Coding Analysis Related to Commercialization of the XPANSION® ® Skin Grafting Instruments Provided by The Institute for Quality Resource Management

The codes provided would be recognized as active payable codes by The Centers for Medicare and Medicaid Services (CMS) and private insurance as well. The payment amounts will vary for private insurance companies.

Included in this document are

CPT: Current Procedural Coding Terminology Codes used by physicians to report the Medicare and other payers the work performed on a patient.

APC: Ambulatory Payment Classification codes which reflect a bundled payment for services performed in a hospital outpatient setting.

ASC: Ambulatory Surgical Center codes which reflect the assignment of CPT codes to certain ASC groups which are then priced.

DRG: Diagnosis related groups which reflect the assignment of clinically similar patients receiving in this scenario a surgical procedure related to skin grafting. The relative weights are developed by CMS using charge data provided to CMS in prior years. The payments are estimates and do not reflect a hospital's specific payment rate, additions for graduate medical education or disproportionate share adjustments.

ICD-9-CM: Codes that reflect the International Classification of Disease Coding and Maintenance committee Version 29 nomenclature for procedures related to autologous skin grafts.

Table 1 represents example of CPT codes that are billable when using the XPANSION® System. The more likely CPT codes are bolded representing procedures for the lower extremities or feet. CPT codes that have a plus (+) in front of the number are to be used in addition to the previous CPT code. These CPT codes indicate an addition to the main category or previous CPT code. The CPT codes provided represent the 2012 Calendar year codes to be used for autologous skin grafting. Not all codes would be relevant, but are provided for informational purposes only.

The payment amounts reflect the most recent update payment rates are based on current law, including the Temporary Payroll Tax Cut Continuation Act of 2011, which provides for a zero percent update for the period of January 1, 2012 to February 29, 2012. The Centers for Medicare & Medicaid Services will work quickly to update MPFS payment rates in the event Congress passes legislation to prevent the negative update from going into effect on March 1, 2012. As changes are made we will provide an update to these payment amounts. The payment amounts do not include the geographic adjustments that vary by the specific wage area index.

Physician payment for a non-facility patient care setting would be similar to a physician's office, or a free standing surgery center that may be physician owned and not considered an ambulatory surgical center (ASC).

Physician payment in a facility represents the payment a physician would receive when billing the CPT code if the procedure was performed in an inpatient setting, hospital outpatient setting or an ASC.

We have included an unlisted CPT code 17999 that should be included to report the work associated with the use of the XPANSION® System to do the work of creating the skin for appropriate transplant

onto the defect sight. Currently there is not reimbursement associated with the code, however it is carrier priced and efforts with local payers may result in early payment while waiting for the specific new codes.

Table 1 Physician CPT Codes for the medical procedure associated with harvesting the tissue, preparation the wound site and then placing the autologous graft. Many of these codes have a 90 day global period. Effective January 2012 placement of skin substitute grafts reimbursement has been lowered to reflect the removal of a 90 day global period.

CPT	Description	Physician Non Facility	Physician Facility
15002	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children	$350.25	$230.77
+15003	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)	$76.58	$46.29
15004	**Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children**	**$400.62**	**$272.98**
+15005	**Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)**	**$126.62**	**$92.92**
15100	**Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**	**$875.45**	**$733.85**
+15101	**Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**	**$188.23**	**$112.32**

CPT	Description	Physician Non Facility	Physician Facility
15120	**Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**	$866.94	$714.45
+15121	**Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**	$211.37	$134.79

17999	**Unlisted procedure, skin, mucous membrane, and subcutaneous tissue**	**$0.00**	**$0.00**

Table 2 Provides reimbursement information when the procedure using the XPANSION® System is provided to a patient in a **hospital outpatient setting**. The Ambulatory Payment Center (APC) payment is derived from the specific CPT code that would represent the procedure. The physician would complete a HCPFA 1500 form using the same codes at the hospital outpatient bill referred to as the Universal Billing Form (UB) 2004.

The status indicator of T indicates that the payment would be 50% of the allowed amount. The CMS reimburses 80% of the payment rate and the patient is responsible for the 20% copayment. The copayment is often covered by Medicare beneficiary supplemental insurance.

The comment indicator CH indicates this is an active HCPCS code in current year and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that is discontinued at the end of the current calendar year.

Use of Revenue Codes to capture the actual cost of the procedure. The cost of surgical devices included in the procedure, unless identified by a pass through code, are included in the bundled payment rate. When using the UB 2004 form it is advised that there be a specific line item indicating the XPANSION® Procedure including a specific charge for the XPANSION® procedure. The following Revenue Codes may be used to help capture the actual use and billing of the XPANSION® System. This process will aid our request for a pass through code and could over time increase the reimbursement for those associated CPT codes.

Revenue code 0272 Sterile Medical Supply
Revenue code 0278 Medical Surgical Supplies, other implants
Revenue code 0361 Minor surgical procedure
Revenue code 0369 Other minor surgical procedure
Revenue code 0761 Treatment room, clinic

The line of with the revenue code should include the name of the specific product allowing the unique implantation of the tissue and a charge. The charge is an example only. All hospital product charges must consider the cost to charge ratio used in determining payment. For example if the line item charge is

$1,000 then the actual payment would be $320.00. If the acquisition cost of an item were $250 then to receive at least an equivalent amount the line item charge would need to be at least $781.25.

