

## Clinical Policy: Skin Substitutes for Chronic Wounds

Reference Number: AZ.CP.PHAR.185

Effective Date: 11.01.2021

Last Review Date: 02.25

Line of Business: Arizona Medicaid (AzCH-CCP)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Patients receiving skin replacement surgery with a skin substitute graft should be under the care of a wound care physician or surgeon. It is imperative that systemic disease be monitored/treated in order to insure adequate healing of the wound site. This policy addresses the medical necessity criteria for skin substitutes in the treatment of chronic wounds.

**AHCCCS preferred drugs** in this class include: Allopatch Pliable Thin, Amnioband Membrane, Amnioband Membrane Particulate, Amnioexcel/Amnioexcel Plus, Apligraf, Cytal 1, 2, 3 & 6 Layer, Dermgraft, Kerecis, Omnigraft, Primatrix, Primatrix AG, Primatrix AG Fenestrated, Primatrix AG Meshed, Primatrix Fenestrated, Primatrix Meshed, Puraply XT, Somagen Meshed Thin, Theraskin.

**AHCCCS non-preferred drugs** in this class include: Affinity, Epifix/Epifex Mesh, Grafix PL Prime/ Grafix Prime, Levena, Oasis® Wound Matrix Fenestrated, EZ DERM.

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of Arizona Complete Health that that skin substitutes are **medically necessary** for diabetic foot ulcers, venous stasis ulcers, or venous leg ulcers when all of the following are met:

#### I. Initial Approval Criteria

##### A. Diabetic foot, Pressure, and Venous ulcers (must meet all):

1. If request is for a non-preferred product, member has tried and failed at least 3 preferred products.

*\*All Skin Substitutes are covered under Medical benefit only. HCPCS codes for the Preferred Skin Substitutes should not require Prior Authorization. Only the HCPCS codes for the Non-Preferred Skin Substitutes require Prior Authorization.*

**Note:** Treatment of any chronic skin wound will typically last no more than 12 weeks.

**Approval duration: 3 months**

##### C. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AHCCCS FFS Prior Authorization Guideline- Coverage of Off-Label Non-FDA Approved Indications.

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#### D. Not Covered

1. It is the policy of Arizona Complete Health that skin substitutes are **not medically necessary** for the following indications or scenarios:
  - a. All indications not noted in section I;
  - b. Decubitus ulcer treatment;
  - c. Continued skin substitute use after treatment failure, which is defined as the repeat or alternative application course (of up to 12 weeks) of skin substitute grafts within one year of any given course of skin substitute treatment for a venous stasis ulcer or diabetic foot ulcer;
  - d. Retreatment of healed ulcers (those showing greater than 75% size reduction and smaller than 1 square cm).

#### II. Continued Therapy

##### A. Diabetic foot, Pressure, and Venous ulcers

1. Re-authorization is not permitted.

**Approval duration: Not Applicable**

##### B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AHCCCS FFS Prior Authorization Guideline- Coverage of Off-Label Non-FDA Approved Indications.

#### III. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

#### Background

According to the Centers for Medicare & Medicaid Services (CMS), chronic wounds of the lower extremities, including venous stasis ulcers (VSU), venous leg ulcers (VLU), Diabetic foot ulcers (DFU) and pressure sores, are a major public health problem. While lower extremity ulcers have numerous causes such as burns, trauma, mixed venous-arterial disease, immobility and vasculitis, nutritional or other neuropathy, over 90% of the lesions in the United States are related to venous stasis disease and diabetic neuropathy.<sup>1</sup>

Standard care for lower extremity wounds and ulcers includes infection control and management of edema, mechanical offloading of the affected limb, mechanical compression, limb elevation, debridement of necrotic tissue, management of systemic disease and counseling on the risk of continued tobacco use. Additionally, maintenance of a therapeutic wound environment with appropriate dressings can facilitate development healthy granulation tissue and re-epithelialization. Dressings are an important part of wound management by not only maintaining

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a moist environment but by stopping contamination, absorbing exudate and helping to prevent further trauma.<sup>1,2</sup>

A wound that has not healed within one to three months may be considered a chronic wound and can be a challenge to treat effectively. Even with advancements in standard wound care and synthetic occlusive dressings, some ulcers fail to heal and may benefit from a skin substitute.<sup>1,2</sup>

For venous leg ulcers (VLU), it is essential to evaluate for presence of saphenous vein reflux prior to consideration of skin substitute. If there is significant saphenous vein incompetency and reflux (valve closure time defined as > 500 milliseconds), or if ulcer bed veins are identified as contributory on ultrasound, a referral to a vascular surgeon or interventional radiologist is required. For significant saphenous vein reflux, endovascular laser or radiofrequency ablation can have enhanced rates of healing compared to other treatments. Without significant reflux, sclerotherapy may also be more beneficial.<sup>3</sup>

There are currently a wide variety of bioengineered products available for soft tissue coverage to affect closure.

