



# artacent<sup>®</sup>

## WOUND

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### 2022 reimbursement guide

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available for download at <https://www.tidesmedical.com/guide>

#### REIMBURSEMENT SERVICES CONTACT:

📞 800-318-9419

📠 337-205-3599

✉ [reimbursement@tidesmedical.com](mailto:reimbursement@tidesmedical.com)

**tidesmedical<sup>®</sup>**

888-494-4441

[www.tidesmedical.com](http://www.tidesmedical.com)



we're here if you need us.

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## taking your business personally.

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**KEVIN KABOOS**  
VP of Reimbursement

At Tides Medical, we sell advanced biologic products like Artacent Wound to help revolutionize access to the power of birth tissue technology. But at the end of the day, we are really in the business of helping people like you. Your business centers around patient care – and it should. With our advanced products and expert service, your patients can get the care they deserve.

As your dedicated Reimbursement Team, we are here to take the complex burden of reimbursement off your shoulders so that you can concentrate on what matters most – your patients. Our team is committed to working with yours to deliver patient-first, over-the-top service. This is at the core of what we do, every single day. **At Tides, helping you with reimbursement is a responsibility we take personally.**

## diagnosis codes (ICD-10 CODES)

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1.

- Artacent Wound® is a human tissue product for transplantation. It is processed and distributed in accordance with FDA requirements for Human Cellular and Tissue-based Products (HCT/P) (21 CFR Part 1271), State regulations, and the guidelines of the American Association of Tissue Banks (AATB). Caution: Federal Law restricts this product to sale by or on the order of a licensed medical professional, not for veterinary use.
- Artacent Wound is a wound covering for patients with various types of wounds including, but not limited to, diabetic ulcers, pressure ulcers, venous stasis ulcers, burns and Mohs surgery.
- We recommend reviewing your Local Coverage Determination (LCD) for approved uses.

# product code (HCPCS CODE)

2.

HCPCS CODE	Q4169
DESCRIPTION	Artacent Wound®, Per square centimeter
MEDICARE PAYMENT RATE	Priced by contractor

- HCPCS codes not listed on the Medicare Part B ASP file are priced individually by Medicare Administrative Contractor (MAC). Contractors may use Wholesale Acquisition Cost® (WAC) +6% or the invoice cost¹.
- For information specific to your MAC, please contact the Tides Medical Reimbursement Hotline, 800-318-9419.

Size	Area	Billing Units
15 mm	1.77 cm²	2
2x2 cm	4.00 cm²	4
4x4 cm	16.00 cm²	16
4x8 cm	32.00 cm²	32

