Symphony™
AROA ECM™

2026 Outpatient Reimbursement Guide



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Aroa Biosurgery Limited provides this guide as a frame of reference for providers only and does not assume any responsibility for coding decisions, nor does it recommend codes for specific patient procedures. Nothing in this guide guarantees coverage by Medicare or other payers. Providers are always responsible for: (1) consulting with their payors, coding specialists, and/or legal counsel regarding any coverage, coding, or payment issues; (2) checking current reimbursement laws, regulations and payor policies; and (3) determining and submitting appropriate codes, charges and modifiers for goods and services it provides. This information is confirmed to be accurate as at 27 January 2026.

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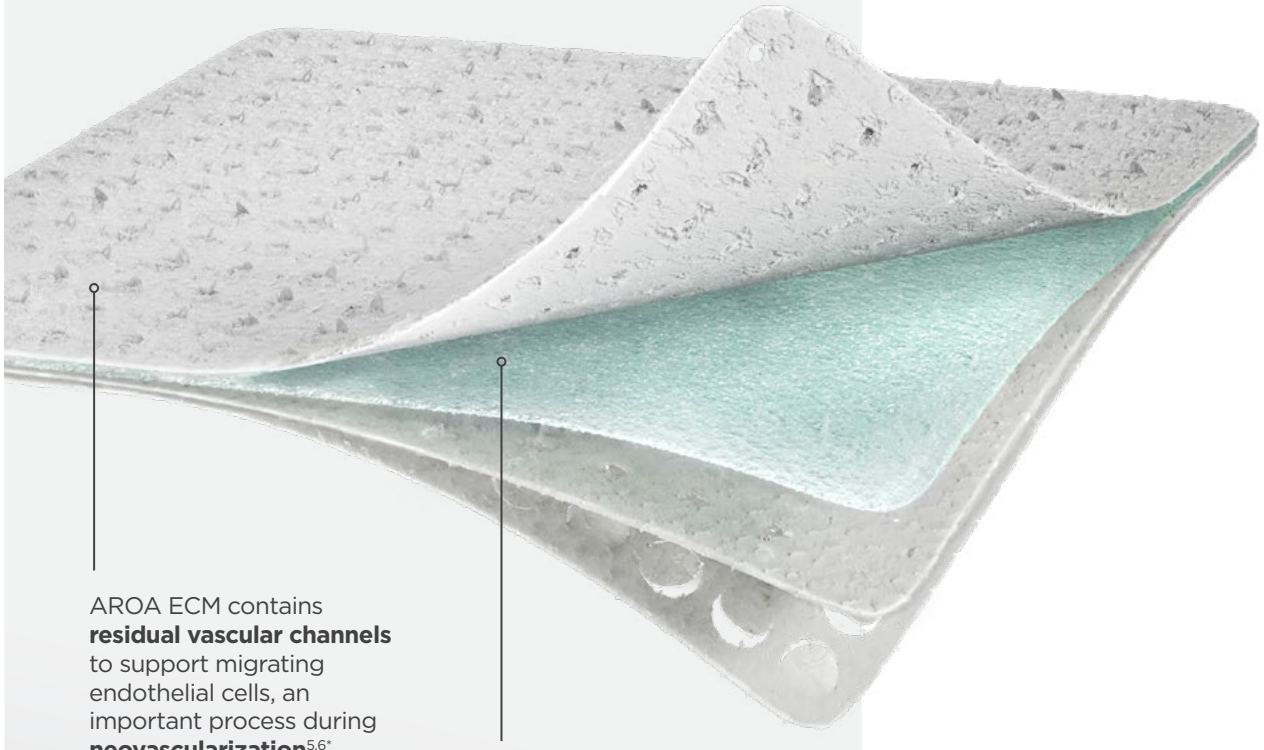
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Built For Complex Wounds

Symphony contains 150+ ECM proteins known to be important in tissue restoration[4]*



AROA ECM contains **residual vascular channels** to support migrating endothelial cells, an important process during **neovascularization**[5,6*]

Hyaluronic acid has been shown to **reduce time to DFU healing** compared to standard treatment[1*]

*Results may not be indicative of clinical performance. **Clinical Evidence:** 1. Yao L et al. Front Endocrinol (Lausanne). 2025;16:1627558. 2. Armstrong DG et al. Int Wound J. 2026;23:e71056. 3. Bosque et al. (2022). Int Wound J. 19(4):741–753. **Pre-clinical Evidence:** 4. Dempsey S G et al. J Proteome Res. 2019;18(4):1657-1668. 5. Smith MJ et al. J Biomater Appl. 2021;36(6):996–1010. 6. Irvine SM et al. Biomaterials. 2011;32(27):6351–6361

Symphony is indicated for use in the management of the following wounds:

