2026 BioTissue® Surgical Coding Sheets - Foot & Ankle

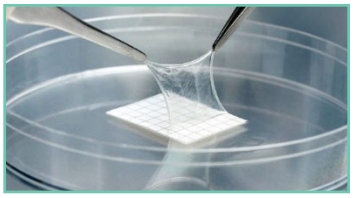
Clarix® 1K & Clarix® 100

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

Clarix 1K and Clarix 100 are cryopreserved human amniotic membrane products 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	Clarix 1K or Clarix 100, 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)	$182.37	Packaged	Packaged
17999	Unlisted Procedure, skin, mucous membrane, and subcutaneous tissue	By Report	Packaged*	N/A
20999	Unlisted procedure, musculoskeletal system, general	By Report	Packaged**	N/A
27899	Unlisted procedure, leg, or ankle	By Report	Packaged**	N/A
28899	Unlisted procedure, foot, or toes	By Report	Packaged**	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	$624.26	$7,413.38	$4,682.29
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	$616.91	$7,413.38	$4,914.65
27654	Repair, secondary, Achilles tendon, with or without graft	$676.37	$7,413.38	$4,714.43
27658	Repair flexor tendon, leg, primary, without graft	$357.06	$3,342.87	$1,644.87
27659	Repair flexor tendon, leg, secondary with or without graft, each tendon	$446.57	$7,413.38	$3,695.53
27665	Repair, extensor tendon leg; secondary, with or without graft, each tendon	$399.47	$7,413.38	$4,836.35
27675	Repair dislocating peroneal tendons; without fibular osteotomy	$468.95	$3,342.87	$1,644.87
27676	Repair dislocating peroneal tendons; with fibular osteotomy	$574.50	$7,413.38	$3,695.53
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s))	$408.49	$3,342.87	$1,644.87
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s))	$489.99	$3,342.87	$1,644.87
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	$443.56	$3,342.87	$1,644.87
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	$503.02	$3,342.87	$1,644.87
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (e.g., anterior tibial extensors into midfoot)	$608.23	$7,413.38	$3,695.53
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 halluxes longus, or peroneal tendon to midfoot or hindfoot)	$702.42	$7,413.38	$3,695.53
ARTHROPLASTY PROCEDURES				
27700	Arthroplasty, ankle	$669.35	$7,413.38	$5,124.73
27702	Arthroplasty, ankle; with implant (total ankle)	$885.46	$27,721.73	$21,837.31
27703	Arthroplasty, ankle; revision, total ankle	$1,017.73	$17,913.59	$14,025.67
FRACTURE, ARTHRODESIS, AND RECONSTRUCTION PROCEDURES				
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	$579.84	$7,413.38	$3,695.53
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	$675.70	$7,413.38	$4,682.29
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	$607.90	$7,413.38	$4,813.11
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	$714.78	$7,413.38	$4,843.35
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	$826.67	$7,413.38	$4,821.39
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	$923.20	$7,413.38	$4,829.98
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	$812.98	$7,413.38	$4,682.29
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	$1,053.46	$13,116.76	$8,938.36

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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	$1,230.16	$13,116.76	$9,196.24
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	$673.03	$7,413.38	$4,876.77
27870	Arthrodesis, ankle, open	$927.88	$13,116.76	$9,693.82
27871	Arthrodesis, tibiofibular joint, proximal or distal	$647.31	$13,116.76	$9,492.21
28035	Release, tarsal tunnel (posterior tibial nerve decompression)	$343.70	$1,995.02	$948.66
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (e.g., Kidney type procedure)	$459.26	$7,413.38	$3,695.53
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal	$438.89	$3,342.87	$1,644.87
28296	Hallux valgus correction with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedure	$484.31	$3,342.87	$1,644.87
28299	Hallux valgus correction by double osteotomy	$563.47	$7,413.38	$4,751.04
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	$385.78	$7,413.38	$3,695.53
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	$371.75	$3,342.87	$1,644.87
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed	$1,048.79	$7,413.38	$4,871.04
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	$1,209.11	$13,116.76	$8,879.17
28445	Open treatment of talus fracture, includes internal fixation, when performed	$976.31	$7,413.38	$4,701.39
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	$619.59	$7,413.38	$4,671.46
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	$542.43	$7,413.38	$4,755.18
28505	Open treatment of fracture, great toe, phalanx, or phalanges, includes internal fixation, when performed	$470.28	$3,342.87	$1,644.87
28525	Open treatment of fracture, phalanx, or phalanges, other than great toe, includes internal fixation, when performed, each	$386.11	$3,342.87	$1,644.87
28531	Open treatment of sesamoid fracture, with or without internal fixation	$174.69	$7,413.38	$4,682.29
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	$612.24	$7,413.38	$5,297.57
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	$675.70	$7,413.38	$5,290.57
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	$793.61	$7,413.38	$4,682.29
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	$461.60	$3,342.87	$1,644.87
28675	Open treatment of interphalangeal joint dislocation, when performed	$394.13	$3,342.87	$1,644.87
28705	Arthrodesis; pantalar	$1,106.57	$17,913.59	$13,461.22
28715	Arthrodesis; triple	$883.79	$13,116.76	$9,510.96
28725	Arthrodesis, subtalar	$729.48	$13,116.76	$9,367.96
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse	$678.37	$13,116.76	$10,044.89
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (e.g., flatfoot correction)	$728.81	$13,116.76	$10,232.44

