Complete ACA™

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## Triple Layer Complete ACA Membrane

**Triple Layer Complete ACA Membrane is a sterile allograft designed for optimal wound covering and protection during the treatment of wounds.**

### Key Features & Properties:

- Provides a reliable protective wound covering backed by decades of science
- Adheres easily to wounds including those with irregular surfaces
- 5-year shelf life at ambient temperature storage

### Complete ACA Membrane Ordering Information | Q4302

| PRODUCT NUMBER | SIZE | TOTAL UNITS (PER SQCM) |
|---|---|---|
| ACA22 | 2x2 | 4 |
| ACA23 | 2x3 | 6 |
| ACA44 | 4x4 | 16 |
| ACA46 | 4x6 | 24 |
| ACA48 | 4x8 | 32 |
| ACA1520 | 15x20 | 300 |

Triple Layer Complete ACA Membrane is an amniotic membrane allograft derived from a prescreened mother with a planned delivery. Triple Layer Complete ACA Membrane is manufactured in compliance with FDA regulations and AATB guidance. The membrane is minimally processed to preserve the native structure of the tissue, dehydrated, and terminally sterilized. **Triple Layer Complete ACA Membrane is confirmed by the FDA Tissue Reference Group to meet the criteria for regulation solely under Section 361 of the PHS Act as defined in 21 CFR Part 1271.**

**Order and Customer Support** | Phone: (817) 961-1288 | Fax: (866) 300-0431
www.legacymedicalconsultants.com | customerservice@legacymedicalconsultants.com

# General Information

Reimbursement and coverage eligibility for the use of Triple Layer Complete ACA Membrane and associated procedures varies by Medicare and private payers. Coverage policies, prior authorizations, contract terms, billing edits, and site-of-service influence reimbursement.

## Place of Service (POS) Codes

POS codes are 2-digit numbers included on health care professional claims to indicate the setting in which a service was provided. The Centers for Medicare and Medicaid Services (CMS) maintain POS codes used throughout the healthcare industry. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers for reimbursement policies regarding these codes.

| Place of Service Code | Place of Service Location | Place of Service Description |
|---|---|---|
| 11 | Office | Location other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or Local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. |
| 12 | Home | Location, other than a hospital or other facility, where the patient receives care in a private residence. |
| 32 | Nursing Facility | A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities. |

Reimbursement inquiries:
reimbursement@legacymedicalconsultants.com

**Triple Layer Complete ACA Membrane** is not included on the Medicare Part B Average Sales Price (ASP) Drug Pricing File published quarterly by the Centers for Medicare and Medicaid Services (CMS).

Average Sales Price information is published quarterly by the Centers for Medicare and Medicaid Services (CMS) in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File. Providers are encouraged to review the ASP Pricing files posted quarterly by CMS and listed by HCPCS on CMS.gov for updates. Payment allowance limits that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the contractors follow the methodology specified in Publication. 100-04, Chapter 17, Drugs and Biologicals, for calculating the Average Wholesale Price (AWP), but substitute WAC for AWP. Providers are encouraged to check with their local MACs for information on established rates. Providers are also encouraged to check with payers to determine if an invoice is required to be submitted with the claim and/or in Box 19 of the CMS-1500 claim form.

## CPT® Coding

The Current Procedural Terminology (CPT) code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes. Physicians should report all surgical and medical services performed, and are responsible for determining which CPT® code(s) are appropriate.

Distributed by:

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**References:**

CMS Manual for that detail Section 20 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9603.pdf