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2019 MEDICARE FACILITY REIMBURSEMENT GUIDE
CLARIX FLO

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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.

Disclaimer: The guidance contained in this document, dated January 1, 2019, is provided for informational purposes only and represents no statement, promise or guarantee by Amniox® Medical Inc. concerning reimbursement, payment, charges. Similarly, all CPT codes and HCPCS codes are supplied for informational purposes only and represent no statement, promise or guarantee by Amniox Medical Inc. that these code selections will be appropriate for a given service or that reimbursement will be made to the provider. This Guide is not intended to increase or maximize reimbursement by a Payer. Amniox Medical Inc. strongly recommends that you consult your individual Payer Organization with regard to its relative and current reimbursement policies.

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).
- 2019 AMA CPT Professional Edition

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