APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

BACKGROUND

Johns Hopkins Health Library defines burns as a type of painful wound caused by thermal, electrical, chemical, or electromagnetic energy. They cite smoking and open flame as the leading causes of burn injury for older adults and scalding as the leading cause of burn injury for children. According to the American Burn Association, burn injuries result in more than 500,000 hospital emergency department visits and approximately 50,000 acute admissions per year in the United States. The most severe burn injuries require admission to a specialty hospital or burn center.

A severe or major burn is classified as any burn that is accompanied by a major trauma, inhalation injury, or a chemical or high-voltage electrical burn. Also considered severe are any burns involving over 20 percent of the total body surface area (TBSA), with the exception of first-degree burns. Burns to high risk individuals such as older adults, young children and anyone with a major comorbidity may be considered severe even if less than 20 percent of their TBSA is involved. Burns to areas like the eyes, ears, face, hands, feet or perineum may require specialized burn center care due to the high risk of functional impairment. In addition, circumferential burns of the extremities
or thorax require a consultation with a burn center as they are an indicator of decreased blood flow. Deep circumferential burns of the chest may impair or prevent mechanical ventilation of the burn victim.4

Burns are not only physically devastating and painful; they can also cause emotional distress to both the burn victim and their loved ones. The victim and family may have many fears related to loss of function and mobility as well as fear of disfigurement and scaring. Management of a severe burn patient must address their burn wound as well as the systemic, psychologic, and social consequences of the injury.1,3

Causes of Burns. There are four main causes of burns; thermal, radiation, chemical, and electrical. A thermal burn is a burn that originates from a heat source. Flames, hot liquids or metals and steam can all cause thermal burns. Radiation burns come from exposure to ultraviolet rays such as the sun, x-ray or radiation. Chemical burns are caused by strong acids or chemical solutions coming in contact with the skin or eyes. Electrical burns come from electrical currents.1

Burn Classification. Burns are classified in terms or degrees. First degree burns, also called superficial partial thickness, only involve the outer layer of skin, the epidermis. These burns will be red and painful but remain dry and without blisters. First degree burns typically heal within about one week. Second degree, or partial thickness burns, extend deeper into the dermis and include blisters and have a wet appearance. Second degree burns are extremely painful and can take 2 to 3 weeks to heal. Third degree, or full thickness, burns have a white or leathery appearance will be dry to the touch. These burns are often without sensation due to nerve damage. They extend the full depth of the skin. Skin grafts are typically required for healing third degree burns. The most severe burns are called fourth degree or full thickness. These burns will extend to the muscles, tendons and/or bone. Skin grafting and even more intensive surgeries or amputations may be required for healing.4

Emergency Burn Care

Emergency care of a burn victim follows the principles of the Advanced Trauma Life Support guidelines for assessment and stabilization of airway, breathing, circulation, disability, exposure, and environment control. All burn patients should receive high flow 100% oxygen as warranted and in some cases may require suction and support ventilation. Primary and secondary assessments for the severity and TBSA of the burn and an evaluation for associated life-threatening injuries should be performed promptly. Pain management should be provided via IV and a nasogastric tube may be placed to decompress the stomach and prevent vomiting. Fluid resuscitation should begin quickly and vitamin C therapy should be considered for patients with greater than 30 percent of TBSA burned. Hypothermia should be prevented by keeping an ambient room temperature and wrapping the victim in clean sheets or blankets.3,4

Once a burn victim has completed initial resuscitation, the next steps in their care can be determined. Burn patients who require mechanical ventilation or cardiac or other hemodynamic monitoring as well as those who have risk factors for multisystem organ failure should be admitted to the ICU. Ongoing fluid therapy is performed to maintain organ perfusion and prevent the patient from going into shock. Effectiveness is monitored by using a central venous catheter and cardiac output monitor as well as a urinary catheter to track strict intake and output amounts. If a patient is at risk for compartment syndrome they will require hourly neurovascular checks in the event an escharotomy is required.3

After stabilization pain management is a priority in the care of burn patients. Morphine is the gold standard in pain management, unless contraindicated, and administration should continue via IV. Thromboprophylaxis should be initiated and follow the same protocol as any other patients admitted to the hospital or center. Enteral nutrition should be initiated within the first 24 hours of their admission and hypermetabolism as well as protein loss, peripheral insulin resistance, and risk for infection should be taken into account when creating a nutritional plan. Patients should also be monitored for trauma induced coagulopathy.3

In any of the following situations a patient is likely to be referred to a specialty hospital or burn center:

