JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Reimbursement Policies** **Reimbursement Policies**	*Policy Number*	RPC.051
		Effective Date	01/20/2026
		Approval Date	10/31/2025
	Subject **Devices, Implants and Skin Substitutes**	*Supersedes Date*	N/A
		Original Date	01/20/2026
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This document applies to the following Participating Organizations:

Johns Hopkins Advantage MD	Johns Hopkins Employer Health Programs, Inc. (EHP)	Johns Hopkins Medical Services Corporation (USFHP)	Priority Partners Managed Care Organization, Inc.

Keywords: Devices, Implants, Skin Substitute

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I. ABOUT OUR REIMBURSEMENT POLICIES

Providers and suppliers are responsible for reviewing the Johns Hopkins Health Plans LLC (JHHP) Reimbursement Policy Reference Guide, which is applicable to this policy. All JHHP Reimbursement Policies are publicly accessible and provide general billing and coding guidance, along with the criteria and supporting information used in certain payment determinations, as detailed in the specific policy.

II. PURPOSE

This policy provides a general overview for outpatient claims submitted to JHHP for the reimbursement of Devices, Implants and Skin Substitutes (e.g., skin substitute grafts and cellular and tissue-based products [CTP]) by participating and non-participating physicians, non-physician practitioners, suppliers, and facilities (collectively referred to as “providers”), who submit claims on a CMS-1500 or UB-04 claim forms, or their electronic equivalents.

III. GENERAL BILLING GUIDELINES

1. Claims submitted for supplies, implants, devices, and skin substitutes/CTP should be billed with the corresponding procedure code, and modifier (if applicable), on the same claim, for the same date of service (DOS).
2. Each revenue code must be correctly paired with a CPT or HCPCS code on every line item, when reported for hospital outpatient claims. If multiple codes are needed to represent distinct or independent items, procedures, or services under the same revenue code, providers should repeat the revenue code accordingly.

IV. IMPLANTS and DEVICES

1. Revenue codes (0270-0279 and 0624) should only be used for supplies, devices and implants that align to their description.
   - Implant revenue code(s) will be considered for reimbursement when the device or implant meets the FDA's definition of an implant, unless an exception applies.
2. Experimental devices that are implantable and have been granted an FDA IDE number should be billed with revenue code 624.
3. Complete and accurate reporting of the codes and the charge(s) for the devices is critical for ensuring proper payment for the procedures that use implanted devices. The following information must be included on the institutional claim (list is not all-inclusive):
   - HCPCS or CPT Code: Corresponding code for the device or implants.
   - Diagnosis
   - Units: Number of devices implanted
   - Total Charges
   - Invoice/Documentation: A copy of the invoice is required to verify that the provider incurred a cost when the cost of an implant or device is submitted for reimbursement.
   - NDC: If applicable (for drug/biologic components of the implant)
   - Modifiers: May be required to indicate laterality, multiple devices, or special circumstances.
   - If applicable, a copy of the Investigational Device Exemption (IDE) approval, the IDE number, and the invoice.
4. Procedure codes submitted without a device may be considered for reimbursement only if they include an appropriate modifier indicating the procedure was discontinued prior to placement of the device.
5. When a device is obtained by the provider at no cost or a reduced cost, it must be reported with the appropriate revenue code, condition code, value code, and modifier(s).

