

tidesmedical[®]

2024 reimbursement guide



CONTACT:

📞 888-494-4441 📠 337-205-3599

✉ reimbursement@tidesmedical.com

🌐 www.tidesmedical.com

advanced products.
expert service.

taking your business personally.



JOE SPELL
CEO

At Tides Medical, we sell advanced biologic products 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.

REIMBURSEMENT TEAM:

Have a question about proper coding? Need help with benefit verification or billing issues for Tides products? 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:

Our Field Reimbursement Managers (FRM) are well versed in Medicare claim requirements. They work directly with clinicians and their staff in providing LCD guidance and support during the claims and billing process. Should you have questions or need reimbursement assistance, call our reimbursement team to get connected with your regional FRM.

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table of contents

1. Product Guidance	4
2. Coverage	5
3. Site Preparation Codes	6
4. Application Codes	6-7
5. Documentation for the Medical Record	8-9
6. Benefits Verification Form	10
7. Sample Claim Form	11

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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.

PAGE 7 ¹ CPT 2024 Professional Edition, 2024 American Medical Association and CMS 2024 PFS Final Rule, www.cms.gov

PAGE 10 ¹ Medicare Claims Processing Manual, Chapter 17 Drugs and Biologicals, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>

product guidance

1.



Diagnosis Codes (ICD-10)

- Artacent AC is a graft for patients with various types of wounds including, but not limited to, diabetic ulcers, pressure ulcers, venous stasis ulcers, burns and Mohs surgery.
- Providers should select the ICD-10 code that most accurately reflects the patient's condition.

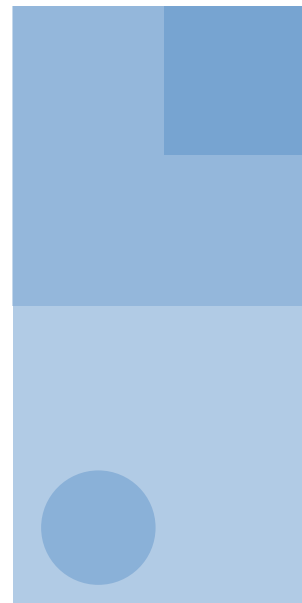
HCPCS Code	Q4190
Description	Artacent AC per square centimeter
Medicare Payment Rate	MCR PT B ASP Methodology

- Product HCPCS are listed on the CMS Medicare Part B Drug and Biological ASP File

<https://www.cms.gov/medicare/medicare-fee-for-service-part-b-drugs/mcrpartbdrugavgsalesprice>

