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2025 Comprehensive Coding & Billing Guide

PREPARED BY MCRA LLC.

Cortiva® Allograft Dermis

Reimbursement Disclaimer: This information is for educational/informational purposes only and should not be construed as authoritative. The information presented here is current as of January 1st 2025 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 American Medical Association (AMA), relevant medical societies, Centers for Medicare & Medicaid Services (CMS), your local Medicare Administrative Contractor (MAC), and other health plans to which you submit claims. Items and services that are billed to payers 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 payers. The decision as to how to complete a reimbursement form, including the amount to bill, is exclusively the responsibility of the provider.

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Product Overview

Cortiva® Allograft Dermis is a non-crosslinked dermis from donated human tissue processed through the Tutoplast® tissue sterilization process. Tutoplast-processed allograft dermis has been shown to be biocompatible with a low inflammatory response, making it suited for repair, replacement, reconstruction or augmentation of soft tissue.
Cortiva® Allograft Dermis implants, when used in wound care procedures, are regulated as 361 human cell and tissue products (HCT/Ps) as defined in US FDA 21 CFR 1271 and are restricted to homologous use. Homologous use means the repair, reconstruction, replacement, or supplementation of a recipient's cells or tissues with an HCT/P that performs the same basic function or functions in the recipient as in the donor.

2025 Outpatient Coding and Medicare Payment

The following may be appropriate when utilizing the Cortiva® Allograft Dermis. Medicare created HCPCS C codes to differentiate between high and low-cost skin substitutes. Currently, Cortiva® Allograft Dermis is considered a low-cost skin substitute therefore, facilities should report the following codes in their facility claims.

CPT CODE[1]	DESCRIPTION	2025 OUTPATIENT HOSPITAL			2025 ASC	
		APC	SI	Medicare National Avg Payment	PI	Medicare National Avg Payment
C5271	Application of skin substitute graft to trunk, arms, legs, total wound surface up to 100 sq. cm; first 25 sq. cm or less wound surface area	5053	T	$612.13	G2	$328.29
+C5272	each additional 25 sq. cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	-----	N	Bundled	N1	Bundled
C5273	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	5054	T	$1829.23	G2	$981.09
+C5274	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)	-----	N	Bundled	N1	Bundled
C5275	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	5053	T	$612.13	G2	$328.29

+C5276	each additional 25 sq. cm wound surface area, or part thereof (List separately in additional to code for primary procedure)	-----	N	Bundled	N1	Bundled
C5277	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	5053	T	$612.13	G2	$328.29
+C5278	each additional 100 sq. cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part there of (List separately in addition to code for primary procedure)	----	N	Bundled	N1	Bundled
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	5051	Q1	$198.70	IO	----

2025 Physician Coding and Medicare Payment

The following may be appropriate when utilizing the Cortiva® Allograft Dermis. Physician services are billed with the following codes in any setting of care.

CPT CODE[1]	DESCRIPTION	2025 Office Medicare National Avg[6]	2025 Facility Medicare National Avg[6]
15271	App of skin sub to trunk, arms, legs up to 100 sq. cm; 1st 25 sq. cm	$148.47	$81.51
+15272	Each additional 25 sq. cm	$23.61	$16.17
15273	App of skin sub to trunk, arms, legs to >100 sq. cm, 1st 100 sq. cm	$295.00	$187.29
+15274	Each additional 100 sq. cm	$76.98	$42.37
15275	App of skin sub to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, multiple digits up to 100 sq. cm; 1st 25 sq. cm	$153.97	$90.57
+15276	Each additional 25 sq. cm	$31.70	$23.94
15277	App of skin sub to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, multiple digits >100 sq. cm	$329.93	$215.75
+15278	Each additional 25 sq. cm	$91.22	$54.02
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	Carrier Priced	Carrier Priced

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Status and Payment Indicators

Hospital Outpatient Status Indicators	
N	There are Items and Services Packaged into APC Rates Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
T	Procedure or service subject to multiple procedure discounting. Paid under OPPS; separate APC payment.
Q1	STVX-Packaged Codes. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," "V," or "X." (2) In all other circumstances, payment is made through a separate APC payment.
ASC Payment Indicators	
G2	Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
IO	Surgical procedure not on ASC allowable list. Paid under OPPS; Addendum B displays APC assignments when services are separately payable.
N1	Service is not separately payable. Payment is packaged into the payment for another service.

