



Reimbursement Resource Guide



FOOT & ANKLE



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Coverage for the use of Amniotic Membrane-derived skin substitutes varies by payor, contract, and the patient's plan.

Importance of documentation

Many payors are silent regarding coverage and have no published policies. When there is no policy in place, coverage and medical necessity are determined on a case-by-case basis at the time of claim submission. For this reason, it is important to document the medical necessity in the patient's record, especially conservative care treatments that have been tried and failed.

Providers remain responsible for correct performance, coding, billing, and documenting medical necessity.

Need answers to reimbursement questions?

The Pinnacle Health Group can help with benefit verification or billing issues for Clarix® wound allografts. Reach out to their team of reimbursement professionals, Monday through Friday, 8:30 AM – 6:00 PM ET to help resolve common reimbursement and billing issues. Their contact information is below:



Email: biotissuesurgical@thepinnaclehealthgroup.com

Phone: **866-369-9290**

Fax: 877-499-2986

Hours: Monday to Friday: 8:30 AM – 6:00 PM ET

2024 BioTissue Surgical Coding Sheets – Foot & Ankle

Clarix 1K & Clarix 100

BioTissue Reimbursement Hotline: **866-369-9290**

Email Address: **biotissuesurgical@thepinnaclehealthgroup.com**

Clarix 1K and Clarix 100 are cryopreserved human amniotic membrane product derived from birth tissue. The biological integrity of the Amniotic Membrane and Umbilical Cord is maintained through a proprietary cryopreservation process, called CryoTek®.



 **Clarix 1K**

Cryopreserved Ultra-Thick
Amniotic Membrane Allograft
derived from Human Umbilical
Cord.



 **Clarix 100**

Cryopreserved Human
Amniotic Membrane Allograft

Allograft

HCPCS	Descriptor	Physician Facility	OPPS	ASC
Q4148	Neox 1K, Neox RT, or Clarix 1K, per square centimeter	N/A	Packaged	Packaged
Q4156	Neox 100 or Clarix 100, per square centimeter	N/A	Packaged	Packaged

Implantation of Allograft - Report in addition to primary surgical procedure

CPT	Descriptor	Physician Facility	OPPS	ASC
+15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (e.g., breast, trunk) (List separately in addition to code for primary procedure)	\$208.55	Packaged	Packaged
17999	Unlisted Procedure, skin, mucous membrane, and subcutaneous tissue	By Report	\$190.94/Packaged*	N/A
20999	Unlisted procedure, musculoskeletal system, general	By Report	\$224.92**	N/A
27899	Unlisted procedure, leg, or ankle	By Report	\$207.01**	N/A
28899	Unlisted procedure, foot, or toes	By Report	\$207.01**	N/A

*CPT 17999 has a "Q1" status indicator in the OPPS. Procedures assigned a Q1 status indicator are packaged if reported on the same claim as a HCPCS code with a status indicator of "S", "T" or "V"; otherwise, it is paid separately.

**Placement of Clarix is typically done in conjunction with another orthopedic procedure that has been assigned a J1 status which triggers all other procedures appearing on the same claim to be packaged (i.e., there will be no separate payment).