- Partial and full-thickness wounds
- Pressure ulcers
- Venous ulcers
- Diabetic ulcers
- Chronic vascular ulcers
- Tunneled/Undermined wounds
- Surgical wounds (donor sites/ grafts, post-Moh's surgery, post-laser surgery, podiatric, wound dehiscence)
- Trauma wounds (abrasions, lacerations, second-degree burns, and skin tears)
- Draining wounds



Reimbursement

For assistance with reimbursement questions, contact Aroa's Reimbursement Team

Monday through Friday from 8am to 5pm EST

Staff can assist with:

- Patient-specific insurance verifications
- Prior authorization and pre-determination support
- General coding information
- General medical policy information for Medicare and Commercial payers
- Published Medicare payment information for most outpatient sites of service

Should you wish to speak to one of our specialist reimbursement support team, please contact us on:

1-800-807-2762

reimbursement@aroa.com

Fax: 1-877-775-3157

Coding

Selecting the appropriate CPT® code is an important component of accurately reporting the clinical services associated with the application of Symphony.

CPT code selection should reflect the specific procedure performed, including the anatomical location, wound surface area, and, when applicable, preparation of the wound or recipient site.

Accurate coding helps ensure that the services provided are appropriately represented on the claim, supports proper reimbursement, and promotes consistency between the procedure performed, the medical record documentation, and the claim submitted to the payer.

The HCPCS code for Symphony

A2009 Symphony
per sq cm

(add-on, list separately in addition to primary procedure)

CPT Code(s) for Applicable Graft Skin Substitute Application Procedure(s)

CAMP	Description
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 cm^2; first 25 cm^2 or less wound surface area.
15272	Each additional 25 cm^2 wound surface area, or part thereof (list separately, in addition to primary procedure code).
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 cm^2; first 100 cm^2 wound surface area, or 1% of body area of infants and children.
15274	Each additional 100 cm^2 wound surface area, or part thereof, or each additional 1% of body area of infants or children, or part therof (list separately, in addition to primary procedure code).
15275	Application of skin substitute graft to face, scalp, eyelid, mouth, neck ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 cm^2; first 25 cm^2 or less wound surface area.
15276	Each additional 25 cm^2 wound surface area, or part thereof (list separately, in addition to primary procedure code).
15277	Application of skin substitute graft face, scalp, eyelid, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 cm^2; first 100 cm2 wound surface area, or 1% of body area of infants and children.
15278	Each additional 100 cm^2 wound surface area, or part thereof, or each additional 1% of body area of infants or children, or part thereof (list separately, in addition to primary procedure code).

AMA Notes: For multiple wounds, sum the surface area of all wounds from all anatomic sites that are grouped together into the same code descriptor. Do not sum wounds from different groupings or anatomic sites (e.g., face and arms). Procedures involving the wrist and/or ankle are reported with codes that include arm or leg in the descriptor. Removal of current graft and/or simple cleansing of the wound is included, when performed. Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure. The supply of skin substitute graft(s) should be reported separately in conjunction to 15271-15278.

Medicare Payment

Note: For calendar year 2026, Medicare established a standardized national payment rate of $127.14 per square centimeter (cm^2) for separately payable skin substitute products in the physician office, Hospital Outpatient Department (HOPD), and Ambulatory Surgical Center (ASC) settings.

Allowable rates provided do not reflect adjustments for geographic location, deductible, copayments, coinsurance, sequestration, multiple procedure discounts, or any other reductions. Commercial rates are confidentially negotiated between payers and providers. To verify specific payment rates, consult with your billing manager, contract manager, office manager, or payer provider relations representative.

Physician Office, Hospital Outpatient Department and Ambulatory Surgery Center.

Stock no.	Product Size	Area	Billing Units	HCPCS Code	Description*
CM03HA002D	16 mm disc	2 cm^2	2	A2009	**Symphony**, per sq cm
CM03HA004S	2 x 2 cm	4 cm^2	4	A2009	**Symphony**, per sq cm
CM03HA006R	2 x 3 cm	6 cm^2	6	A2009	**Symphony**, per sq cm
CM03HA012R	4 x 3 cm	12 cm^2	12	A2009	**Symphony**, per sq cm
CM03HA016S	4 x 4 cm	16 cm^2	16	A2009	**Symphony**, per sq cm
CM03HA025S	5 x 5 cm	25 cm^2	25	A2009	**Symphony**, per sq cm
CM03HA050R	10 x 5 cm	50 cm^2	50	A2009	**Symphony**, per sq cm

*** This is an add-on code, list separately in addition to primary procedure.**
**** The national rate of $127.14 is influenced by the relevant GPCI (geographic practice cost index)**

Units

Medicare claims submitted for skin substitutes should bill the administered portion of product used, whereas one (1) billable unit is equal to 1 cm^2 administered. Effective January 1, 2026, only the administered portion is payable. If a portion is discarded, it is not appropriate to bill Medicare for discarded units under any circumstance. Providers are encouraged to check with other contracted health plans to determine proper billing units.