## MAC REGION PRICING

Invoice Cost

Noridian Healthcare Solutions

CGS Medicare

NGS Medicare

WAC +6%

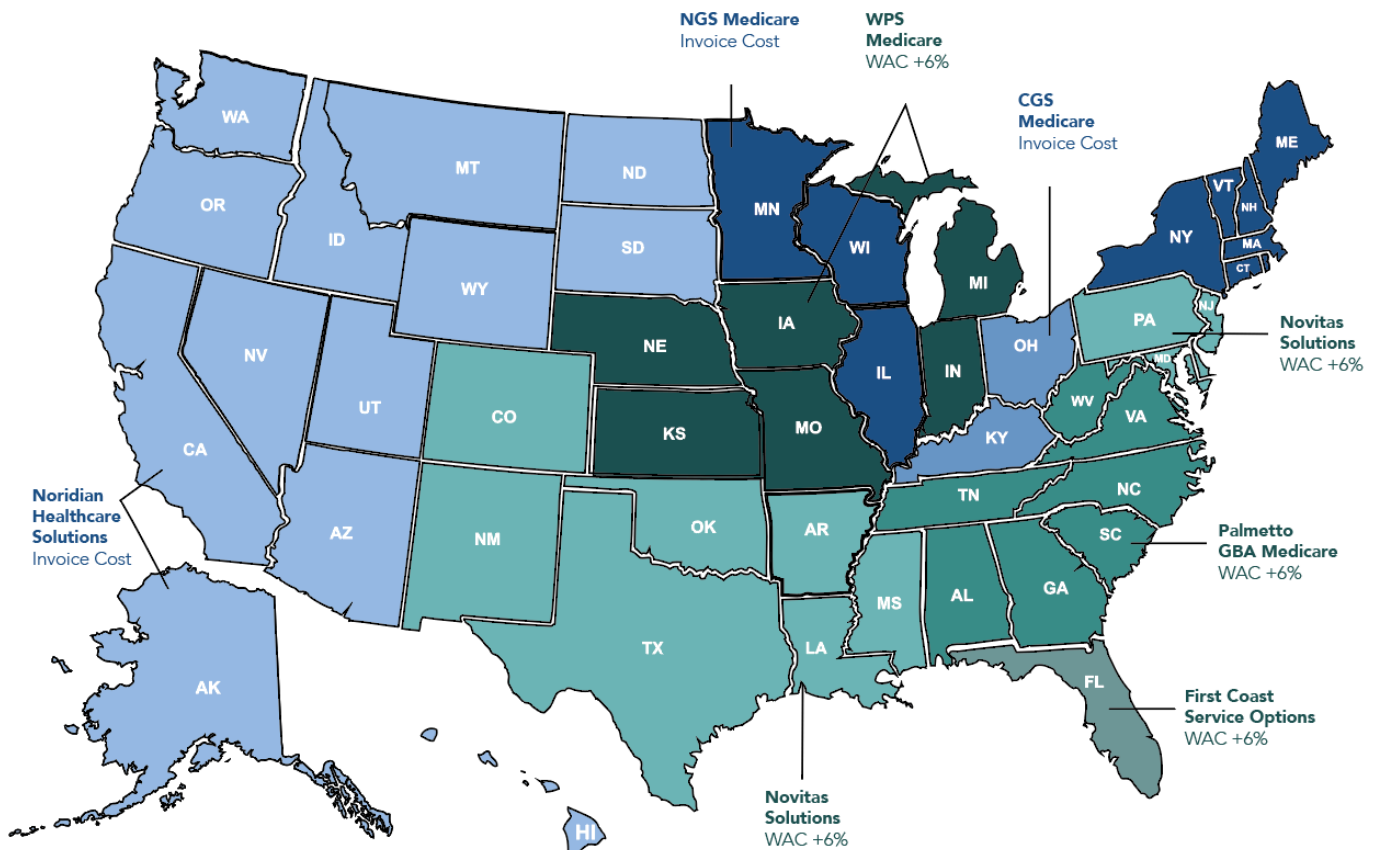
Novitas Solutions

WPS Medicare

Palmetto GBA Medicare

First Coast Service Options

ALLOWABLE RATE FOR MEDICARE in the WAC +6% MACs: \$418.70 per unit



## site preparation codes

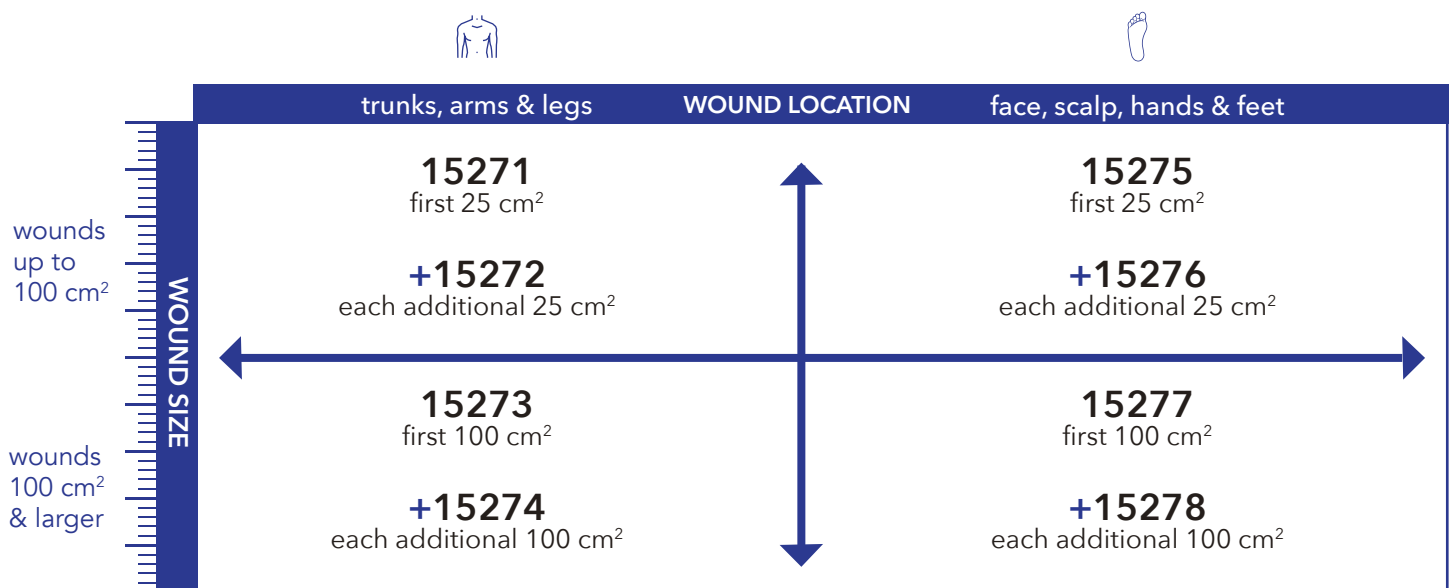
3.