**Burn Center Referral Criteria**1,2,4

- Partial-thickness burns of greater than 10 percent of the total body surface area
Burns that involve the face, hands, feet, genitalia, perineum, or major joints
Third-degree burns in any age group
Electrical burns, including lightning injury
Chemical burns
Inhalation injury
Burn injury in patients with preexisting medical disorders that could complicate management, prolong recovery or affect mortality
Burns and concomitant trauma (such as fractures) when the burn injury poses the greatest risk of morbidity or mortality. If the trauma poses the greater immediate risk, the patient’s condition may be stabilized initially in a trauma center before transfer to a burn center. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
Burns in children; children with burns should be transferred to a burn center verified to treat children. In the absence of a regional pediatric burn center, an adult burn center may serve as a second option for the management of pediatric burns.
Burn injury in patients who will require special social, emotional, or rehabilitative intervention.

Burn Surgery and Wound Management
In the past burns were treated with painful debridement of blisters, daily soaking and scrubbing, and frequent bandage changes with topical medications. Today, tissue regeneration and grafting is rapidly becoming the new standard of care in burn injuries. The goal of treating a burn wound is to replace damaged or missing tissue with similar, healthy tissue and restore full function to the involved area with minimal to no scar tissue formation. Second, third and fourth degree burns most often require some sort of surgical procedure to allow for healing. Although some of the most severe burns may require multisystem surgeries or amputations, most burn injuries are treated with the application of skin grafts.\(^3,5,6\)

One of the greatest advances in burn treatment has been early excision of necrotic tissue and closure of thermal burn wounds. Early excision and grafting provide an skin substitute for the wound, but further reconstructive surgeries may be still be required to restore a normal appearance and function. By performing early excision and grafting the patient’s length of stay in the hospital is significantly reduced as is the risk for hypertrophic scarring, joint contracture, infection and stiffness. Early closure also allows for quicker rehabilitation and lower mortality rates. As with any surgical procedure there are also risks and challenges. Major challenges associated with burn surgery include: extensive tissue loss and limited availability of tissue, other exposed structures, scaring and limited tissue pliability.\(^7\)

Skin Grafts. Skin grafting consists of taking tissue from another source and placing it over a wound. Sources include unaffected skin from another location on the burn victim’s body, cadaveric skin grafts and amniotic chorion/membrane. The ability of a skin graft to be successful relies on many factors. The graft bed must be suitable to sustain the graft during the imbibition phase of healing. Also, there must be sufficient perfusion to the graft either from the graft bed or from another supply such as a flap repair. Skin grafts are used for coverage of exposed bone and tendons only if there is a vascularized layer of periosteum or the paratenon is intact.\(^7,8\)

Split Thickness Skin Grafts. Split thickness skin grafts (STSG) include the epidermis and varying amounts of dermis and range from 8/1000 of an inch to 12/1000 of an inch thick. They can be expanded in size using meshing techniques and are the most commonly used donor tissue. Because STSGs are versatile and self-regenerating they are used to reconstruct large areas. When the victim’s own skin is used, donor sites may be reharvested after 10-15 days of healing.\(^7\) Disadvantages of STSG include fragility, abnormal pigmentation, lack of smooth texture, alopecia, and contractures. Split thickness grafts may also result in a masklike appearance and be less aesthetically pleasing than alternatives. If a donor site is used, healing is painful and split thickness grafts are more likely to form contractures.\(^7\)

Full Thickness Skin Grafts. Full-thickness skin grafts (FTSG) include all layers of the dermis. They are used in areas of special anatomical and functional importance which require more pliability than what can be provided by a split thickness graft. FTSG are commonly used to create a better aesthetic and functional result and when grafting.
is required for the face, head, hands and perineum. Although not expandable, full thickness grafts can still be meshed to adapt to uneven surfaces and allow for hematomas and seromas to drain.7 Advantages of FTSG include improved texture, pliability, elasticity, aesthetics, and color match. They are also more resistant to secondary contracture in comparison with split-thickness skin grafts. Disadvantages of FTSG are their limited availability and their decreased chance of survival in areas of limited vascularity. Since full thickness grafts are thicker than split thickness, they can also be more difficult to match with recipient site color and skin texture. The main survival risk of a FTSG is initial lack of adhesion due to the presence of a hematoma or seroma that can inhibit revascularization.7

**Tissue expansion.** Tissue expansion is technique used to gradually stretch areas of pliable skin for use in skin grafting. Tissue expansion may be used in situations where there is limited availability of reconstructive tissue, specialized tissue is needed, such as hair-bearing tissue for the scalp, and sites where cosmetic issues are of concern with color, thickness, and texture matching. Tissue expansion occurs by inserting an expander under non-burned tissue near the recipient site and slowly inflating the expander to create new tissue. Once the expander is removed, the extra skin can be used to replace lost tissue. This technique has been applied to multiple anatomical areas and is particularly useful in the head and neck areas.7,8