Device Coding and Modifiers

HCPCS	DESCRIPTION
C1889	Implantable/insertable device, not otherwise classified
Q4100	Skin substitute, not otherwise specified
MODIFIERS	**DESCRIPTION**
JC	Skin substitute used as a graft
JD	Skin substitute not used as a graft
JW	Drug amount discarded/not administered to any patient
JZ	Zero drug amount discarded/not administered to any patient

Coding Tips

- CPTs® 15271, 15273, 15275 and 15277 have a medically unlikely unit (MUE) of 1 unit, which means that providers may only bill 1 unit per day.

- Add-on codes 15272, 15274, 15276 and 15278 are billed as 1 unit for each additional amount of graft material as specified; either each additional 25cm2 or 100cm2 applied.
- If reporting a skin substitute product with HCPCS code Q4100 (Skin substitute, not otherwise specified), the product name, package size purchased, amount applied and amount wasted must be reported in the claim narrative/remarks or the claim will be returned to the provider.[i]
- For the purpose of reporting skin substitutes, Q4100 is used to report low-cost skin substitutes. For Medicare, Q4100 should not be reported with 15271-15278.[ii]

2025 Inpatient Coding and Medicare Payment

Inpatient procedures are coded using the ICD-10-PCS coding system. In the inpatient setting, the hospital payment will be determined by the payer using a combination of the ICD-10-CM and ICD-10-PCS codes. Based on these codes submitted, the hospital will be paid one fixed payment based on the assigned Medicare Severity Diagnosis Related Group (MS– DRG). In the inpatient setting, all costs other than physician services are considered part of the facility expenses and would be reported by the facility using the appropriate revenue codes.

ICD-10-PCS codes are comprised of seven characters:

- 1st character is Section.
- 2nd character is Body System.
- 3rd character is Root Operation.
- 4th character is Body Part.
- 5th character is Approach.
- 6th character is Device.
- 7th character is Qualifier.

Below is a guide to help select the appropriate inpatient ICD-10-PCS code(s) that may be applicable. Be sure to select the appropriate root operation (3rd character) depending on the primary objective of the procedure. This guide is not meant to be exhaustive. These ICD-10-PCS codes are valid from October 1, 2024, through September 30, 2025.

ICD-10-PCS Procedure Coding Guide

Use the following guide in selecting the appropriate ICD-10-PCS code(s). There may be more than one PCS code reported if additional root operations are performed.
Note: not all combinations are available with the below listed characters. Validate that the combination selected is available in the PCS coding tables[iii]. The **bolded** numeral or letter represents the character to be selected. There should be a total of 7 characters in the PCS code that is selected.
For example, if the procedure is Replacement of Left Upper Leg Skin with Nonautologous Tissue Substitute, Full Thickness, External Approach, the appropriate PCS code would be 0HRJXK3. This code represents the primary procedure, and any integral procedures performed in addition to the primary procedure are not separately coded.

Section (Character 1)
0 Medical and Surgical
Body System (Character 2)
H Skin and Breast
Root Operation (Character 3)
R Replacement
Body Part (Character 4)
J Skin, Left Upper Leg Or Select other Body Part (not all are listed here)
Approach (Character 5)
X External
Device (Character 6)
K Nonautologus Tissue Substitute
Qualifier (Character 7)
3 Full Thickness **4** Partial Thickness **Z** No Qualifier

2025 MS-DRG Payment

The following possible MS-DRG assignments are provided below along with the 2025 Medicare national payment rates.