Code	Description
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
+15003	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)
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
+15005	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)

- The surgical site preparation codes may not be reimbursed in the physician office; payer guidelines vary.
- Code may only be billed once per wound and the documentation should reflect medical necessity.
- If billed on the same day as the Artacent Wound® application, the application codes are subject to the multiple procedure reduction rule.
- For additional details on the utilization of the surgical site preparation codes please contact the payer directly.

## application codes

4.



see page 7 for a more detailed description of application codes



# application codes

## 4.

CPT® <sup>1</sup> Code	CPT® Description	Medicare National Average Payment 2022 Non-Facility (Office)	Medicare National Average Payment 2022 Facility
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	\$152.27	\$77.52
+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)	\$23.53	\$15.57
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	\$305.23	\$178.91
+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)	\$80.63	\$40.14
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	\$157.46	\$87.90
+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)	\$30.80	\$23.19
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	\$334.30	\$204.18
+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.)	\$93.44	\$50.87

[illegible]

1. Verify the size of Artacent Wound® applied and bill the appropriate number of units. Artacent Wound is considered a single use product; always bill for the entire piece.
2. Understand the CPT® code descriptors: look at total surface area and anatomical location.
3. Review add-on CPT® codes for larger wounds (between 25-100 cm<sup>2</sup>).
4. Verify your billed charge for Artacent Wound. Review applicable allowables and your cost. Determine your charge using the methodology you use for other products/services.
5. The Tides Reimbursement Hotline is available to answer any questions you may have when billing for Artacent Wound.

## REIMBURSEMENT SERVICES:

 800-318-9419

 337-205-3599

✉ [reimbursement@tidesmedical.com](mailto:reimbursement@tidesmedical.com)





The following guidelines are suggested based on general documentation practices. For specific information please reference your Local Coverage Determination (LCD).

- notes

[illegible]

## claims form cgs, ngs

6a.

## SAMPLE CMS 1500 CLAIM FORM FOR ARTACENT WOUND FOR CGS AND NGS ONLY

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jones, John J.		3. PATIENT'S BIRTH DATE MM DD YY 09 19 1931 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1234 Any Street		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY Anywhere		CITY	
STATE LA		STATE	
ZIP CODE 99999		ZIP CODE	
TELEPHONE (Include Area Code) (999)999-9999		TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned business representative.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned business representative.	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR FIRST DATE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. E11.621		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
2. _____		23. PRIOR AUTHORIZATION NUMBER XXXXX	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
07 01 20 07 01 20 11 Q4169 1 xxx xx 4			
07 01 20 07 01 20 11 15275 RT 1 xxx xx 1			
31. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR (I certify that the statements apply to this bill and are made in good faith.)			