Sizes & Billing Units

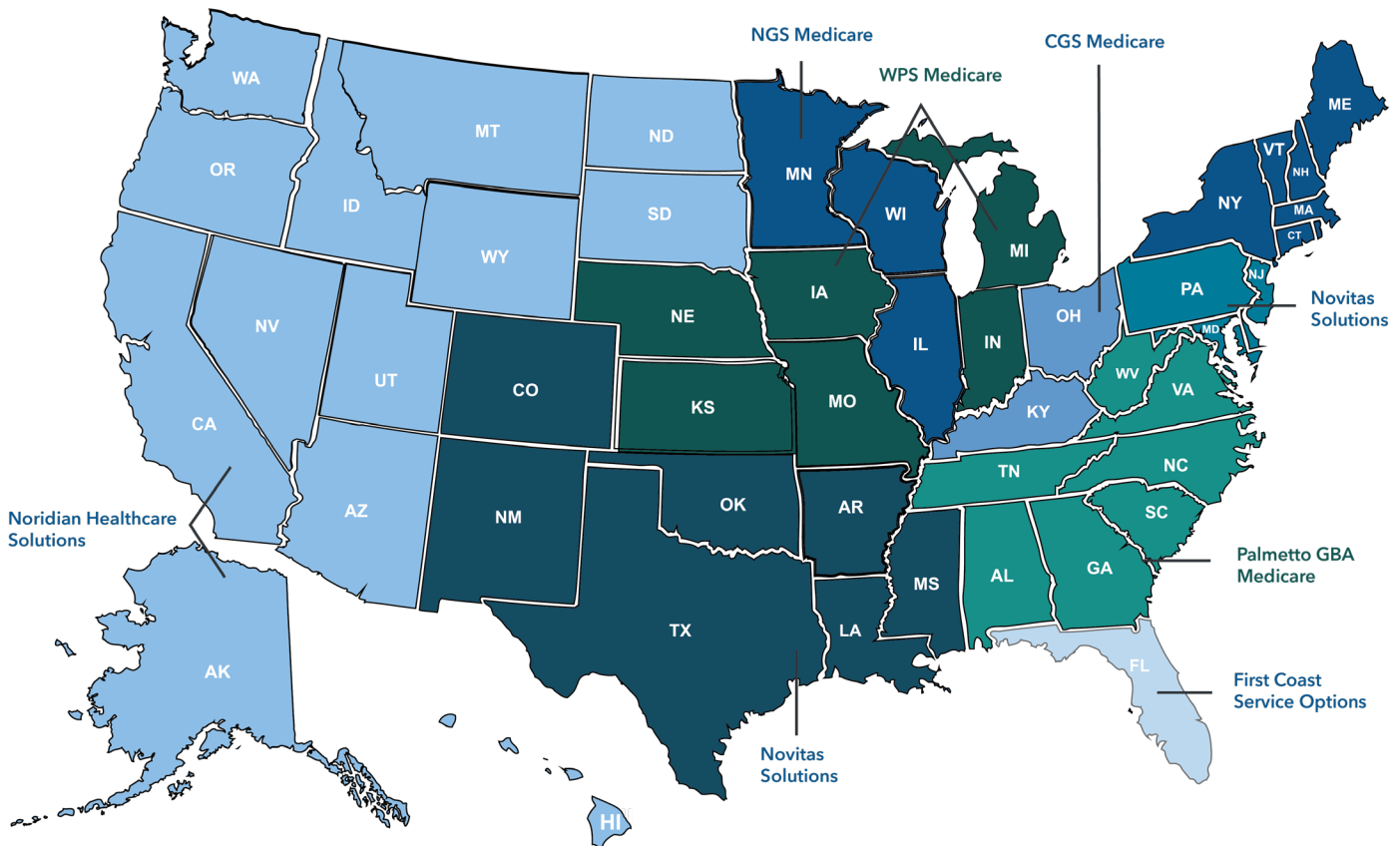
Size	AC Part #	Area	Billing Units
15 mm	ACA0015	1.77 cm ²	2
2x2 cm	ACA0202	4.00 cm ²	4
4x4 cm	ACA0404	16.00 cm ²	16
4x8 cm	ACA0408	32.00 cm ²	32



coverage for skin substitutes

2.

- **Based on medical necessity: Noridian, NGS, WPS and Palmetto** do not have an active Local Coverage Determination (LCD) for Skin Substitutes. Coverage is based on medical necessity. All guidelines in the product's instructions for use must be followed. Coverage cannot be guaranteed and is ultimately determined by the payer.
- **LCD: Novitas Solutions (L35041), CGS (L36690), First Coast (L36377)** have active Local Coverage Determinations (LCD) for Skin Substitutes. The LCD should be reviewed for all coverage requirements including covered indications, documentation requirements and limitations. Please see the LCD numbers referenced above.
- **MUE (Medically Unlikely Edits):** Medicare covers up to 128 units per application of Artacent AC.
- We recommend reviewing your Local Coverage Determination (LCD) for approved uses.



