clarix®

AMNIOX REIMBURSEMENT HOTLINE 866-369-9290
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2019 MEDICARE FACILITY REIMBURSEMENT GUIDE
CLARIX CORD 1K, CLARIX 100 & CLARIX FLO

CLARIX CORD 1K, CLARIX 100 and CLARIX FLO are cryopreserved human umbilical cord and/or amniotic membrane products. The biological integrity of the Amniotic Membrane and Umbilical Cord is maintained through a proprietary and patented cryopreservation process, called CRYOTEK®. These products are registered with the Food and Drug Administration (FDA) as Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/P) under Section 361 of the Public Health Service (PHS) Act.

clarix® CORD 1K

clarix® 100

CLARIX CORD 1K	CLARIX 100
Cryopreserved umbilical cord matrix	Cryopreserved amniotic membrane matrix

ALLOGRAFT

HCPCS	DESCRIPTOR	PHYSICIAN FACILITY	HOPPS	ASC
Q4148	Neox Cord 1K, Neox Cord RT, or Clarix Cord 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

HCPCS	DESCRIPTOR	PHYSICIAN FACILITY	HOPPS	ASC
15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure)	$225.24	Packaged	Packaged
17999	Unlisted Procedure, skin, mucous membrane and subcutaneous tissue (List separately in addition to code for primary procedure)	By Report	$176.45/ Packaged*	N/A
20999	Unlisted procedure, musculoskeletal system, general	By Report	$214.89	N/A
22999	Unlisted procedure, abdomen, musculoskeletal system	By Report	$214.89	N/A
23929	Unlisted procedure, shoulder	By Report	$214.89	N/A
24999	Unlisted procedure, humerus or elbow	By Report	$214.89	N/A
26989	Unlisted procedure, hands or fingers	By Report	$214.89	N/A
27299	Unlisted procedure, pelvis or hip joint	By Report	$214.89	N/A
27599	Unlisted procedure, femur or knee	By Report	$214.89	N/A
27899	Unlisted procedure, leg or ankle)	By Report	$214.89	N/A
28899	Unlisted procedure, foot or toes	By Report	$214.89	N/A

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

REVENUE

REVENUE CODE	DESCRIPTOR
636	Pharmacy Extension 025X-Drug Requiring Detailed Coding

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COMMON SHOULDER PROCEDURES

HCPCS	DESCRIPTOR	PHYSICIAN FACILITY	HOPPS	ASC
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	$851.96	$5,699.59	$2,742.94
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	$884.04	$5,699.59	$2,742.94
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	$1,008.37	$5,699.59	$2,742.94
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	$1,094.15	$5,699.59	$2,742.94

Note: In the HOPPS, 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.

COMMON UPPER EXTREMITY PROCEDURES

HCPCS	DESCRIPTOR	PHYSICIAN FACILITY	HOPPS	ASC
24301	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)	$779.17	$5,699.59	$2,742.94
24357	Tenotomy, elbow, lateral, or medial (e.g. epicondylitis, tennis elbow, golfer's elbow); percutaneous	$431.03	$2,623.34	$1,256.16
25110	Excision, lesion of tendon sheath, forearm	$353.90	$1,313.34	$704.72
25115	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths e.g. tenosynobitis, fungus, Tbc, or other granulomas, rheumatoid arthritis; flexors	$785.65	$1,313.34	$704.72
25290	Tenotomy, open flexor or extensor tendon, forearm and/or wrist, single, each tendon	$451.57	$2,623.34	$1,256.16
26145	Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon	$531.58	$1,313.34	$704.72
26160	Excision of lesion sheath or joint capsule (e.g. cyst, mucous cyst, or ganglion), hand or finger	$345.61	$1,313.34	$704.72
26180	Excision of tendon, flexor or extensor, each tendon	$460.58	$1,313.34	$704.72
26350	Repair or advancement, flexor tendon, not in zone 2 digital flexor sheath (e.g. no man's land); primary or secondary without free graft, each tendon	$722.58	$2,623.34	$1,256.16
26352	Secondary with free graft (includes obtaining graft), each tendon	$829.26	$2,623.34	$1,256.16
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (e.g. no man's land); primary, without free graft, each tendon	$822.05	$2,623.34	$1,256.16
26357	Secondary, without free graft, each tendon	$919.00	$2,623.34	$1,256.16
26358	Secondary, with free graft (includes obtaining graft, each tendon)	$1,016.66	$2,623.34	$1,256.16
26440	Tenolysis, flexor; palm or finger, each tendon	$627.44	$1,313.34	$704.72
26455	Tenolysis, extensor tendon, hand or tendon, finger, including forearm, each tendon	$409.40	$1,313.34	$704.72
26500	Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure)	$629.24	$5,699.59	$2,742.94
26502	With tendon or facial graft (includes obtaining graft) (separate procedure)	$722.22	$2,623.34	$1,256.16
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	$595.37	$2,623.34	$1,256.16