**Field 21**

Enter appropriate ICD-10 diagnosis code(s)

**Field 19**

Enter appropriate invoice information

**Field 24F**

Enter appropriate charges for each line item

**Field 23**

Enter if prior authorization is required

**Field 24B**

Enter appropriate code indicating where service was provided.

**Field 24D**

Enter applicable HCPCS/CPT® codes and modifiers. Check directly with the payer to determine specific modifier requirements.

**Field 24E**

Enter diagnosis code(s) corresponding with code(s) in Field 21.

**Field 24G**

Enter appropriate number of units for each service provided. Artacent Wound is billed per sq. cm. (this is an example, sizes vary)

15 mm = 2 units  
2x2 cm = 4 units  
4x4 cm = 16 units  
4x8 cm = 32 units

For internal use only.

# claims form FIRST COAST, NOVITAS, PALMETTO, WPS

6b.

SAMPLE CMS 1500 CLAIM FORM FOR ARTACENT WOUND FOR FIRST COAST, NOVITAS, PALMETTO &amp; WPS ONLY

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jones, John J.		3. PATIENT'S BIRTH DATE MM DD YY 09 19 1931 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1234 Any Street		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY Anywhere		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
STATE LA		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
ZIP CODE 99999		TELEPHONE (Include Area Code) (999) 999-9999	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. E11.621		22. MEDICAID RESUBMISSION CODE XXXXX	
23. PRIOR AUTHORIZATION NUMBER XXXXX		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	
B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
E. DIAGNOSIS POINTER		F. \$ CHARGES	
G. DAYS OR UNITS		H. EPSDT Family Plan	
I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
07 01 20 07 01 20 11		Q4169 1 xxx xx 4	
07 01 20 07 01 20 11		15275 RT 1 xxx xx 1	
31. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR (I certify that the statements apply to this bill and are made in good faith)		32. SIGNATURE OF AUTHORIZED PERSON	

**Field 21**

Enter appropriate ICD-10 diagnosis code(s)

**Field 24F**

Enter appropriate charges for each line item

**Field 23**

Enter if prior authorization is required

**Field 24B**

Enter appropriate code indicating where service was provided.

**Field 24D**

Enter applicable HCPCS/CPT® codes and modifiers. Check directly with the payer to determine specific modifier requirements.

**Field 24E**

Enter diagnosis code(s) corresponding with code(s) in Field 21.

**Field 24G**

Enter appropriate number of units for each service provided. Artacent Wound is billed per sq. cm. (this is an example, sizes vary)

15 mm = 2 units  
2x2 cm = 4 units  
4x4 cm = 16 units  
4x8 cm = 32 units

For internal use only.



# patient intake form

7.

The patient intake form should be filled out in its entirety and faxed to 337-205-3599. Once received, the Hotline team will complete the benefits investigation and return results to your office within 24-48 hours. Case managers are available Monday-Friday from 9:00am - 5:00pm CST to answer questions.

This form is available on the Tides Medical website at [www.tidesmedical.com/intake](http://www.tidesmedical.com/intake)