**Amniotic Membrane.** Another tissue used in skin grafting is human amniotic membrane. Besides of its abundant availability, there have been many advantages of amniotic membrane reported such as reduced pain at grafting site, decreased wound bacterial counts, accelerated wound healing and promotion of growth of granulation tissue of chronic wounds and exposed bones. It is also easy to use, adheres well to wound surfaces and contains collagen and growth factors which lead to reduction of scar tissue formation.6,7,8 Modern day processing methods have provided the medical community with safe amniotic tissue allografts. In 2006, a dehydrated amnion chorion membrane (dHACM) allograft (EpiFix; MiMedx Group, Inc., Marietta, GA), was made available in the market as an allograft product for the treatment of acute and chronic wounds. These allografts come in various sizes and configurations and are preserved and sterilized to allow for safe, off-the-shelf use in a variety of clinical situations.6,9 New grafts are usually kept in long-term dressings for three to four days before being examined. Examinations can be performed in the intensive care unit or operating room. New grafts must maintain adequate vascularity and hemostasis as well as being protected from excessive mobilization and high contact or friction. Adequate nutrition must be maintained for healing and patients of advanced age or those with comorbidities must be monitored closely.3,7

### Position Statement

**Applicable To:**
- Medicaid – All Markets
- Medicare – All Markets

**Exclusions**

Burn Treatment and Skin Substitutes are not a covered benefit when any of the following are true:10,11

1. Member does not meet the eligibility requirements listed; OR
2. Member does not meet the criteria listed in; OR
3. Procedure, product, or service duplicates another provider’s procedure, product, or service; OR
4. Procedure, product, or service is experimental, investigational, or part of a clinical trial.

WellCare will not cover skin substitutes for any ONE of the following diagnoses and conditions:

1. Infected ulcers;
2. Wounds or ulcers that are progressing toward closure with traditional wound care dressings and treatment;
3. Eschar, or any necrotic material;
4. Ulcers with sinus tracts or tunnels;
5. Underlying osteomyelitis;
6. Surrounding cellulitis;
7. A Member with known hypersensitivity to bovine products, bovine collagen and chondroitin materials;
8. Arterial disease with an ankle brachial index (ABI) (systolic ankle blood pressure over the systolic brachial blood pressure) of less than 0.70 or a lack of pedal pulses;
9. Uncontrolled diabetes (for purposes of this policy, controlled diabetes is based on documentation in the health record);
10. Active Charcot’s arthropathy of the ulcer extremity;
11. Vasculitis;
12. Uncontrolled rheumatoid arthritis, rheumatoid ulcers, or both;
13. Other uncontrolled collagen vascular diseases;
14. A Member who is under treatment with high-dose corticosteroids or immunosuppressants;
15. A Member who has undergone radiation, chemotherapy, or both within the month immediately preceding proposed skin substitute treatment.
16. EpiFix® for wounds that probe to the bone or are infected.
17. Dermagraft® for the treatment of dystrophic epidermolysis bullosa.

Coverage
Burn Treatment

Burn Treatment (including the procedure, product, service) and Skin Substitutes are considered medically necessary and a covered benefit when the procedure, product, or service:\textsuperscript{10,11}

1. Is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Member’s needs; AND
2. Can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; AND
3. Is furnished in a manner not primarily intended for the convenience of the Member, the Member’s caretaker, or the Provider.

The following skin substitutes are covered:\textsuperscript{11}

1. \textbf{Apligraf®}
   - \textbf{Apligraf® for Venous Stasis Ulcers (VSU)}
     Apligraf is covered when ALL of the following conditions are met in the treatment of partial or full thickness venous stasis ulcers and documented in the Member’s health record:
     a. Ulcers are of more than one (1) months’ duration; \textbf{AND}
     b. Measurement of the initial ulcer size, the ulcer size following cessation of conservative management, and the size at the beginning of skin substitute treatment; \textbf{AND}
     c. Ulcers have failed to respond to documented conservative measures used for more than four (4) weeks duration (failed to decrease the ulcer by 50%); \textbf{AND}
     d. The ulcer must be free of infection (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge) and underlying osteomyelitis, and treatment of the underlying disease must be provided and documented in conjunction with the skin substitute treatment; \textbf{AND}
     e. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70.