MS-DRG[iv]	DRG Description	2025 MEDICARE PAYMENT
570	SKIN DEBRIDEMENT WITH MCC	$21,425.00
571	SKIN DEBRIDEMENT WITH CC	$11,920.00
572	SKIN DEBRIDEMENT WITHOUT CC/MCC	$8,130.00
573	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITH MCC	$43,825.00
574	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITH CC	$24,658.00
575	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITHOUT CC/MCC	$14,209.00
576	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITH MCC	$38,396.00
577	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITH CC	$18,950.00
578	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITHOUT CC/MCC	$12,030.00
579	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH MCC	$23,195.00
580	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH CC	$12,618.00
581	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITHOUT CC/MCC	$10,242.00
622	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH MCC	$26,646.00
623	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH CC	$13,622.00
624	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITHOUT CC/MCC	$7,139.00
628	OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITH MCC	$28,086.00
629	OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITH CC	$16,014.00
904	SKIN GRAFTS FOR INJURIES WITH CC/MCC	$27,478.00
905	SKIN GRAFTS FOR INJURIES WITHOUT CC/MCC	$11,730.00
907	OTHER O.R. PROCEDURES FOR INJURIES WITH MCC	$28,351.00
908	OTHER O.R. PROCEDURES FOR INJURIES WITH CC	$14,355.00
909	OTHER O.R. PROCEDURES FOR INJURIES WITHOUT CC/MCC	$9,026.00

2025 ICD-10-CM Diagnosis Coding

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Cortiva® Allograft Dermis may be used in various applications. Below are some examples of diagnosis codes that may be applicable. This is not meant to be an exhaustive list.

ICD-10-CM CODES	DESCRIPTION
L97.211	Non-Pressure Chronic Ulcer of Right calf limited to breakdown of skin
L97.212	Non-Pressure Chronic Ulcer of Right calf with fat layer exposed
L97.213	Non-Pressure Chronic Ulcer of Right calf with necrosis of muscle
L97.214	Non-Pressure Chronic Ulcer of Right calf with necrosis of bone
L97.221	Non-Pressure Chronic Ulcer of Left calf limited to breakdown of skin
L97.222	Non-Pressure Chronic Ulcer of Left calf with fat layer exposed
L97.223	Non-Pressure Chronic Ulcer of Left calf with necrosis of muscle
L97.224	Non-Pressure Chronic Ulcer of Left calf with necrosis of bone
L97.311	Non-Pressure Chronic Ulcer of Right ankle limited to breakdown of skin
L97.312	Non-Pressure Chronic Ulcer of Right ankle with fat layer exposed
L97.313	Non-Pressure Chronic Ulcer of Right ankle with necrosis of muscle
L97.314	Non-Pressure Chronic Ulcer of Right ankle with necrosis of bone
L97.321	Non-Pressure Chronic Ulcer of Left ankle limited to breakdown of skin
L97.322	Non-Pressure Chronic Ulcer of Left ankle with fat layer exposed
L97.323	Non-Pressure Chronic Ulcer of Left ankle with necrosis of muscle
L97.324	Non-Pressure Chronic Ulcer of Left ankle with necrosis of bone
L97.411	Non-Pressure Chronic Ulcer of Right heel & midfoot limited to breakdown of skin
L97.412	Non-Pressure Chronic Ulcer of Right heel & midfoot with fat layer exposed
L97.413	Non-Pressure Chronic Ulcer of Right heel & midfoot with necrosis of muscle
L97.414	Non-Pressure Chronic Ulcer of Right heel & midfoot with necrosis of bone
L97.421	Non-Pressure Chronic Ulcer of Left heel & midfoot limited to breakdown of skin
L97.422	Non-Pressure Chronic Ulcer of Left heel & midfoot with fat layer exposed
L97.423	Non-Pressure Chronic Ulcer of Left heel & midfoot with necrosis of muscle
L97.424	Non-Pressure Chronic Ulcer of Left heel & midfoot with necrosis of bone
L97.511	Non-Pressure Chronic Ulcer of Other part of right foot limited to breakdown of skin
L97.512	Non-Pressure Chronic Ulcer of Other part of right foot with fat layer exposed
L97.513	Non-Pressure Chronic Ulcer of Other part of right foot with necrosis of muscle
L97.514	Non-Pressure Chronic Ulcer of Other part of right foot with necrosis of bone
L97.521	Non-Pressure Chronic Ulcer of Other part of left foot limited to breakdown of skin
L97.522	Non-Pressure Chronic Ulcer of Other part of left foot with fat layer exposed
L97.523	Non-Pressure Chronic Ulcer of Other part of left foot with necrosis of muscle
C43.60	Malignant melanoma of unspecified upper limb, including shoulder
C43.61	Malignant melanoma of right upper limb, including shoulder
C43.62	Malignant melanoma of left upper limb, including shoulder
C43.70	Malignant melanoma of unspecified lower limb, including hip
C43.71	Malignant melanoma of right lower limb, including hip
C43.72	Malignant melanoma of left lower limb, including hip
C43.8	Malignant melanoma of overlapping sites of skin
C44.601	Unspecified malignant neoplasm of skin of unspecified upper limb, including shoulder
C44.602	Unspecified malignant neoplasm of skin of right upper limb, including shoulder
C44.609	Unspecified malignant neoplasm of skin of left upper limb, including shoulder
D03.60	Melanoma in situ of unspecified upper limb, including shoulder
D03.61	Melanoma in situ of right upper limb, including shoulder