<b>tidesmedical<sup>®</sup> Digital Patient Intake Form</b>			<b>Hotline Contact Info</b> Phone: 1-800-318-9419 E-fax: 337-205-3599	
Rep Name: _____			Rep Email: _____	
<b>PROVIDER INFORMATION</b>				
Provider Name		Provider NPI		
Practice Name		Practice NPI	Practice Tax ID	
Address, City, State Zip				
Office Contact Name		Phone	Fax	
Office Contact Email			Preferred Contact Method <input type="checkbox"/> Fax <input type="checkbox"/> Email	
<b>TREATING FACILITY (IF DIFFERENT FROM ABOVE)</b>				
Facility Name				
Phone	Fax	NPI	Tax ID	
Address, City, State Zip				
<b>PATIENT INFORMATION (*NAME AND DOB REQUIRED)</b>				
Patient Name*		Phone	Date of Birth*	
Address, City, State Zip				
<b>INSURANCE INFORMATION (PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE CARDS)</b>				
Primary Insurance		Member ID	Phone	
Secondary Insurance		Member ID	Phone	
<b>ARTACENT WOUND TREATMENT INFORMATION</b>				
	Diagnosis Codes *REQUIRED	Wound Size (sq cm)	Graft Application	
Wound 1			<input type="checkbox"/> 15271: Application of graft to trunk, arms, legs, total wound surface area up to 100cm <sup>2</sup> ; First 25cm <sup>2</sup> wound surface area or less	
Wound 2			<input type="checkbox"/> 15273: Application of graft to trunk, arms, legs, total wound surface area greater than or equal to 100cm <sup>2</sup> ; First 100cm <sup>2</sup> wound surface area	
Wound 3			<input type="checkbox"/> 15275: Application of graft to face, scalp, feet, etc. total wound surface area up to 100cm <sup>2</sup> ; First 25cm <sup>2</sup> wound surface area or less	
Place of Service *REQUIRED			<input type="checkbox"/> 15277: Application of graft to face, scalp, feet, etc. total wound surface area greater than or equal to 100cm <sup>2</sup> ; First 100cm <sup>2</sup> wound surface area	
<input type="radio"/> Physician Office <input type="radio"/> Patient Home <input type="radio"/> Hospital Outpatient (HOPD)			<input type="radio"/> Assisted Living <input type="radio"/> Surgery Center <input type="radio"/> Nursing Facility <input type="radio"/> Other: _____	
<b>HIPAA AUTHORIZATION</b>				
By submitting this form you certify that you have received the necessary patient consent to release the medical and/or other patient information referenced on this form to Tides Medical for the purpose of using and re-disclosing this information, as necessary, for insurance verification, prior authorization, and/or claims support.				
The Tides Medical <sup>®</sup> Hotline is an information service program. Reimbursement and coverage results are based on the information provided to Tides Medical <sup>®</sup> from the third party payer. Coverage and reimbursement are subject to change at any time. The Hotline results are not a guarantee of coverage and payment now or in the future.				
Fax this form to Reimbursement Services: 337-205-3599				

## meet our reimbursement support team: reimbursement that's right for you.

### HOTLINE REIMBURSEMENT TEAM:

Have a question about proper coding? Need help with benefit verification or billing issues for Artacent Wound®? Just give us a call! Our in-house team of reimbursement professionals is available Monday through Friday, 9:00 am to 5:00 pm CST, to help resolve common reimbursement and billing issues.

### FIELD REIMBURSEMENT MANAGERS:

Depending on where your office is, you may need specialized assistance in navigating regional MAC reimbursement procedures and requirements. That's why Tides employs dedicated Field Reimbursement Managers (FRM) who are well-versed in regional standards and work directly with clinicians and their staff to tackle any reimbursement challenge.



## the small print.

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The reimbursement information provided is for informational purposes only. Coding and coverage should always be confirmed directly with the payer. Information provided in this guide was gathered from outside sources and does not represent a guarantee of coverage or payment now or in the future. Coding should always accurately reflect the services provided.

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<sup>1</sup> Medicare Claims Processing Manual, Chapter 17 Drugs and Biologicals, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>

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<sup>1</sup> CPT 2019 Professional Edition, 2019, American Medical Association and CMS 2019 PFS Final Rule, [www.cms.gov](http://www.cms.gov)

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<sup>1</sup> Medicare Claims Processing Manual, Chapter 17 Drugs and Biologicals, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>

#### PAGE 9

<sup>1</sup> Medicare Claims Processing Manual, Chapter 17 Drugs and Biologicals, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>

#### PAGE 13

<sup>1</sup> Medicare Claims Processing Manual, Chapter 17 Drugs and Biologicals, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>





we're here if you need us.

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**REIMBURSEMENT  
SUPPORT SERVICES**

**supporting you,**  
so you can focus  
on what you  
do best.

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**CONTACT A REIMBURSEMENT SPECIALIST FOR HELP TODAY**

📞 800-318-9419

📠 337-205-3599

✉ [reimbursement@tidesmedical.com](mailto:reimbursement@tidesmedical.com)

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[www.tidesmedical.com](http://www.tidesmedical.com) | 888-494-4441 | 1819 w. pinhook road, suite 206 lafayette, la 70508