Example for coding on a UB 2004 Hospital Outpatient Claim Form
Rev Code
0278 XPANSION® System ***$950.00*** **[Example charge for the line item]**

Procedure CPT codes are required to be reported on the same claim as the XPANSION® System

Table 2 Ambulatory Payment Classification for CPT codes Describing the Procedure

CPT	APC	CI	SI	Relative Weight	Payment Rate	Minimum Unadjusted Copayment
15002	0135		T	4.965	$347.63	$69.53
+15003	0135		T	4.965	$347.63	$69.53
15004	**0134**	**CH**	**T**	**3.2535**	**$227.8**	**$45.56**
+15005	**0135**		**T**	**4.965**	**$347.63**	**$69.53**
15040	0134		T	3.2535	$227.8	$45.56
15050	**0134**	**CH**	**T**	**3.2535**	**$227.8**	**$45.56**
15100	**0137**		**T**	**21.3126**	**$1,492.22**	**$298.45**
+15101	**0137**		**T**	**21.3126**	**$1,492.22**	**$298.45**
15120	**0137**		**T**	**21.3126**	**$1,492.22**	**$298.45**
+15121	**0137**		**T**	**21.3126**	**$1,492.22**	**$298.45**
17999	**0012**		**T**	**0.3874**	**$27.12**	**$5.48**

Table 3 reflects the assignment of the specific CPT codes to ASC groups. The grouping of a surgical procedure results in a bundled payment. The cost of surgical devices included in the procedure, unless identified by a pass through code, are included in the bundled payment rate.

The payment is subject to multiple procedure discounting therefore the payment when 2 or more codes are on the same claim reflects 50% of the amount shown under the column for Final Payment for the Calendar Year 2012.

Table 3 Ambulatory Surgical Center Payment for Selected CPT Codes

CPT	ASC Subject To Multiple Procedure Discounting	Final CY 2012 Payment Indicator	Final CY 2012 Payment Weight	Final CY 2012 Payment
15002	Y	A2	4.7053	$ 200.57
+15003	Y	A2	4.7053	$ 200.57
15004	**Y**	**A2**	**3.0833**	**$ 131.43**
+15005	**Y**	**A2**	**4.7053**	**$ 200.57**
15040	Y	A2	3.0833	$ 131.43
15050	Y	A2	3.0833	$ 131.43
15100	**Y**	**A2**	**20.198**	**$ 860.98**
+15101	**Y**	**A2**	**20.198**	**$ 860.98**
15120	**Y**	**A2**	**20.198**	**$ 860.98**
+15121	**Y**	**A2**	**20.198**	**$ 860.98**

Table 4 Represents the **Medical Severity -Diagnosis Related Group** (**MS-DRG)** that could be assigned to a procedure using the XPANSION® System for autologous skin grafting. Assignment of an MS-DRG is based upon the combination of ICD-9-CM diagnosis and procedure codes, therefore the list provided is expansive and may not apply in all cases. MS-DRG payment is specific for patients that have been formally admitted to the hospital. Hospital admission includes an order by a physician that the patient is to be admitted for a treatment of a medical condition that cannot be properly medically managed in an outpatient setting. The patient will be assigned to a room and there will be room and board charges on their insurance claim.

The estimated payment does not reflect hospital specific MS-DRG payment rates, the large urban teaching labor cost, the graduate medical education add on, or the additional payment for disproportionate share of low income patients. This is just an average reflecting the 2012 hospital payment update, therefore most hospital MS-DRG payment should be higher that our estimates.

Billing for the XPANSION® System for a hospital inpatient stay would be reported using the Revenue Codes as provide for hospital outpatient billing. They use the same UB 2004 form.

Table 4 MS-DRG Reflecting the Reimbursement to the Hospital for the Inpatient Admission

MS-DRG	TYPE	MS-DRG Title	Relative Weighs	Arithmetic mean LOS	Reimbursement Estimate
					$5631.16
463	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.0438	14.7	$28,402
464	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.9658	8.5	$16,701
465	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.7406	4.8	$9,802
570	SURG	SKIN DEBRIDEMENT W MCC	2.5158	10.1	$14,167
571	SURG	SKIN DEBRIDEMENT W CC	1.5427	6.9	$8,687
572	SURG	SKIN DEBRIDEMENT W/O CC/MCC	0.9872	4.7	$5,559
573	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	3.4249	12.5	$19,286
574	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	2.6984	10.8	$15,195
575	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.2271	5.2	$6,910
576	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	3.4936	10.7	$19,673
577	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	1.8118	5.8	$10,203
578	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.0684	3.1	$6,016
579	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.6935	9.7	$15,168
580	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.4801	5.1	$8,335
581	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	0.9497	2.4	$5,348

622	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.8339	13.9	$21,589
623	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.8542	7.6	$10,441
624	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	0.9965	4.3	$5,611
904	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	3.1057	10.7	$17,489
905	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.1702	4.5	$6,590
906	SURG	HAND PROCEDURES FOR INJURIES	1.0566	3.3	$5,950
927	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	12.1033	27.3	$68,156
928	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	4.8909	15.3	$27,541
929	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.1779	7.2	$12,264