Revenue Code

Code	Descriptor
636	Pharmacy Extension 025X-Drug Requiring Detailed Coding

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Common Lower Extremity Procedures				
CPT	Descriptor	Physician Facility	OPPS	ASC
TENDON PROCEDURES				
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	\$652.84	\$6,823.42	\$3,393.01
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	\$665.28	\$6,823.42	\$4,458.07
27654	Repair, secondary, Achilles tendon, with or without graft	\$710.13	\$6,823.42	\$4,275.11
27658	Repair flexor tendon, leg, primary, without graft	\$368.00	\$3,087.24	\$1,518.96
27659	Repair flexor tendon, leg, secondary with or without graft, each tendon	\$469.82	\$6,823.42	\$3,393.01
27665	Repair, extensor tendon leg; secondary, with or without graft, each tendon	\$423.00	\$6,823.42	\$4,423.64
27675	Repair dislocating peroneal tendons; without fibular osteotomy	\$492.74	\$3,087.24	\$1,518.96
27676	Repair dislocating peroneal tendons; with fibular osteotomy	\$605.69	\$6,823.42	\$3,393.01
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s))	\$419.07	\$3,087.24	\$1,518.96
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s))	\$505.51	\$3,087.24	\$1,518.96
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	\$463.93	\$3,087.24	\$1,518.96
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	\$529.08	\$3,087.24	\$1,518.96
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (e.g., anterior tibial extensors into midfoot)	\$633.19	\$6,823.42	\$3,393.01
27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (e.g., anterior tibial or posterior through interosseous space, flexor or digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	\$737.30	\$6,823.42	\$3,393.01
ARTHROPLASTY PROCEDURES				
27700	Arthroplasty, ankle	\$644.00	\$6,823.42	\$5,190.49
27702	Arthroplasty, ankle; with implant (total ankle)	\$950.77	\$17,774.76	N/A
27703	Arthroplasty, ankle; revision, total ankle	\$1,095.81	Inpatient Only	N/A
FRACTURE, ARTHRODESIS, AND RECONSTRUCTION PROCEDURES				
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	\$603.07	\$6,823.42	\$3,393.01
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	\$721.92	\$6,823.42	\$3,393.01
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	\$642.36	\$6,823.42	\$4,345.95
27814	Open treatment of bimalleolar ankle fracture (e.g., lateral, and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	\$759.24	\$6,823.42	\$4,385.22
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	\$866.96	\$6,823.42	\$4,415.38
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	\$975.98	\$6,823.42	\$4,387.50
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (e.g., pilon or tibial plafond), with internal fixation, when performed; of fibula only	\$782.49	\$6,823.42	\$4,441.85
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (e.g., pilon or tibial plafond), with internal fixation, when performed; of tibia only	\$1,109.56	\$12,552.87	\$8,755.39

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Common Lower Extremity Procedures, continued

CPT	Descriptor	Physician Facility	OPPS	ASC
FRACTURE, ARTHRODESIS, AND RECONSTRUCTION PROCEDURES, continued				
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (e.g., pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	\$1,311.24	\$12,552.87	\$8,661.07
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	\$703.26	\$6,823.42	\$4,551.97
27870	Arthrodesis, ankle, open	\$996.28	\$12,552.87	\$9,300.00
27871	Arthrodesis, tibiofibular joint, proximal or distal	\$686.89	\$12,552.87	\$8,195.51
28035	Release, tarsal tunnel (posterior tibial nerve decompression)	\$355.88	\$1,841.54	\$897.79
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (e.g., Kidney type procedure)	\$484.22	\$6,823.42	\$3,393.01
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal	\$457.71	\$3,087.24	\$1,518.96
28296	Hallux valgus correction with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedure)	\$508.45	\$3,087.24	\$1,518.96
28299	Hallux valgus correction by double osteotomy	\$589.65	\$6,823.42	\$4,333.72
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	\$404.67	\$6,823.42	\$3,393.01
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	\$385.68	\$3,087.24	\$1,518.96
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed	\$1,108.90	\$6,823.42	\$4,479.69
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	\$1,283.41	\$12,552.87	\$8,668.71
28445	Open treatment of talus fracture, includes internal fixation, when performed	\$1,037.86	\$6,823.42	\$4,442.42
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	\$637.78	\$6,823.42	\$4,256.32
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	\$561.16	\$6,823.42	\$4,386.36
28505	Open treatment of fracture, great toe, phalanx, or phalanges, includes internal fixation, when performed	\$492.74	\$3,087.24	\$1,518.96
28525	Open treatment of fracture, phalanx, or phalanges, other than great toe, includes internal fixation, when performed, each	\$405.65	\$3,087.24	\$1,518.96
28531	Open treatment of sesamoid fracture, with or without internal fixation	\$180.72	\$6,823.42	\$3,393.01
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	\$658.07	\$6,823.42	\$4,404.29
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	\$700.96	\$6,823.42	\$4,782.45
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	\$823.08	\$6,823.42	\$4,342.54
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	\$483.57	\$3,087.24	\$1,518.96
28675	Open treatment of interphalangeal joint dislocation, when performed	\$412.20	\$3,087.24	\$1,518.96
28705	Arthrodesis; pantalar	\$1,202.21	\$17,774.76	\$12,699.07
28715	Arthrodesis; triple	\$929.49	\$12,552.87	\$9,821.71
28725	Arthrodesis, subtalar	\$771.35	\$12,552.87	\$9,005.07
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	\$717.99	\$12,552.87	\$9,594.93
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (e.g., flatfoot correction)	\$767.10	\$12,552.87	\$9,495.71