   - \textbf{Apligraf® for Neuropathic Diabetic Ulcers (DFU)}
     Apligraf is covered when ALL the following conditions are met in the treatment of neuropathic diabetic foot ulcers and documented in the Member’s health record:
     a. The Member has a primary diagnosis of foot ulcer and a secondary diagnosis of Type 1 or 2 diabetes mellitus with a glycated hemoglobin (HbA1c) of less than 12%; \textbf{AND}
     b. Full thickness ulcers of greater than three (3) weeks’ in duration, which extend through the dermis
but without tendon, muscle, capsule or bone exposure; AND
c. Measurement of the initial ulcer size, the ulcer size following cessation of conservative management, and the size at the beginning of skin substitute treatment; AND
d. Ulcers have failed to respond to documented conservative measures used for more than four (4) weeks’ duration (failed to decrease the ulcer by 50%); AND
e. Appropriate steps to off-load pressure during treatment are being taken; AND
f. The ulcer must be free of infection (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge) and underlying osteomyelitis, and treatment of the underlying disease must be provided and documented in conjunction with skin substitute treatment; AND
g. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70.

2. Dermagraft®

Dermagraft® is covered when ALL the following conditions are met for the treatment of full-thickness diabetic foot ulcers:

a. The ulcer has persisted for six (6) weeks or longer; AND
b. The ulcer extends through the dermis, but without tendon, muscle, joint capsule, or bone exposure; AND
c. The Member has a primary diagnosis of foot ulcer and a secondary diagnosis of Type 1 or 2 diabetes mellitus with a current HbA1C that does not exceed 12%; AND
d. Ulcers are located on foot or toes and are free of infection, (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge), underlying osteomyelitis, surrounding cellulitis, sinus tracts, eschar, or any necrotic material that would interfere with adherence of a living skin equivalent and wound healing; AND

e. Appropriate steps to off-load pressure during treatment are being taken; AND
f. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70; AND
g. Dermagraft® is used in conjunction with standard wound care regimens.

3. Integra®

The application of Integra is covered when indicated for either of the following:

a. Post-excisional treatment of life-threatening full-thickness or deep partial-thickness thermal injuries where sufficient autograft is not available at the time of excision or not desirable due to the physiological condition of the Member; OR
b. Repair of scar contractures when other therapies have failed or when donor sites for repair are not sufficient or desirable due to the physiological condition of the Member.

4. AlloDerm®

The application of AlloDerm® is covered when indicated for either of the following:

a. Skin grafting: AlloDerm® is often used in conjunction with a split-thickness skin graft. AlloDerm® is laid down first and is then covered by a thin split-thickness autograft. Both the application of AlloDerm® and the split-thickness autograft are coded separately; OR
b. Plastic surgeries on various soft tissue defects, such as abdominal wall reconstruction, breast reconstruction post-mastectomy, and tympanoplasty. Although reconstructive procedures require prior approval, the application of AlloDerm does not.
5. **TheraSkin®**

- **TheraSkin® for Venous Stasis Ulcers**

  TheraSkin® is covered in the treatment of partial or full-thickness lower extremity ulcers which extend through the dermis with or without tendon, muscle, joint capsule or bone exposure, when ALL the following conditions are met:

  a. Ulcers have demonstrated a failed or insufficient response to no fewer than four (4) weeks of conservative wound-care measures consisting of, at minimum, regular dressing changes, debridement of necrotic tissue and standard therapeutic compression; **AND**

  b. Documentation of response, or lack thereof, requires measurement of the initial ulcer at baseline, following cessation of conservative or conventional management. Documentation must also contain a measurement of the ulcer immediately prior to the placement of TheraSkin®; **AND**

  c. Ulcers are free of infection, (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge), underlying osteomyelitis, surrounding cellulitis, sinus tracts, eschar, or any necrotic material that would interfere with adherence of a living skin equivalent and wound healing; **AND**

  d. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70.

- **TheraSkin® for Diabetic Foot Ulcers**

  TheraSkin® is covered for the treatment of full-thickness diabetic foot ulcers when ALL the following conditions are met:

  a. The ulcer has persisted for greater than three (3) weeks duration; **AND**

  b. The ulcer extends through the dermis, with or without tendon, muscle, joint capsule, or bone exposure; **AND**

  c. The Member has a primary diagnosis of foot ulcer and a secondary diagnosis of Type 1 or 2 diabetes mellitus with a current HbA1C that does not exceed 12%; **AND**

  d. Ulcers are located on foot or toes and are free of infection, (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge), underlying osteomyelitis, surrounding cellulitis, sinus tracts, eschar, or any necrotic material that would interfere with adherence of a living skin equivalent and wound healing; **AND**

  e. Appropriate steps to off-load pressure during treatment are being taken;

  f. The Member has adequate arterial blood supply to the foot; as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70; **AND**

  g. TheraSkin® is used in conjunction with standard wound care regimens.