site preparation codes

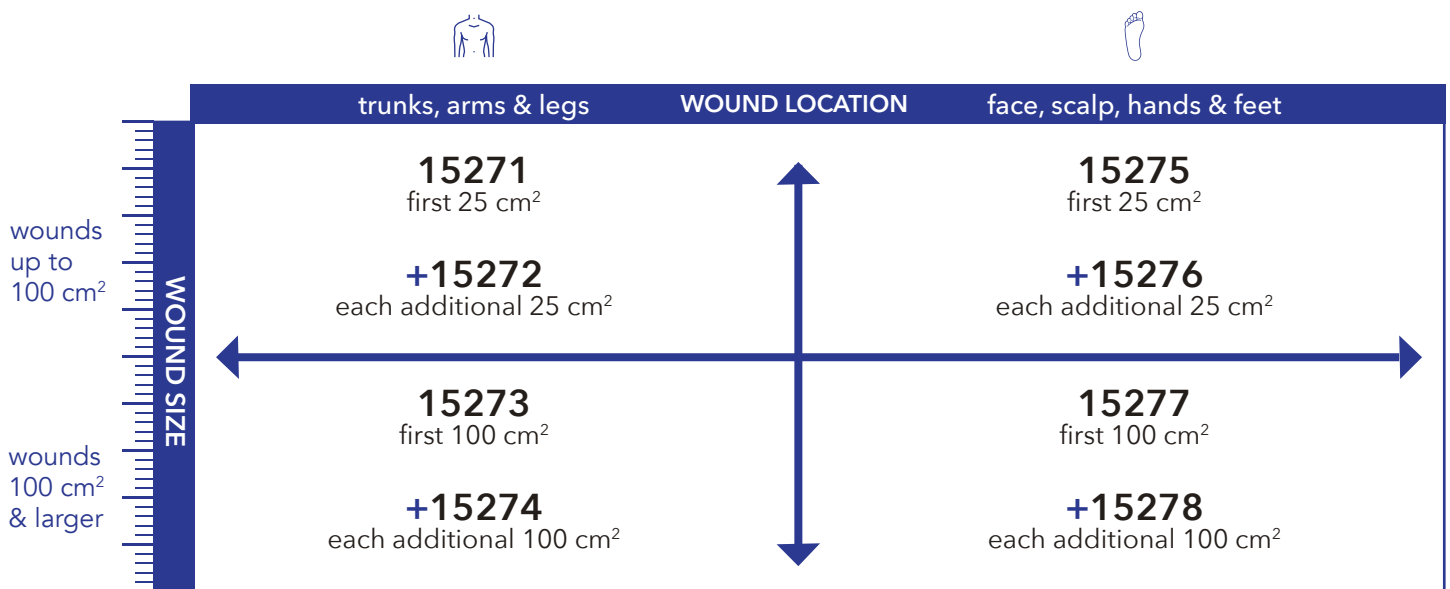
3.

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 product 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®1 Code	CPT® Description	Medicare National Average Payment 2024 Non-Facility (Office)	Medicare National Average Payment 2024 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	\$151.61	\$81.86
+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)	\$24.23	\$16.37
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	\$303.21	\$189.92
+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)	\$79.57	\$43.22
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	\$156.19	\$90.70
+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)	\$31.76	\$24.23
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	\$334.65	\$216.44
+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.)	\$92.99	\$54.03

documentation for the medical record

5.

GENERAL DOCUMENTATION ELEMENTS

- Every page** of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]).
- The documentation includes the legible **signature** of the physician or non-physician practitioner responsible for and providing the care to the patient.
- The medical record supports the use of the selected **ICD-10-CM code(s)**.
- The submitted **CPT/HCPCS code** must describe the service performed.

STANDARD OF CARE TREATMENT INCLUDES, BUT IS NOT LIMITED TO:

- Comprehensive patient assessment
- History, exam
- Ankle-brachial index (ABI) and any other vascular test performed
- Diagnostic tests as indicated
- Implemented treatment plan

ULCER DESCRIPTION (each ulcer at baseline and every encounter)

- Size
- Location
- Stage
- Duration
- Presence of infection
- Standard of care treatment given
- Response of the ulcer to treatment documented in the medical record at least every 30 days
- Reason(s) for any repeat application specifically addressed

DOCUMENTATION OF SKIN REPLACEMENT SURGERY

- Assessment outlining the plan for skin replacement surgery and the choice of skin substitute graft/CTP for the 12-week period as well as any anticipated repeat applications within the 12-week period
- An operative note that supports the application of the skin substitute graft procedure for each relevant date of service and that includes:
 - Date, time, and location of ulcer(s) treated
 - Reason for the procedure
 - Complete description of the procedure including skin substitute/CTP and package size used (with identifying package label in the chart)
 - Relevant findings

PRODUCT WASTE DOCUMENTATION

- Date & Time
- Location of the ulcer
- Approximate amount of product unit used
- Approximate amount of product unit discarded
 - Use **Modifier JW** for the skin substitute that was not applied to wound, wastage
 - Use **Modier JZ** if zero drug amount was discarded
- Reason for the wastage (including the reason for using a package size larger than was necessary for the size of the ulcer, if applicable)
- Manufacturer's serial/lot/batch or other unit identification number of graft/CTP material

documentation for the medical record

5.

