N1	Packaged
5054	T	$1,715.36	**15275**	**Application of Skin Substitute Graft**	G2	$866.81
N/A	N	Packaged	**+15276**	**Each Additional Area**	N1	Packaged
5054	T	$1,715.36	**15277**	**Application of Skin Substitute Graft**	G2	$866.81
N/A	N	Packaged	**+15278**	**Each Additional Area**	N1	Packaged

*T = Multiple procedure reductions apply
N = Payment packaged, not separately payable

***G2 = Payment based on OPPS relative payment rate
N1 = Payment included in APC rate

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

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2021 Coding for Matrion

Code[1]	Code Description
Q4201	Matrion™, per square centimeter

Medicare requires that the code Q4201, for the Matrion product used in the application procedure, is reported on the same claim with the appropriate application code(s), Therefore, the Matrion code Q4201, the appropriate modifier(s), and the appropriate number of sq. cm must be reported on the claim with the application code(s).

- If the physician/qualified healthcare professional (QHP) applies (as a graft, not an implant) the entire piece of Matrion to a patient, for whom the product was purchased by the facility, the facility should report Q4201 JC and the total number of sq cm purchased for the patient.
- If the physician/QHP discards a portion of the Matrion purchased for the patient, the facility should verify how the Medicare Administrative Contractor (MAC) wants the facility to report the discarded portion. All the MACs direct the physician/QHP to document the number of sq cm purchased for the patient, the number of sq cm applied, and the number of sq cm discarded.
  - Even though a portion of the product was discarded, some MACs direct the facility to report Q4201 JC and the total number of sq cm purchased for the patient.
  - Other MACs direct the facility to report the portion of the product applied with the JC modifier and the portion of the product discarded with the JW modifier.
    Example: If 20 sq. cm of Matrion were purchased by the facility for the patient and 15 sq. cm were applied as a graft and 5 sq cm were discarded, the facility should report the product code on two claim lines: Q4201 JC with 15 units on the first claim line, and Q4201 JW with 5 units on the second claim line.

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

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.*

[1] 2021 HCPCS, www.cms.gov

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