26746	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each	$769.07	$2,623.34	$1,256.16
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	$530.14	$1,313.34	$704.72
64718	Neuroplasty and/or transposition; ulnar nerve at elbow	$614.11	$1,631.48	$781.32
64719	Neuroplasty and/or transposition; ulnar nerve at wrist	$416.61	$1,631.48	$781.32
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	$444.00	$1,631.48	$781.32

Note: In the HOPPS, 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.

COMMON LOWER EXTREMITY PROCEDURES

HCPCS	DESCRIPTOR	PHYSICIAN FACILITY	HOPPS	ASC
27412	Autologous chondrocyte implantation, knee	$1,698.52	$5,699.59	N/A
27415	Osteochondral allograft, knee, open	$1,404.44	$10,713.88	$8,575.19
27416	Osteochondral autograft(s), knee, open (e.g. mosiacplasty (includes harvesting of autograft[s]).	$1,009.09	$5,699.59	$3,762.24
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	$681.14	$2,623.34	$1,256.16
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	$698.08	$5,699.59	$2,742.94
27654	Repair, secondary, achilles tendon, with or without graft	$735.67	$5,699.59	$2,742.94
27658	Repair flexor tendon, leg, primary, without graft	$385.26	$2,623.34	$1,256.16
27659	Repair flexor tendon, leg, secondary with or without graft, each tendon	$489.77	$5699.59	$2,742.94
27665	Repair, extensor tendon leg; secondary, with or without graft, each tendon	$429.59	$5,699.59	$2,742.94
27675	Repair dislocating peroneal tendons; without fibular osteotomy	$508.51	$2,623.34	$1,256.16
27676	Repair dislocating peroneal tendons; with fibular osteotomy	$622.40	$5,699.59	$2,742.94
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s)	$439.68	$2,623.34	$1,256.16
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s)	$568.70	$2,623.34	$1,256.16
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	$480.76	$2,623.34	$1,256.16
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through sane incision), each	$565.81	$2,623.34	$1,256.16
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (e.g., anterior tibial extensors into midfoot)	$662.40	$5,699.59	$2,742.94
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	$773.40	$5,699.59	$2,742.94
27700	Arthroplasty, ankle	$633.93	$5,699.59	$2,742.94
27702	Arthroplasty, ankle; with implant (total ankle)	$998.64	Inpatient Only	
27703	Arthroplasty ankle; revision, total ankle	$1,152.53	Inpatient Only	
28035	Release, tarsal tunnel (posterior tibial nerve decompression)	$369.76	$1,631.48	$781.32
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (e.g., Kidner type	$504.91	$5,699.59	$2,742.94

28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal	$478.60	$2,623.34	$1,256.16
28296	Hallux valgus correction with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedure	$534.10	$2,623.34	$1,256.16
28299	Hallux valgus correction by double osteotomy	$605.46	$2,623.34	$1,256.16
28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	$418.41	$5,699.59	$2,742.94
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	$393.55	$2,623.34	$1,256.16
28750	Arthrodesis, great toe; metatarsophalangeal joint	$606.54	$5,699.59	$3,892.49
28755	Arthrodesis, great toe; interphalangeal joint	$344.53	$5,699.59	$2,742.94
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g., mosiacplasty) includes harvesting of the autograft[s])	$1,093.07	$5,699.59	$2,742.94
29867	Arthroscopy, knee, surgical; osteochondral allograft	$1,324.08	$10,713.88	N/A