Common Lower Extremity Procedures, continued

CPT	Descriptor	Physician Facility	OPPS	ASC
FRACTURE, ARTHRODESIS, AND RECONSTRUCTION PROCEDURES, continued				
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (e.g., Miller type procedure)	\$683.94	\$12,552.87	\$9,745.39
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	\$610.60	\$6,823.42	\$4,891.14
28750	Arthrodesis, great toe; metatarsophalangeal joint	\$570.66	\$6,823.42	\$4,745.74
28755	Arthrodesis, great toe; interphalangeal joint	\$332.31	\$6,823.42	\$3,393.01
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (e.g., Jones type procedure)	\$566.73	\$6,823.42	\$4,275.11

Note: In the OPPS, CMS has assigned all of the CPT codes listed above a “J1” status indicator; as such, payment for all covered Part B services reported on the claim are packaged with the primary service for the claim, except services with OPPS SI=F, G, H, L and U.

Imaging

CPT	Descriptor	Physician Facility	OPPS	ASC
73620	Radiologic examination, foot; 2 views	\$7.20	\$86.67/Packaged*	Packaged
73630	Radiologic examination, foot; complete, minimum 3 views	\$7.86	\$86.67/Packaged*	Packaged
73650	Radiologic examination, calcaneus, minimum 2 views	\$7.53	\$86.67/Packaged*	Packaged
76881	Ultrasound, extremity, nonvascular, real time with image documentation; complete	\$41.91	\$104.87	\$10.48
76882	Ultrasound, extremity, nonvascular, real time with image documentation, limited; anatomic specific	\$31.76	\$104.87	Packaged

*Assigned a “Q1” status indicator. Procedures assigned a Q1 status indicator are packed if reported on the same claim as a HCPCS code with a status indicator of “S”, “T” or “V”; otherwise, it is paid separately.

Inpatient

DRG	Descriptor	Payment
500	Soft Tissue Procedures with MCC	\$22,704.79
501	Soft Tissue Procedures with CC	\$12,152.68
502	Soft tissue procedure w/o CC/MCC	\$9,681.11
503	Foot Procedures with MCC	\$18,777.59
504	Foot Procedures with CC	\$12,092.46
505	Foot Procedures without CC/MCC	\$11,942.63
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC	\$22,135.56
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC	\$14,288.87
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures w/o CC/MCC	\$10,463.19
562	Fracture, sprain, strain and dislocation except femur, hip, pelvis & thigh with MCC	\$10,647.33
563	Fracture, sprain, strain & dislocation except femur, hip, pelvis & thigh w/o MCC	\$6,270.63
907	Other OR Procedures for Injuries with MCC	\$26,042.45
908	Other OR Procedures for Injuries with CC	\$14,031.91
909	Other OR Procedures for Injuries w/o MCC/CC	\$9,496.27

Notes & References

The payment rates specified in this document are Centers for Medicare & Medicaid Services (CMS) national unadjusted averages. Actual payment rates will vary based on geographic adjustments and are updated quarterly. Commercial payment rates will vary per contract.

CY 2024 Changes to Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule with Comment and Final CY 2024 Payment Rates (CMS 1786-FC); Addendum B and ASC Addenda.

CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS 1786-FC); Addendum B. All MPFS Fee Schedules calculated using CF of \$32.74 effective January 1, 2024.

DRG values were calculated using a base rate of \$6,497.77 and Capital Standard Payment of \$503.83. The base payment rate assumes the hospital submitted quality data and is a user of EHR. A hospital's base payment rate will change if the hospital does not meet either or both of these measures. Calculations were based on data provided in FY 2024 IPPS Final Rule (Tables 1B, 1D, and 5).

Current Procedural Terminology (CPT®) is a registered trademark of the American Medical Association.

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BioTissue Reimbursement Hotline: **866-369-9290**

Email Address: biotissuesurgical@thepinnaclehealthgroup.com

Sample Form CMS-1450 / UB-04

The CMS-1450 form, also known as UB-04 form, is approved by the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee for facility and ancillary paper billing.