Reason CTP is Medically Necessary

DOCUMENTATION FOR **DFU**

- Presence of a chronic, non-infected DFU having failed to respond to documented standard of care of treatment for 30 days with documented compliance to prescribed treatment
- Failure to respond to standard care of treatment - defined as an ulcer that has increased in size or depth by at least 40%, or no change in baseline size or depth, or no sign of improvement or indication that improvement is likely (such as granulation, epithelization, or progress towards closing)
- Measurements:**
 - Initial ulcer
 - Immediately prior to placement of skin substitute graft
 - At the completion of at least 30 days

- Assessment of Type 1 vs. Type 2 diabetes
- Management history with attention to certain comorbidities (e.g. vascular disease, neuropathy, osteomyelitis)
- Review of current blood glucose levels/ hemoglobin A1c (HbA1c)
- Diet and nutrition status
- Activity level
- Physical exam that includes assessment of skin and ulcer, ABI, and check of off-loading device or assessment of footwear

Implemented Treatments

- Debridement as appropriate
- Form of offloading
- Infection control
- Management of exudate - maintenance of a moist environment (moist saline gauze, other classic dressing, bioactive dressing, etc.)
- Smoking history, and that the patient received counseling on the effect of smoking on surgical outcomes and treatment for smoking cessation (if applicable) as well as outcome of counselling (if applicable)

DOCUMENTATION FOR **VLU**

- Presence of a chronic, non-infected VLU having failed to respond to documented standard of care of treatment for 30 days with documented compliance to prescribed treatment
- Failure to respond to standard care of treatment - defined as an ulcer that has increased in size or depth by at least 40%, or no change in baseline size or depth, or no sign of improvement or indication that improvement is likely (such as granulation, epithelization, or progress towards closing)
- Measurements:**
 - Initial ulcer
 - Immediately prior to placement of skin substitute graft
 - At the completion of at least 30 days

- Assessment of clinical history (prior ulcers, thrombosis risks)
- Physical exam (edema, skin changes)
- ABI
- Diagnostic testing to verify superficial or deep venous reflux, perforator incompetence, and chronic (or acute) venous thrombosis present

- Debridement as appropriate
- Form of compression
- Infection control
- Management of exudate - maintenance of a moist environment (moist saline gauze, other classic dressing, bioactive dressing, etc.)
- Smoking history, and that the patient received counseling on the effect of smoking on surgical outcomes and treatment for smoking cessation (if applicable) as well as outcome of counselling (if applicable)

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

benefits verification form

6.

In **myportal**, access the Benefits Verification Form to digitally submit with ease. Once received, our reimbursement team will complete the benefits investigation and notify you of results in 24-48 hours. Case managers are available Monday-Friday from 9:00 am-5:00 pm CT to answer questions.

To download a faxable copy, visit www.tidesmedical.com/intake.

Find this form on **myportal** for easier submissions!

tidesmedical® Benefits Verification Form

Agent Name: _____ Agent Email: _____

TYPE OF INSURANCE VERIFICATION REQUESTED

New patient New wound Re-verification New insurance Additional applications Different product

PATIENT & INSURANCE INFORMATION (*NAME AND DOB REQUIRED) List the patient's name on this form when attaching a face sheet.

Patient Name*		Date of Birth	
Address	City	State	ZIP
Is the patient currently residing in a skilled nursing facility and receiving Part A benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Insurance	Member ID	Phone	
Secondary Insurance	Member ID	Phone	

PROVIDER & FACILITY INFORMATION

Provider Name*		Provider Tax ID	
Provider NPI	PTAN#		
Facility Name			
Address	City	State	ZIP
Facility NPI	Facility Tax ID	Facility PTAN#	
Phone	Fax	Preferred Contact Method <input type="checkbox"/> Fax <input type="checkbox"/> Email	
Facility Contact Name	Phone	<input type="checkbox"/> Portal	
Email Address	Fax		

PRODUCT & TREATMENT INFORMATION

Product *REQUIRED: Artacent AC* Biovance* Helicoll* MLG Complete™

Anticipated Application Date _____ Number of Anticipated Applications _____

	Diagnosis Codes *REQUIRED	Wound Size (sq cm)	Has this wound received a skin substitute in the last 12 months?
Wound 1			<input type="checkbox"/> Yes <input type="checkbox"/> No
Wound 2			<input type="checkbox"/> Yes <input type="checkbox"/> No

For additional wounds, please submit another intake.

Place of Service *REQUIRED

<input type="checkbox"/> Physician Office (POS 11)	<input type="checkbox"/> HOPD/CAH (POS 22)	<input type="checkbox"/> Surgery Center (POS 24)
<input type="checkbox"/> Patient Home (POS 12)	<input type="checkbox"/> Assisted Living (POS 13)	<input type="checkbox"/> Nursing Facility (POS 32)

*Please submit this form along with a copy of the patient's insurance card (front/back) and any supporting clinical notes.
Note: Prior use of skin substitutes or global periods related to the same wound may impact reimbursement.*

HIPAA AUTHORIZATION

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.

Reimbursement and coverage results are based on the information provided to Tides Medical® from the third party payer. Coverage and reimbursement are subject to change at any time. Benefits Verification results from the Tides Medical information service program are not a guarantee of coverage and payment now or in the future.

Fax this form to Reimbursement Services: 337-205-3599

Incomplete forms may lead to processing delays

MKT-020, Rev. 08

Reimbursement Info

888-494-4441

337-205-3599

Don't forget to select the correct product.

When submitting an intake for non Artacent products, refer to the product specific reimbursement guides available through your sales agent or FRM.

10

sample claim form

SAMPLE CMS 1500 CLAIM FORM FOR TIDES PRODUCTS

b. OTHER INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME			
INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I, THE SIGNER, AS THE INSURED'S OR AUTHORIZED PERSON'S SIGNATURE, I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment of benefits.									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services rendered to the insured.									

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY MM DD YY		17. NAME OF REFERRING PROVIDER		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		FROM TO		\$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS 1. E11 261		24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
		07 01 20 07 01 20 11		Q4190 JZ				1 xxx xx xx 4	
		07 01 20 07 01 20 11		15275 RT				1 xxx xx xx 1	

25. FEDERAL TAX I.D. NUMBER		31. SIGNATURE OF PHYSICIAN OR OTHER PROVIDER INCLUDING DEGREES OR CERTIFICATIONS (I certify that the statements on this form apply to this bill and are made a true and correct copy of the original.)		29. AMOUNT BILLED \$		30. PROVIDER INFO & PH #	
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For internal use only.

Field 21
Enter appropriate ICD-10 diagnosis code(s)

Field 24D
Enter applicable HCPCS/CPT® codes and modifiers. Check directly with the payer to determine specific modifier requirements.

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.

Modifier Codes
Enter JW (Discarded, not administered), or enter JZ (Zero wasted)

Field 24E
Enter diagnosis code(s) corresponding with code(s) in Field 21.

Field 24G
Enter appropriate number of units for each service provided. Product is billed per sq. cm. See Coverage map and size for correct billing units (this is an example, sizes vary).
15 mm = 2 units
2x2 cm = 4 units
4x4 cm = 16 units
4x8 cm = 32 units
7x7 cm = 36 units

helpful billing tips to remember:

Verify the size of products applied and bill the appropriate number of units. Tides products are considered single use products; always bill for the entire piece.

Understand the CPT® code descriptors: look at total surface area and anatomical location.
Review add-on CPT® codes for larger wounds.

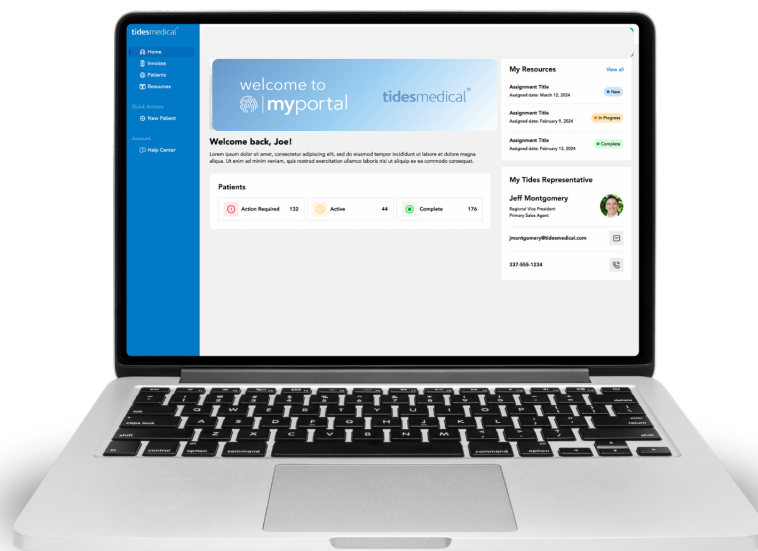
Verify your billed charge for your Tides product. Review applicable allowables and your cost. Determine your charge using the methodology you use for other products/services.

The Tides Reimbursement Team is available to answer any questions you may have when billing for Tides products.

SUPPORT AT EVERY STEP WITH:



- Submit benefits verification
- Track patient cases
- Search, filter, and view invoices
- Access materials and more help



login or register for myportal at www.tidesmedical.com/customer

CONTACT A REIMBURSEMENT SPECIALIST FOR HELP TODAY

📞 888-494-4441

📠 337-205-3599

✉ reimbursement@tidesmedical.com

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