Note: In the HOPPS, 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

HCPCS	DESCRIPTOR	PHYSICIAN FACILITY	HOPPS	ASC
73620	Radiologic examination, foot; 2 views	$7.93	$62.30Packaged*	Packaged
73630	Radiologic examination, foot; complete, minimum 3 views	$8.65	$62.30/Packaged*	Packaged
73650	Radiologic examination, calcaneus, minimum 2 views	$8.29	$62.30/Packaged*	Packaged
76881	Ultrasound, extremity, nonvascular, real time with image documentation; complete	$32.44	$112.51	$57.66
76882	Ultrasound, extremity, nonvascular, real time with image documentation, limited; anatomic specific	$25.23	$112.51	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
502	Soft tissue procedure w/o CC/MCC	$7,778.51
508	Major shoulder or elbow joint procedure w/o CC/MCC	$8,720.17
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC	$18,568.16
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC	$11,358.99
517	Other Musculoskeletal System and Connective Tissue OR Procedures w/o CC/MCC	$8,319.53
563	Fracture, sprain, strain & dislocation except femur, hip, pelvis & thigh w/o MCC	$5,049.31
907	Other OR Procedures For Injuries W MCC	$25,400.79
908	Other OR Procedures For Injuries W CC	$12,006.06
909	Other OR Procedures For Injuries Without MCC/CC	$7,985.15

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CLARIX FLO

CLARIX FLO

Lyophilized umbilical cord and amniotic membrane product in particulate form for the replacement or supplementation of damaged or inadequate integumental tissue.

ALLOGRAFT PARTICULATE

HCPCS	DESCRIPTOR	PHYSICIAN FACILITY	HOPPS	ASC
Q4155	NEOX FLO or CLARIX FLO, 1mg	N/A	Packaged	Packaged

INJECTION

HCPCS	DESCRIPTOR	PHYSICIAN FACILITY	HOPPS	ASC
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	$40.72	$247.48	$24.14
20551	Injection; single tendon origin/insertion	$41.44	$247.48	$25.22
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	$39.28	$247.48	$30.27
20553	Injection(s); single or multiple trigger point(s), 3 or more muscle(s)	$44.69	$247.48	$35.31
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	$37.12	$247.48	$23.06
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	$48.29	$247.48	$40.00
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	$38.56	$247.48	$24.50
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	$55.14	$598.81	$43.24
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	$47.57	$247.48	$28.83
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	$63.07	$247.48	$49.01
22899	Unlisted procedure, spine	By Report	$225.09	Not Payable in ASC
20999	Unlisted procedure, musculoskeletal system	By Report	$225.09	Not Payable in ASC
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	N/A	$59.75/Packaged*	Packaged

*CPT 96372 has a "Q1" status indicator. 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.

IMAGING

HCPCS	DESCRIPTOR	PHYSICIAN FACILITY	HOPPS	ASC
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$32.80	Packaged	Packaged
77002	Fluoroscopic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device)	$28.47	Packaged	Packaged
77012	CT guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), radiological supervision and interpretation	$75.68	Packaged	Packaged
77021	MR guidance for needle placement (e.g. for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	$74.96	Packaged	Packaged

REVENUE

REVENUE CODE	DESCRIPTOR
636	Pharmacy Extension 025X-Drug Requiring Detailed Coding

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.
- Hospital Outpatient Prospective Payment – Final Rule with Comment and Final CY2019 Payment Rates (CMS-1695-FC); Addendum B and ASC Addenda.
- CY 2019 Revision to Payment Policies under the Physician's Fee Schedule and Other Revisions to Part B (CMS-1693-F); Addendum B. All MPFS Fee Schedules calculated using CF of $36.0391 effective January 1, 2019
- DRG values calculated using a base rate of $5565.30 and Capital Standard Payment of $459.41. The national average hospital Medicare base rate is an average of the sum of four categories: Hospital Submitted Quality Data and is a Meaningful EHR User, Hospital Did NOT Submit Quality Data and is a Meaningful EHR User, Hospital Submitted Quality Data and is NOT a Meaningful EHR User, Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User. This information is provided as a benchmark reference only. There is no official publication of the average hospital base rate; therefore, the national average payments provided are approximate. Actual reimbursement will vary by geographic region, status as a teaching facility, share of low-income patients, status of submitting quality data, status as a meaningful electronic health user, participation in the Hospital Value-Based Purchasing (VBP), and Hospital Readmissions Reduction Program (HRRP). Calculations were based on data provided in FY 2019 IPPS Final Rule CN (Tables 1A, 1D, and 5).
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