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2026 Comprehensive Coding & Billing Guide

PREPARED BY MCRA, an IQVIA Business.

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 1, 2026 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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Implant Overview

Cortiva® Allograft Dermis is a non-crosslinked dermis from donated human tissue and sterilized 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.

2026 Outpatient Coding and Medicare Payment

The following may be appropriate when utilizing the Cortiva® Allograft Dermis.

CPT CODE[1]	DESCRIPTION	2026 OUTPATIENT HOSPITAL[2]			2026 ASC[3]	
		APC	SI	Medicare National Avg Payment	PI	Medicare National Avg Payment
15271	App of skin sub to trunk, arms, legs up to 100 sq. cm; 1st 25 sq. cm	5053	T	$755.08	G2	$404.93
+15272	Each additional 25 sq. cm	-----	N	$0.00	N1	$0.00
15273	App of skin sub to trunk, arms, legs to >100 sq. cm, 1st 100 sq. cm	5054	T	$2107.97	G2	$1,128.57
+15274	Each additional 100 sq. cm	-----	N	$0.00	N1	$0.00
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	5053	N	$755.08	P3	$94.66
+15276	Each additional 25 sq. cm	-----	N	$0.00	N1	$0.00
15277	App of skin sub to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, multiple digits >100 sq. cm	-----	N	$2,107.97	G2	$1,128.57
+15278	Each additional 25 sq. cm	5053	T	$0.00	N1	$0.00
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	5051	Q1	$204.98	Excluded	$0.00

2026 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. The physician will only include an HCPCS code for the skin sub if the service is performed in an office setting. A Hospital or ASC would handle the device billing on its claim under OPPS.

CPT CODE[1]	DESCRIPTION	2026 Office Medicare National Avg[6]	2026 Facility Medicare National Avg[6]
15271	App of skin sub to trunk, arms, legs up to 100 sq. cm; 1st 25 sq. cm	$157.98	$75.15
+15272	Each additional 25 sq. cm	$25.72	$14.70
15273	App of skin sub to trunk, arms, legs to >100 sq. cm, 1st 100 sq. cm	$321.98	$171.68
+15274	Each additional 100 sq. cm	$86.84	$38.74
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	$160.32	$84.17
+15276	Each additional 25 sq. cm	$33.73	$22.04
15277	App of skin sub to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, multiple digits >100 sq. cm	$361.39	$197.39
+15278	Each additional 25 sq. cm	$101.20	$48.76
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	Carrier Priced	Carrier Priced

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 an HCPCS code assigned status indicator "S," "T," "V," or "X." (2) In all other circumstances, payment is made through a separate APC payment.
S1	Skin substitute assigned to a new APC based on their Food and Drug Administration (FDA) regulatory category.
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.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on MPFS non-facility PE RVUs.
S2	Skin substitute supply group; paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.

Device Coding and Modifiers

Starting CY 2026, Medicare will consistently use HCPCS Q or A codes in all settings of care for coding and payment of skin subs. CMS replaced the general HCPCS Q4100 code for skin sub NOS and created three new skin sub NOS Q codes categorized by FDA pathway. This table shows the best code for Cortiva® Allograft Dermis implants, when used in wound care procedures.

HCPCS	DESCRIPTION	2026 OUTPATIENT HOSPITAL			2026 ASC	
		APC	SI	Medicare National Avg Payment	PI	Medicare National Avg Payment
C1889	Implantable/insertable device, not otherwise classified	-----	N/A	$0.00	N/A	$0.00
Q4433	361 HCT/P skin substitute product, not otherwise specified (list in addition to primary procedure)	6002	S1	$127.14	S2	$127.14

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

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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 25cm^2 or 100cm^2 applied.

- When reporting a skin substitute product with HCPCS code Q4433 (361 HCT/P skin substitute product, not otherwise specified) and specifying units per square centimeter, the claim narrative or remarks must include the product name, purchased package size, amount applied, and amount wasted. Claims missing this information will be returned to the provider.[i]

- If you are not using Cortiva allograft dermis as a skin substitute, you should use C1889 (Implantable/insertable device, not otherwise classified) and record charges to reflect the costs of the product used with an appropriate revenue code.

2026 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, 2025, through September 30, 2026.

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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. The bolded numeral or letter represents the character to be selected. The selected PCS code should have a total of 7 characters..

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

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2026 MS-DRG Payment

The following possible MS-DRG assignments are provided below along with the 2026 Medicare national payment rates.

MS-DRG[iii]	DRG DESCRIPTION	2026 MEDICARE PAYMENT
570	SKIN DEBRIDEMENT WITH MCC	$21,401.00
571	SKIN DEBRIDEMENT WITH CC	$12,294.00
572	SKIN DEBRIDEMENT WITHOUT CC/MCC	$8,341.00
573	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITH MCC	$47,672.00
574	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITH CC	$25,260.00
575	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITHOUT CC/MCC	$13,076.00
576	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITH MCC	$35,664.00
577	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITH CC	$19,288.00
578	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITHOUT CC/MCC	$11,689.00
579	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH MCC	$23,565.00
580	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH CC	$12,574.00
581	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITHOUT CC/MCC	$10,501.00
622	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH MCC	$25,899.00
623	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH CC	$13,053.00
624	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITHOUT CC/MCC	$9,109.00
628	OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITH MCC	$27,118.00
629	OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITH CC	$15,854.00
904	SKIN GRAFTS FOR INJURIES WITH CC/MCC	$26,728.00
905	SKIN GRAFTS FOR INJURIES WITHOUT CC/MCC	$10,794.00
907	OTHER O.R. PROCEDURES FOR INJURIES WITH MCC	$27,937.00
908	OTHER O.R. PROCEDURES FOR INJURIES WITH CC	$14,518.00
909	OTHER O.R. PROCEDURES FOR INJURIES WITHOUT CC/MCC	$9,552.00

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2026 ICD-10-CM Diagnosis Coding

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.

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 2026 AMA. All CPT codes are owned and licensed by the American Medical Association.

[2] 2026 Medicare Outpatient Hospital Fee Schedule: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-a-b-updates

[3] 2026 Medicare ASC Fee Schedule: https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda

[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-andGuidance/Guidance/Transmittals/downloads/r1657cp.pdf

[6] 2026 Medicare Physician Fee Schedule: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices

[*] Data on File at Evergen.

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

[ii]

[iii] 2026 Medicare IPPS Fee Schedule: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps