January 29, 2025

Nevada Medicaid Web Announcement 3543

Skin Substitution Services and Products Open for Billing for Wound Care Management

Nevada Medicaid is expanding its coverage for wound care management to reimburse qualified providers for additional skin substitute services. Refer to Medicaid Services Manual (MSM) Chapter 600, Physician Services, Attachment A, Policy #6-02 for the complete wound care management policy requirements.

Effective on claims with dates of service on or after August 28, 2024, the following Healthcare Common Procedure Coding System (HCPCS) codes in Table 1 are open for billing by the provider types (PT) in Table 2:

Table 1.

Procedure Code	Description
Q4133	(Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter)
Q4186	(Epifix, per square centimeter)
Q4101	(Apligraf, per square centimeter)

Table 2.

Provider Type	Description
10	Outpatient Surgery, Hospital Based
12	Hospital, Outpatient
20	Physician, M.D., Osteopath, D.O.
21	Podiatrist
24	Advanced Practice Registered Nurse
46	Ambulatory Surgical Centers, Freestanding
77	Physician's Assistant

The above procedure codes require prior authorization (PA) with the following information:

- The treating provider must submit a signed and dated wound care treatment plan or submit a letter of medical necessity that includes the following documentation:
    - The planned interventions for the problem identified
    - The treatment goals
    - The expected outcomes

A signed and dated treatment plan or a letter of medical necessity is considered current when signed and dated within 30 calendar days prior to or on the date the procedure is performed. If the signed and dated treatment plan or letter of medical necessity is older than 30 days, PA may be denied.

Additionally, effective on claims with dates of service on or after August 28, 2024, the Current Procedural Terminology (CPT) codes below are open for billing by PTs 10, 12, 21, and 46. These procedure codes do not require PA.

Procedure Code	Description
15271	Application of skin substitute (wound surface up to 100 sq cm) to trunk, arms or legs
15272	Application of skin substitute (wound surface up to 100 sq cm) to trunk, arms or legs
15273	Application of skin substitute (wound surface up to 100 sq cm)
15274	Application of skin substitute (wound surface up to 100 sq cm)
15275	Application of skin substitute (wound surface up to 100 sq cm) to face, scalp
15276	Application of skin substitute (wound surface up to 100 sq cm) to face, scalp
15277	Application of skin substitute (wound surface greater than or equal to 100 sq cm)
15278	Application of skin substitute (wound surface greater than or equal to 100 sq cm)

Any claims submitted by PTs 10, 12, 20, 21, 24, 46 or 77 for these procedure codes with dates of service on or after August 28, 2024, that denied with error code 4801 (No billing rule for procedure) will be reprocessed automatically. Results of the reprocessed claims will appear on a future remittance advice.

When claims are reprocessed, please be aware that all system and clinical claim editor edits are applicable. As a result, there may be no additional payment, and other claim denials may be received. Providers have the right to appeal denied claims, including those denied upon reprocessing. Please refer to Medicaid Services Manual Chapter 100 and the Billing Manual for information concerning the claim appeal process and time frames.