➤ Areas highlighted in Yellow are **Required.**

➤ Areas highlighted in Blue are **Situational/ Required, if applicable/ Optional.**

For complete instructions on preparing the CMS-1450/UB-04, please go to the following link: [Medicare Claims Processing Manual Crosswalk \(cms.gov\)](#)

SOURCE: [Medicare Claims Processing Manual Crosswalk \(cms.gov\)](#)

1		2		3a PAT. CNTL. # b. MED. REC. # 5 FED. TAX NO.		4 TYPE OF BILL	
8 PATIENT NAME				9 PATIENT ADDRESS			
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION	
14 TYPE		15 SRC		16 DHR		17 STAT	
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42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO.		53 AGG. BEN.	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME		59 P. REL.		60 INSURED'S UNIQUE ID		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
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Appeal Resources - Sample Letter Templates

Physician's Sample Appeal Letter:

This is a general template and must be tailored to the patient's specific situation and demonstrate sufficient medical necessity for the service, procedure, or therapy involved.

Insurance Company Name
Insurance Company Address
Insurance Company City, State ZIP

Re: Patient's Name
Insurance
Group/Policy Numbers
Subscriber ID Number

Dear [name of contact person at insurance company],

It is my understanding that [patient's name] has received a denial for [name of procedure] because the procedure is [state specific reason for the denial i.e., not considered medically necessary, experimental, etc.].

As you know, [patient's name] has been under my care since [date] for the treatment of [state diagnosis]. [Give a brief medical history emphasizing the most recent events that directly influence your decision to recommend the denied therapy.]

For this reason, I am writing to provide you with information regarding [name of procedure/treatment]. [Give a brief, yet specific description of the procedure/treatment and why you believe it should be approved].

I have also included a list of several Journal articles supporting the use of [name of procedure/treatment] for [patient's name] [patient's diagnosis].

Based on the information included, I ask that you reconsider your previous decision to deny and authorize prompt payment of their claim. Should you have any questions, please do not hesitate to call me at [insert phone number].

Sincerely,
Your Name
Your Street Address
Email address
Phone Number
Fax Number
Cell Phone Number

Enclosures:
Statement of Medical Necessity if requested.
Journal or peer-reviewed literature/bibliography supporting the service in question.



BioTissue Reimbursement Hotline: 866-369-9290

Email Address: biotissuesurgical@thepinnaclehealthgroup.com

Patient's Sample Appeal Letter Template: (Addressing Medical Necessity)

Insurance Company Name
Insurance Company Address
Insurance Company City, State ZIP

Re: Request for reconsideration of coverage denial.

Your Name
Insurance
Group/Policy Numbers
Subscriber ID Number

Dear [name of representative] or Claims Review Department,

After consulting with my physician, [doctor's name], I have decided to appeal your decision to deny coverage of [his/her] recommended treatment plan for [enter the name of type of surgery or treatment your doctor has recommended that was denied by your insurance company].

Your letter dated [date of denial letter] stated that "[quote the exact reasons for denial from the letter]". On [date], Dr. [name] diagnosed me with [diagnosis]. [If you have obtained any other medical opinions that confirm this diagnosis, list those physicians, also. List any diagnostic test, such as an MRI, x-ray, or CT scan, that was used by your doctor to reach this diagnosis]. This serious medical condition has [describe how your medical condition has affected the quality of your everyday life, the level of pain and disability you are experiencing, your ability to work and any other effects]. Since [date], I have tried various other treatments for my condition. These treatments include: [list treatments, surgeries, non-surgical therapies, and medications].

I am greatly encouraged that my doctor believes I am a good candidate for [name of surgery or treatment that was denied coverage]. [He/she] also believes I will have significant relief from [name what the treatment will do for you, such as relieve pain] after the [name of surgery or treatment that was denied coverage] and will be able to eventually discontinue [list therapies, medications, and other medical treatment your insurer is currently paying for]. Please read Dr. [name]'s Letter of Medical Necessity which is included in this packet. In this letter, Dr. [name] describes my medical history, diagnosis and the rationale used in determining that I should have [name of surgery or treatment that was denied coverage]. This surgery has been [pick appropriate descriptions: approved by the FDA, proven to be safe and effective, proven to have an extremely low complication or re-admission rate, considered a covered treatment by Medicaid, Medicare, and the following private payors: (name insurers)].

I am confident in Dr. [name]'s experience in performing (recommending) this [surgery/treatment.] [He/she] is [doctor's credentials, such as board certification in a given specialty field of medicine, any professional titles such as medical director, any special training in this specific procedure] and has performed this procedure since [date] in more than [number] surgeries. Please contact Dr. [name] or me if you need more information about the efficacy, safety, and effectiveness of the [name of surgery or treatment that was denied coverage]. For your information, I have attached peer review studies, clinical studies and articles from scientific journals regarding this procedure.

I look forward to hearing from you by [date that is within the insurance policy's guidelines]. My contact information is listed below.

Sincerely,

Your Name
Your Street Address, E-mail Address, Phone Number, Fax Number, Cell Phone Number

cc: Doctors' names
Employer name if applicable
Enclosures: [List everything in your appeals packet]
Include a Statement of Medical Necessity from your medical provider.



Appeal Support – Clarix® 100 and Clarix® 1K Bibliography

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BioTissue Reimbursement Hotline: **866-369-9290**Email Address: **biotissuesurgical@thepinnaclehealthgroup.com**

Service Request Form for BioTissue Product

SERVICE: ☐ Prior Authorization (PA) ☐ Pre-Determination (PD) ☐ PA / PD Appeal ☐ Claim Denial / Appeal

PROVIDER INFORMATION

Name of Rendering Physician:

Physician NPI:

Physician TIN:

Medicare PTAN:

Place of Service: ☐ Physician Office ☐ Ambulatory Surgical Center ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Other (Specify) _____

Practice/Facility Name:

Address:

Facility NPI:

Facility TIN:

BioTissue Representative:

Anticipated Procedure Date:

Contact Person:

Contact Phone:

Contact Email Address:

Contact Fax:

PATIENT INFORMATION

Patient Name:

Address:

City:

State:

Zip code:

Gender:

DOB:

Home Phone:

Cell Phone:

Primary Ins:

Ins ID#

Group#

Ins. Phone:

Subscriber Name:

Subscriber DOB:

Secondary Ins:

Ins ID#

Group#

Ins. Phone:

Subscriber Name:

Subscriber DOB:

CLINICAL/PROCEDURE INFORMATION

ICD-10 Diagnosis Code(s)

CPT/Procedure Code(s)

HCPCS/Product/Supply Code(s)

Primary

Secondary

Products to be utilized:

☐ Clarix®1K™ (Q4148)

☐ Clarix®100 (Q4156)

Number of Grafts:

Size of Graft:

Milligrams to be used (if applicable):

Do you have a Business Associate Agreement on file? ☐ Yes ☐ No If no, patient consent is required and must be included

REQUIRED DOCUMENTATION

Please attach all supporting clinical documentation (e.g., plan of care, previous conservative care progress notes, and lab reports, etc.) To obtain a prior authorization or pre-determination.



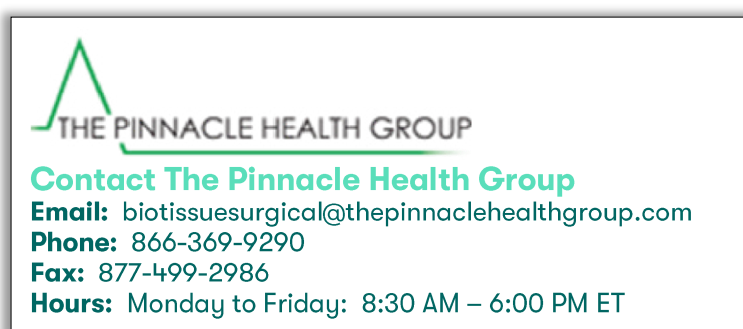
BioTissue Reimbursement Hotline: **866-369-9290**

Email Address: **biotissuesurgical@thepinnaclehealthgroup.com**

Reimbursement Assistance Resource

Have additional reimbursement questions?

The Pinnacle Health Group can help with benefit verification or billing issues for Clarix® wound allografts. Reach out to their team of reimbursement professionals, Monday through Friday, 8:30 AM – 6:00 PM ET to help resolve common reimbursement and billing issues. Their contact information is below:



Requesting / Submitting Prior Authorization Requests (PAs)

Requesting Prior Authorization	Contact Pinnacle, or if you contact the payor, requesting prior authorization and the payor states, "PA not necessary" or "No PA required" ask that they verify that the selected code is a covered, payable code. Also requesting a pre-determination is suggested.
If the PA is denied, identify the reason	Contact the payor for clarification regarding the denial. Reach out to Pinnacle for assistance with the appeal.