NOTE: The "actual units used" and to be billed to CMS for an application of a CAMPS includes ALL graft material used to medically and reasonably treat the patient's wound, including the graft material used to cover the peri-wound area and to over-lay the wound area to properly affix the graft. The Provider must factually document in the patient's medical record why and what they did to apply and affix the CAMP to the patient's wound.

Billing

It is recommended that the provider review clinical evidence for Symphony. Providers should also review applicable Medicare Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and commercial payer medical policies to ensure compliance with all applicable requirements and coverage guidelines.

Always refer to the payer's current coverage policy or contact the payer for complete documentation instructions.

General Documentation & Medical Necessity Checklist

Based on current wound care standards for the application of skin substituates, the following is a general list of suggested documentation and information that should be included in the patient's medical record:

- Name of professional managing the patient's underlying condition(s)
- 4 weeks of conservative care that failed and patient compliance during conservative care
- If wound/ulcer was infected or had osteomyelitis, but it has resolved, document that the patient is no longer on antibiotics before the first skin substitute application
- The DFU/VLU does not have progressive necrosis, active Charcot arthropathy of the wound/ulcer extremity, active vasculitis, or ischemia
- If treating a DFU did the ulcer fail to reduce in size (less than 50%) while receiving conservative care?
- If treating a DFU is the patient's diabetes under control (e.g., A1C test date and results)?
- If treating a VLU was compression used?
- If the skin substitute is on the payer's "covered" list
- The CAMP was applied according to Instructions for Use, was applied in a single layer, and was not folded or layered
- If the skin substitute is applied over exposed bone, tendon, joint capsule or muscle, document that the Instructions for Use states that use
- Application number for each wound/ulcer
- Improvement in response to skin substitute treatment (by size and by development of granulation tissue and/or epithelial tissue)
- Payers may have other specific documentation requirements. Always be sure to review and include all required information included in the medical policy or LCD, for example but not limited to wastage, manufacturer's serial/lot/batch/identification number, etc.

Modifiers

Payers may require use of select modifiers. Please check with insurers to identify which modifier may be applicable and under which circumstances. Below is a select list of modifiers commonly used with skin substitutes:

Modifier - 50 indicates a bilateral procedure during the same operative session (often used when the same surgical service is performed on both left and right sides of the body; standard multiple procedure payment reductions may apply)

Modifier - 51 indicates that multiple procedures were performed on the same patient by the same provider during the same surgical session (often involved with Moh's procedures; standard multiple procedure payment reductions may apply)

Modifier - 59 indicates a distinct procedural service as is used to identify procedures/services, other than E/M services, which are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual (often involved debridement procedures; standard multiple procedure payment reductions may apply)

Modifier - FB may be required when billing for clinical evaluation grafts provided without cost to the provider or when full credit is received for replaced devices (refer to payer direction for specific reporting requirements for charges and modifiers for your specific scenario)

Modifier - GF may be required when Medicare services are rendered in a Critical Access Hospital (CAH) by a nurse practitioner pr physician assistant

***NOTE:** Medicare 2026 Final Rules clarified that skin substitute products are considered "incident-to supplies," no longer regulated as drugs and biologicals. Therefore, not subject to the Medicare discarded drug policy (and associated modifiers) at this time.

Claims Filing Checklist

Clean claims are those that have been reviewed for accuracy and submitted to the payer clean of errors. To ensure prompt and accurate payment, these steps may help.



- ☐ Verify the patient's insurance eligibility and coverage before applying a skin substitute.
- ☐ Obtain necessary prior authorization or pre-determination.
- ☐ Check codes billed are supported by documentation and include correct date(s) of service and all required provider and patient data.
- ☐ Verify all codes (CPTs, HCPCS, and ICD-10-CM codes), units, and modifier(s) are correctly entered on claims – a simple transposition error can delay processing, cause the claim to be processed incorrectly, or may deny and require rebilling as a corrected claim or appeal.
- ☐ Check payer policies for compliance with covered indications, diagnoses, and/or frequency limits
- ☐ Most electronic claims software and/or clearinghouses perform simple proofreading functions that can assist in flagging claims for clerical errors prior to submission to the payer; however, those same flags can also be bypassed (when appropriate) to allow claims to be processed as-is.

Symphony Reimbursement Case Examples

This section provides four hypothetical case studies across four Medicare beneficiaries to illustrate how Symphony® (HCPCS A2009) may be billed alongside skin substitute application CPT codes in the physician office, hospital outpatient department (HOPD), and ambulatory surgical center (ASC) settings.