V. SKIN SUBSTITUTE GRAFTS/CELLULAR and TISSUE–BASED PRODUCTS (CTP)

1. Consistent with CMS guidance, when reporting a skin substitute product, the related procedure code must also be reported on the same claim, for the same DOS to be considered for reimbursement.
   - CMS is responsible for maintaining the skin substitute products' low-cost and high-cost group assignments.
   - Applicable skin substitute application or replacement procedure codes are defined in the Outpatient Code Editor (OCE) HCPCS data file.
2. In accordance with CMS, low-cost skin substitute products may only be reported with low-cost skin substitute procedures, while high-cost skin substitute products may only be reported with high-cost skin substitute procedures; mismatching the product to the procedure may result in an incorrect payment or denial.
3. Physicians and non-physician practitioners who perform procedure codes CPT 15271-15278 (application of skin substitute) may also bill separately for a covered skin substitute code, when applied in a non-facility setting.
4. Skin graft/CTP procedures are subject to Multiple Procedure Reduction guidelines with the other procedures performed on the same day.
5. The HCPCS code of the applicable skin substitute grafts/CTP and the units billed must be consistent with the medical record regarding wound description and size.
   - To determine the surface area for application of skin substitute graft codes for multiple wounds, all wound areas within the same anatomic site should be added. If the skin substitute graft is applied to wounds on a different anatomic site, the corresponding application code for the anatomical site for each DOS should be reported.
6. JHHP expects that where multiple sizes of a specific product are available, the size that best fits the wound with the least amount of wastage will be utilized.
   - The amount billed as wastage cannot exceed the price of the package.

7. Any amount of wasted skin substitute grafts/CTP must be clearly documented in the medical record with ALL the following information (at a minimum):
   - Date, time, and location of wound(s) treated.
   - Description/name of skin substitute grafts/CTP and package size
   - Approximate amount of product unit used.
   - Approximate amount of product unit discarded.
   - Reason for the wastage (including the reason for using a package size larger than was necessary for the size of the wound, if applicable).
   - A copy of the invoice for the product used and the manufacturer's serial/lot/batch or other unit identification number of grafts/CTP material.

VI. INAPPROPRIATE BILLING OF ITEMS and SERVICES

1. Payment for an implant, device, supply or service that is inclusive (or bundled) into another service, item or procedure, is not separately reimbursable.
2. If the service represents something that is not a true skin substitute, the service will be non-covered.
3. Skin substitute codes are not to be reported for application of non-graft wound dressings (e.g., gel, powder, ointment, foam, liquid, or injected skin substitutes).
4. No payment will be made for supplies, absorbable materials and liquids, or items that are designed to be removed or discarded during the same operative session or single episode of care.
5. No payment will be made for items, procedures or services that JHHP considers experimental, investigational, or unproven.

VII. EXCEPTIONS & EXCLUSIONS

1. **Maryland Waiver Providers**: Maryland hospitals that are excluded from OPPs payment methodology are required to bill items and services in accordance with the Health Services Cost Review Commission (HSCRC) rules and regulations and will be reimbursed under the HSCRC payment methodology.
2. **AdvantageMD**: JHHP processes and reimburses claims in accordance with CMS guidance. Please consult the authoritative guidance found on the CMS website and Medicare Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.
3. **Priority Partners**: JHHP processes and reimburses claims in accordance with the Maryland Medicaid Administration Professional Services Provider Manual and COMAR guidance. Please refer to MDH and COMAR for additional guidance not addressed in this policy.
   - Rev codes 273 and 277 are not payable, per MDH guidance.
4. **USFHP**: JHHP will process and reimburse claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

VIII. CODES, TERMS and DEFINITIONS

The information outlined below is only applicable to this policy.

Term	Definition

Absorbable Material and Liquids	Absorbable materials and liquids are considered part of the outpatient hospital services provided. Liquids or other materials that are absorbed by the surrounding tissue will not be considered for reimbursement.
Implant	The Electronic Code of Federal Regulations (eCFR) defines an Implant as "a device that is placed into a surgically or naturally formed cavity of the human body. A device is regarded as an implant for the purpose of this part only if it is intended to remain implanted continuously for a period of 30 days or more, unless the Commissioner determines otherwise to protect human health" (21 CFR Part 860). Revenue code 0278 cannot be reported for an implant that does not meet the FDA product classification guidelines and definition for what is considered an implant.
Investigational Device Exemption (IDE)	The FDA definition of an IDE refers to the regulations under 21 CFR 812. An approved IDE means that the Institutional Review Board (and FDA for significant risk devices) has approved the sponsor's study application and all the requirements under 21 CFR 812 are met. An investigational device exemption (IDE) allows the investigational device to be used in a clinical study in order to collect safety and effectiveness data.
Skin Substitute	Per the Current Procedural Terminology (CPT) codebook definition, skin substitute grafts include non-autologous human skin (dermal or epidermal, cellular and acellular) grafts (e.g., homograft, allograft), non-human skin substitute grafts (i.e., xenograft), and biological products that form a sheet scaffolding for skin growth. CMS also refers to skin substitutes as "wound care management products".
Supplies and Instruments	A supply or instrument is not considered an implant and will not be considered for reimbursement if it is purposed to be removed or discarded during the same inpatient or outpatient procedure or single episode of care in which they are placed in the body. • Supplies (e.g., guide wires, staples, sutures, clips). • Surgical dressings (e.g., gel, powder, ointment, foam, liquid) • Surgical instruments (including instrument components) • Liquids or other materials absorbed by surrounding tissue, that are not considered implants.