Autologous skin grafts, also referred to as autografts, are permanent covers that use skin from different parts of the individual's body. These grafts consist of the epidermis and a dermal component of variable thickness. A split-thickness skin graft (STSG) includes the entire epidermis and a portion of the dermis. A full thickness skin graft (FTSG) includes all layers of the skin. Although autografts are the optimal choice for full thickness wound coverage, areas for skin harvesting may be limited, particularly in cases of large burns or venous stasis ulceration. Harvesting procedures are painful, disfiguring and require additional wound care.<sup>2,4</sup>

Allografts which use skin from another human (e.g., cadaver) and Xenografts which use skin from another species (e.g., porcine or bovine) may also be employed as temporary skin replacements, but they must later be replaced by an autograft or the ingrowth of the patient's own skin.<sup>2,4</sup>

Bioengineered Skin / Cultured Epidermal Autografts (CEA) are autografts derived from the patient's own skin cells grown or cultured from very small amounts of skin or hair follicle. Production time is prolonged. One such product is grown on a layer of irradiated mouse cells, bestowing some elements of a xenograft. Wide spread usage has not been available due to limited availability or access to the technology.<sup>2,4</sup>

### Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are

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included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
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)

HCPCS® Codes	Description
A2001	InnovaMatrix AC, per sq cm

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HCPCS®* Codes	Description
A2002	Mirragen Advanced Wound Matrix, per sq cm
A2003	bio-ConneKt Wound Matrix, per sq cm
A2004	XCelliStem, per sq cm
A2005	Microlyte Matrix, per sq cm
A2006	NovoSorb SynPath dermal matrix, per sq cm
A2007	Restrata, per sq cm
A2008	TheraGenesis, per sq cm
A2009	Symphony, per sq cm
A2010	Apis, per sq cm
Q4100	Skin substitute, nos
Q4101	Apligraf, per sq cm
Q4102	Oasis wound matrix, per sq cm
Q4103	Oasis burn matrix, per sq cm
Q4104	Integra bilayer matrix wound dressing (BMWD), per sq cm
Q4105	Integra dermal regeneration template (DRT) or Integra Omnigraft dermal regeneration matrix, per sq cm
Q4106	Dermagraft, per sq cm
Q4107	Graftjacket, per square centimeter
Q4108	Integra matrix, per sq cm
Q4110	Primatrix, per square centimeter
Q4111	Gammagraft, per sq cm
Q4115	Alloskin, per sq cm
Q4117	Hyalomatrix, per sq cm
Q4118	Matristem micromatrix, 1mg
Q4121	TheraSkin, per sq cm
Q4122	DermACELL, DermACELL AWM or DermACELL AWM Porous, per sq cmr
Q4123	AlloSkin RT, per sq cm
Q4124	Oasis ultra tri-layer wound matrix, per sq cm
Q4126	MemoDerm, DermaSpan, TranZgraft or InteguPly, per sq cm
Q4127	Talymed, per sq cm
Q4128	FlexHD, AllopatchHD, or Matrix HD, per sq cm
Q4132	Grafix Core and GrafixPL Core, per sq cm
Q4133	Grafix PRIME, GrafixPL PRIME, Stravix and StravixPL, per sq cm
Q4134	Hmatrix, per sq cm
Q4135	Mediskin, per sq cm
Q4136	E-Z Derm, per sq cm
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter
Q4140	BioDFence, per square centimeter
Q4141	Alloskin AC, per square centimeter

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HCPCS®* Codes	Description
Q4146	Tensix, per square centimeter
Q4147	Architect, Architect PX, or Architect FX, extracellular matrix, per square centimeter
Q4148	Neox Cord 1K, Neox Cord RT, or Clarix Cord 1K, per square centimeter
Q4151	AmnioBand or Guardian, per sq cm
Q4152	DermaPure, per sq cm
Q4153	Dermavest and Plurivest, per sq cm
Q4154	Biovance, per sq cm
Q4156	Neox 100 or Clarix 100, per sq cm
Q4157	Revitalon, per sq cm
Q4158	Kerecis Omega3, per sq cm
Q4159	Affinity, per sq cm
Q4160	Nushield, per square centimeter
Q4161	bio-ConneKt wound matrix, per sq cm
Q4163	Woundex, bioskin, per sq cm
Q4164	Helicoll, per square cm
Q4165	Keramatrix or Kerasorb, per sq cm
Q4166	Cytal, per square centimeter
Q4169	Artacent wound, per sq cm
Q4170	Cygnus, per sq cm
Q4173	Palingen or Palingen Xplus, per sq cm
Q4175	Miroderm, per sq cm
Q4176	Neopatch or therion, per square centimeter
Q4178	FlowerAmnioPatch, per sq cm
Q4180	Revita, per sq cm
Q4184	Cellesta or Cellesta Duo, per sq cm
Q4186	Epifix, per square centimeter
Q4187	Epicord, per square centimeter
Q4188	AmnioArmor, per sq cm
Q4195	PuraPly, per square cm
Q4196	PuraPly AM , per square cm
Q4197	Puraply XT, per square cm
Q4199	Cygnus matrix, per sq cm
Q4201	Matrion, per sq cm
Q4203	Derma-Gide, per sq cm
Q4232	Corplex, per sq cm
Q4237	Cryo-Cord, per sq cm
Q4238	Derm-Maxx, per sq cm
Q4239	Amnio-Maxx or Amnio-Maxx Lite, per sq cm
Q4254	Novafix DL, per sq cm

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Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	10.1.21	10.21
Removed clinical criteria as preferred Skin Substitutes are No Auth Required status under medical benefit; Clarified that for Non-Preferred Skin Substitutes, trial and failure of at least 3 preferred products are required; added the following HCPCS codes: A2001-A2010, Q4199, Q4201, Q4232 and Q4254. Removed Q4119, Q4174.	02.09.23	02.23
1Q 2024 annual review: no changes	02.01.24	
1Q 2025 annual review; Removed reference to Care1st Health plan and logos. Removed reference to retired policy AZ.CP.PMN.53 Off-Label Use policy added AHCCCS FFS Prior Authorization Guideline-Coverage of Off-Label Non-FDA Approved Indications.	02.10.25	

#### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or



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regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members/enrollees**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members/enrollees**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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