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)	$631.95	$13,116.76	$9,646.35
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	$577.50	$7,413.38	$5,216.09
28750	Arthrodesis, great toe; metatarsophalangeal joint	$536.75	$7,413.38	$5,187.12
28755	Arthrodesis, great toe; interphalangeal joint	$467.28	$7,413.38	$3,695.53
28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (e.g., Jones type procedure)	$537.09	$7,413.38	$4,705.52

Note: In the OPPS, CMS has assigned all 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	$7.68	$88.91/Packaged*	Packaged
73630	Radiologic examination, foot; complete, minimum 3 views	$8.02	$88.91/Packaged*	Packaged
73650	Radiologic examination, calcaneus, minimum 2 views	$7.68	$88.91/Packaged*	Packaged
76881	Ultrasound, extremity, nonvascular, real time with image documentation; complete	$42.75	$106.81	Packaged
76882	Ultrasound, extremity, nonvascular, real time with image documentation, limited; anatomic specific	$32.06	$106.81	Packaged

*Assigned a "Q1" status indicator. Procedures assigned a Q1 status indicator are packed if reported on the same claim as a HCPPCS 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	$23,029.49
501	Soft Tissue Procedures with CC	$12,720.50
502	Soft tissue procedure w/o CC/MCC	$9,793.79
503	Foot Procedures with MCC	$20,310.16
504	Foot Procedures with CC	$13,601.72
505	Foot Procedures without CC/MCC	$13,045.78
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC	$23,190.31
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC	$15,121.84
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures w/o CC/MCC	$11,182.20
562	Fracture, sprain, strain and dislocation except femur, hip, pelvis & thigh with MCC	$10,367.93
563	Fracture, sprain, strain & dislocation except femur, hip, pelvis & thigh w/o MCC	$6,516.34
907	Other OR Procedures for Injuries with MCC	$27,937.66
908	Other OR Procedures for Injuries with CC	$14,518.59
909	Other OR Procedures for Injuries w/o MCC/CC	$9,552.20

*Payment amounts rounded.

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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 by contract.

CY 2026 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Final CY 2026 Payment Rates (CMS-1834-FC); Addendum B and ASC Addenda.

CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; (CMS-1832-F); Addendum B. All MPFS Fee Schedules calculated using CF of $33.4009 effective Jan. 1, 2026.

DRG values were calculated using a base labor + non-labor rate of $6,752.61 and Capital Standard Payment of $524.15. The base payment rate assumes the hospital submitted quality data and is a user of EHR. The weighted rate used the 10% Cap Applied. A hospital's base payment rate will change if the hospital does not meet either or both measures. Calculations were based on data provided in FY 2026 IPPS Final Rule (Tables 1B, 1D, and Table 5).

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Procedure coding should be based upon medical necessity, procedures and supplies provided to the patient. Coding and reimbursement information is provided for educational purposes and does not assure coverage of the specific item or service in each case. BioTissue and The Pinnacle Health Group make no guarantee of coverage or reimbursement of fees. These payment rates are nationally unadjusted average amounts and do not account for differences in payment due to geographic variation. Contact your local Medicare Administrative Contractor (MAC) or CMS for specific information as the payment rates listed are subject to change. To the extent that you submit cost information to Medicare, Medicaid, or any other reimbursement program to support claims for services or items, you are obligated to accurately report the actual price paid for such items, including any subsequent adjustments. CPT® five-digit numeric codes, descriptions, and numeric modifiers only are Copyright AMA.

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BioTissue Surgical

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