CPT/HCPCS Code List (Not all-inclusive, additional codes may apply)

CPT/HCPCS Code	Definition
A2001-A2010	HCPCS codes A2001-A2010 are for non-autologous skin (dermal or epidermal, cellular, and acellular) grafts (e.g., homograft, allograft), non-human skin substitute grafts (i.e., xenograft), and biological products that form a sheet scaffolding for skin growth.
15002-15005	Surgical preparation or creation of the recipient site
15271-15278	Application of skin substitutes
97602	Active wound care management; the removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.

Modifiers: The appropriate modifier must be appended to the correct CPT code, on the claim form, for the provider who rendered the service, or the claim may be pended or denied.

Modifier	Definition
JC	Skin substitute used as a graft
JD	Skin substitute not used as a graft
JG	Drug or biological acquired with 340B drug pricing program discount. Non-excepted off-campus provider-based departments of a hospital paid under the provider fee schedule are required to report this modifier.
JW	Drug / biological discarded / not administered to any patient. This modifier must be used to report discarded amounts of a single-dose container drug in order to obtain payment for a discarded amount of drug from single dose or single use packaging. Note: The JW modifier is required if suppliers are not administering a drug, but there are amounts discarded during the preparation process before supplying the drug to the patient.
JZ	Zero drug/ biological discarded/ not administered to any patient. This modifier is required on claims for single-dose container drugs to attest when there are no discarded amounts.

Revenue Code	Definition
270	General

271	Nonsterile
272	Sterile
273	Take-home supplies
274	Prosthetic/orthotic devices
275	Pacemaker
276	Intraocular lens
278	Take-home oxygen
279	Other Implants
624	Other supplies/devices

IX. REFERENCES

This policy has been developed through consideration of the following:

- CY 2026 PFS Final Rule Skin Substitute Products
- CMS Regulations & Guidance
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT® Copyright American Medical Association.
- eCFR: 21 CFR § 812.3 Definitions
- Discarded Drugs and Biologicals– JW and JZ Modifiers
- MDH- Transmittals (maryland.gov)
- MDH Provider Information Site
- MDH Professional Claims Billing Guidance (CMS 1500)
- MDH Institutional Claims Billing Guidance (UB-04)
- Medicare Claims Processing Manual CH. 17-Drugs and Biologicals
- MLN Matters Number: MM14315
- National Uniform Billing Committee (UB-04)
- NUBC Updated Guidance on Other Implant Revenue Code (0278)
- National Uniform Claim Committee CMS-1500 Claim
- OIG: Payment Trends for Skin Substitutes Raise Major Concerns About Fraud, Waste, and Abuse
- TRICARE Manuals

X. APPROVALS

Date	Review/Revision	Reason For Modification	Approved By
10/31/2025	New Policy	N/A	Reimbursement, Authorization, Coding and Configuration Committee (RAC)

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XI. POLICY NOTIFICATION CHART

	Yes/No	If yes in 2nd column, notify the following department of policy revisions:
Does this policy relate to NCQA?	No	Quality Improvement
Does this policy relate to Qlarant/MDH requirements?	No	Quality Improvement
Does this policy relate to DHA contractual requirements?	Yes	USFHP Administration