D03.62	Melanoma in situ of left upper limb, including shoulder
D03.70	Melanoma in situ of unspecified lower limb, including hip
D03.71	Melanoma in situ of right lower limb, including hip
D03.72	Melanoma in situ of left lower limb, including hip
D04.60	Carcinoma in situ of skin of unspecified upper limb, including shoulder
D04.61	Carcinoma in situ of skin of right upper limb, including shoulder
D04.62	Carcinoma in situ of skin of left upper limb, including shoulder

Medicare Coverage Determinations (NCD/LCD)

Check with your local Medicare Administrative Contractor (MAC) regarding any relevant National Coverage Determination (NCDs) or Local Coverage Determinations (LCDs). Medicare may cover these products on a case-by-case basis, with evidence of medical necessity. While traditional Medicare does not require or allow prior authorization or prior approval for procedures, Medicare Advantage plans are managed by commercial payers who may require prior authorization for Medicare Advantage patients. Check with your plan administrator for any prior authorization requirements.

Commercial Coverage Determinations

Commercial insurance coverage policies vary, and many require prior authorization for any procedure. We encourage health care professionals to contact payer(s) directly with questions regarding coverage policies or guidelines for Cortiva® Allograft Dermis.

Unlisted Codes Billing Information

How do I submit an unlisted code? To avoid delay in payment, it is best to submit the following at the time of submission of an unlisted code:

1. Claim

On the claim form (CMS 1500), include the unlisted code and an appropriate charge amount. The character limit for box 19 is 80. For example, "XXXXT, comparable to XXXXX, payment of $XXX.XX expected." Note: Medicare does not accept any abbreviations or acronyms in box 19 and will reject the claim until an appropriate entry is submitted.

2. Cover Letter

A cover letter summarizing the procedure that was performed, comparable procedures and pricing information, and any clinical evidence supporting the efficacy of the procedure. Reference or attach any supporting published articles or clinical information.

3. Supporting Documentation

Supporting documentation should include:

- A clear description of the nature, extent, and medical necessity for the procedure.
- A detailed description of comparable CPT/HCPCS procedure code(s) you've identified and their associated RVUs and/or payments and an explanation of how they are similar to the unlisted code. The comparable procedure(s) should be as similar as possible to the unlisted procedure. It can be similar in technique, approach, time, equipment and/or effort required by provider.
- A description of any procedures performed at the same time
- Any extenuating circumstances which may have complicated the service or procedure

- Time, effort, and equipment necessary to provide the service
- The number of times the service was provided.

How is payment determined for an Unlisted code?

Payers will manually review any supporting documentation and any comparable codes or expected pricing submitted by the provider. They will use this information to determine an appropriate payment.

Under the OPPS, CMS generally assigns the unlisted service or procedure codes to the lowest level APC within the most appropriate clinically related series of APCs. Payment for items reported with unlisted codes is often packaged. [v]

For non-OPPS payment purposes, when an unlisted service or procedure code is reported, a report describing the service or procedure shall be submitted with the claim. Pertinent information includes a definition or description of the nature, extent, and need for the procedure or service, as well as the provider's time, effort, and equipment necessary to provide the service. [vi]

Additional Tips

Create Template Letters – For commonly performed unlisted procedures, create letter templates and/or electronic medical record documentation templates (i.e., dot phrases for operative notes) that are easily customizable to each patient. Make sure to have any supporting clinical evidence readily available as well. It is important that the author enters specific information related to the patient's care.

Special Billing Instructions – Contact the payer prior to submission to determine any specific instructions needed to submit an unlisted code. Do they accept electronic claims? How would they like the provider to attach supporting documentation or chart notes?

Prior Authorization - Obtain prior authorization, when possible. Use the example letter below to provide detailed information to the payer regarding the procedure and why an unlisted is needed. Request the appropriate billing instructions from the payer (i.e., whether electronic submission is acceptable, etc.). Generally, Medicare does not require pre-authorization.

Appeal – Be prepared with an appeal letter (similar to the cover letter), if necessary, describing why this service should be paid. Again, this letter must contain specific information related to the patient's care.

Multiple Unlisted Codes – CPT descriptions will specify how many units are included in the procedure, so follow the code descriptions just as you would for a Category I code regarding how many units to bill.

Modifiers - Modifiers are not necessary for unlisted codes because these codes do not describe specific procedures. Instead, when reporting an unlisted code to describe a procedure or service, it is necessary to submit supporting documentation (e.g., a procedure report) along with the claim to provide an adequate description of the nature, extent, and need for the procedure, as well as the time, effort, and equipment necessary to provide the service as previously described.

ABN – It may be appropriate to have providers collect an Advance Beneficiary Notice (ABN), or

another financial waiver, from patients, and/or to collect a pre-payment if payment is denied.

Sample Cover/Appeal Letter

(Date)

Attn: (Contact Name)
(Title)
(Insurance Company Name)
(Address)

Re: (Patient's Name)
Date of Birth:
Dates of Service:
Group Number:
Subscriber/Policy Number:

Dear (Contact Name):
On (date of service), I performed a (name of procedure) on the above-mentioned patient. (Patient's Name) was diagnosed with (diagnosis). This patient also has (any associated symptoms or co-morbidities). [If applicable, include additional information such as alternative treatments that have failed and what health problems may have occurred if the patient did not undergo the procedure. Describe anticipated outcomes and/or the medical benefits of the treatment.]

This procedure has been assigned an unlisted CPT code - (insert CPT code and descriptor). This procedure may be reasonably compared to the existing CPT code (code number and description), and its associated charge of $_____.
In terms of physician work and practice expense, the submitted unlisted code is (comparable or ___% more/less difficult) for the reasons mentioned in my attached chart notes. Therefore, I have submitted a charge of $_____ for this procedure and expect payment of $_____.

Attached, please find a detailed copy of my chart notes (which includes an explanation of the unlisted code procedure) and claim form. Also, the following clinical evidence is attached supporting the efficacy of this procedure:
(List/summarize clinical evidence available)
Sincerely,

(Physician's Signature)

Cortiva® Allograft Dermis is processed by:

RTI Surgical, Inc.
11621 Research Circle
Alachua, FL 32615

[1] CPT® is a registered trademark of the American Medical Association (AMA). Copyright 2025 AMA. All CPT codes are owned and licensed by the American Medical Association.
[2] 2025 Medicare Outpatient Hospital Fee Schedule: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc
[3] 2025 Medicare ASC Payment: https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc

4 Medicare NCCI Add-on Code Edits: https://www.cms.gov/ncci-medicare/medicare-ncci-add-code-edits
5 CMS Manual System: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r1657cp.pdf
6 2025 Medicare Physician Fee Schedule: https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f

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[i] https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=59226&ver=4
[ii] https://www.cms.gov/files/document/r11164CP.pdf

iv 2025 Medicare IPPS Fee Schedule: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page
[v] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r1657cp.pdf
[vi] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r1657cp.pdf