Key assumptions used in these examples

- Symphony units are assumed to match the treated wound area exactly (1 HCPCS A2009 unit per 1 cm^2) with no wastage billed.
- Examples assume a single treated wound per encounter and do not include debridement, E/M, imaging, anesthesia, supplies beyond Symphony, or diagnosis-specific coverage edits.
- 2026 Medicare reimbursement for Symphony is at $127.14 per cm^2.
- CPT code selection is based on anatomic site and total wound surface area treated.
- National unadjusted averages are shown; actual reimbursement may vary by locality, payer edits, sequestration, and claim-specific facts.

Patient A

Physician Office (POS 11) | Venous leg ulcer | Medial lower leg | Wound size: 12 cm^2

Single chronic VLU on the lower leg. The wound is on the leg and total treated area is less than 25 cm^2. CPT 15271 is appropriate.

Element	Coding / units	2026 national rate	Potential reimbursement
Physician procedure payment	15271	National physician rate(s) for applicable CPT code(s)	$157.99
Symphony product	A2009 x 12 units	$127.14 per cm^2	$1,525.68
		Total Physician Payment	**$1,683.67**

Patient B

Ambulatory Surgical Center (ASC) (POS 24) | Diabetic foot ulcer | Dorsal foot | Wound size: 18 cm^2

A second illustrative episode for Patient B, included to show ASC reimbursement. The wound is on the foot and less than 25 cm^2 or less. CPT 15275 is appropriate.

Element	Coding / units	2026 national rate	Expected reimbursement
Physician procedure payment	15275	National physician rate(s) for applicable CPT code(s)	$84.17
		Total Physician Payment	**$84.17**
Facility payment	15275	ASC national rate	$94.66
Symphony product	A2009 x 18 units	$127.14 per cm^2	$2,288.52
		Total Facility Payment	**$2,383.18**

Patient C

HOPD (POS 22) | Venous leg ulcer | Lateral calf | Wound size: 38 cm^2

Lower-extremity VLU treated in the HOPD. Physician professional payment follows facility rates; the add-on HOPD facility payment for 15272 is packaged.

Element	Coding / units	2026 national rate	Expected reimbursement
Physician procedure payment	15271, +15272 x1	National physician rate(s) for applicable CPT code(s)	$89.85
		Total Physician Payment	**$89.85**
Facility payment	15271, +15272 x1	HOPD national unadjusted rate (add-on facility code packaged when applicable)	$755.08
Symphony product	A2009 x 38 units	$127.14 per cm^2	$4,831. 8
		Total Facility Payment	**$5,586.88**

Methodology notes

- Office cases use physician non-facility rates for the procedure code(s).
- HOPD cases show the physician facility professional amount and the separate HOPD facility payment. Add-on facility code 15272 is packaged in the HOPD example.
- The ASC case shows the physician facility professional amount plus the ASC facility payment.
- Symphony reimbursement is calculated as wound size in cm^2 × $127.14 per cm^2.

Claim Denials & Appeals

Overcoming Common Denial Reasons

Denials can occur for various reasons, even on claims where there are no errors in coding or coverage. Here are some of the most common denial reasons and suggested actions to take to overturn them.

Error	Examples	Suggested Action
Incorrect Processing by Payer	• Claim appears clean, no errors in coding or coverage can be found, but payment is denied or lower than expected	Call the payer and request additional information. If due to payer error, request they send claim back through for reconsideration.
Clerical (Technical)	• Incorrect Patient ID, missing signatures • Missing or incorrect codes (e.g., transposed numbers) • Incorrect units	Prepare and submit a corrected claim
Billing	• Non-covered or non-allowed service; • Incorrect code(s) or placement of code(s); • Duplicate claim; • Missing authorization number	Prepare and submit a corrected claim. If corrected claim is reprocessed and denied, submit an appeal.
Medical Necessity	• Diagnosis code (ICD-10) not covered; • Medical record documentation, in accordance with respective medical policy, does not support the claim the services performed were medically necessary	Prepare and submit an appeal. Aproductspecific template can be obtained by contacting the Reimbursement Team

Appeal Strategies

- File claims and appeals as soon as possible and within the payer's timely filing limit.
- Verify the payer's preferred methods for receiving appeals (online portal, fax, necessary cover sheet, etc.).
- Clean appeals are equally important as clean claims: Verify all submitted documentation aligns with the patient's encounter, proper coding, and payer medical policies.
- Once submitted, check status to confirm the payer received the appeal. Document the date received, appeal reference number, and verify the expected time for reconsideration. Continue to follow up through resolution.

Should you wish to speak to one of our specialist reimbursement support team, please contact us on:

1-800-807-2762

reimbursement@aroa.com

Fax: 1-877-775-3157



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