6. **EpiFix®**

- **EpiFix® for Venous Stasis Ulcers**

  EpiFix® is covered in the treatment of partial or full-thickness lower extremity ulcers which extend through the dermis, with or without tendon, muscle, joint capsule or bone exposure, when the following conditions are met:

  a. Ulcers have demonstrated a failed or insufficient response to no fewer than four (4) weeks of conservative wound-care measures consisting of, at minimum, regular dressing changes, debridement of necrotic tissue and standard therapeutic compression; **AND**

  b. Documentation of a response, or lack thereof, requires measurement of the initial ulcer at baseline, following cessation of conservative or conventional management. Documentation must also consist of measurement of the ulcer immediately prior to the placement of EpiFix®; **AND**

  c. Ulcers are free of infection, (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge), underlying osteomyelitis, surrounding cellulitis, sinus tracts, eschar, or any necrotic
material that would interfere with adherence of a living skin equivalent and wound healing; AND
d. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70.

- **EpiFix® for Diabetic Foot Ulcers**

  EpiFix® is covered for the treatment of full-thickness diabetic foot ulcers when ALL the following conditions are met:
  a. The ulcer has persisted for greater than three (3) weeks duration; AND
  b. The ulcer extends through the dermis, with or without tendon, muscle, joint capsule, or bone exposure; AND
  c. The Member has a primary diagnosis of foot ulcer and a secondary diagnosis of Type 1 or 2 diabetes mellitus with a current HbA1C that does not exceed 12%; AND
  d. Ulcers are located on a foot or toes and are free of infection, (increased exudates, odor, swelling, heat, pain, tenderness, purulent discharge), underlying osteomyelitis, surrounding cellulitis, sinus tracts, eschar, or any necrotic material that would interfere with adherence of a living skin equivalent and wound healing; AND
  e. Appropriate steps to off-load pressure during treatment are being taken; AND
  f. The treated foot has an adequate blood supply as evidenced by either the presence of a palpable pedal pulse or an ankle-brachial index (ABI) of greater than or equal to 0.70; AND
  g. EpiFix® is used in conjunction with conservative wound care regimens.

In addition, the following limitations and requirements apply:11

- Apligraf® is limited to 88 units within 365 calendar days with no more than five (5) applications per ulcer.
- Dermagraft® is limited 304 units every 12 weeks. When reasonable healing progress is noted, re-application may continue to a maximum of eight (8) applications in 12 weeks.
- TheraSkin® is limited to eight (8) applications per ulcer. Each application is limited to 80 units per day, to a maximum of 640 units every 12 weeks. Re-application of TheraSkin® within one (1) week for the same ulcer is not allowed. Re-application of TheraSkin® is not allowed for the same ulcer if satisfactory and reasonable healing progress is not noted after 12 weeks of therapy.
- Integra® coverage is limited to the application of a quantity of material that closely approximates the size of the wound. The number of units billed must closely correlate with the wound size. The maximum daily allowable units are 60.
- EpiFix® is limited to five (5) applications per ulcer; the initial application, then additional applications may be applied at a minimum of one (1) week intervals, for up to a maximum of four (4) applications in 12 weeks, when there is evidence of wound healing.

**For North Carolina Only**

Medicaid and the State of North Carolina Health Choice (NCHC) shall not require prior approval for burn treatment injury diagnoses.10

Medicaid and NCHC shall require prior approval for scar revisions. The provider shall obtain prior approval before rendering scar revisions. Refer to clinical coverage policy 1-O-3, Keloid Excision and Scar Revision at [http://dma.ncdhhs.gov/](http://dma.ncdhhs.gov/).10

**CODING**

Covered CPT Codes – No covered codes.

Covered HCPCS Codes

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 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

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 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

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 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; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

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 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; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Apligraf®
Q4101 Apligraf, per sq cm

Dermagraft
Q4106 Dermagraft, per sq cm

TheraSkin®
Q4121 TheraSkin, per sq cm

Integra®
C9363 Skin substitute (Integra Meshed Bilayer Wound Matrix), per sq cm

EpiFix®
Q4131 Grafix Prime and GrafixPL Prime, per sq cm
11000 Debridement of extensive eczematous or infected skin; up to 10% of body surface
11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
11046 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
11047 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Covered ICD-10 Codes
T28.xxx Burn and corrosion of other internal organs
T27.xxx Burn and corrosion of respiratory tract
T20.xxx Burn and corrosion of head, face, and neck
T22.xxx Burn and corrosion of shoulder and upper limb, except wrist and hand

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.
REFERENCES


MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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