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AROA™

Aroa U.S. reimbursement primer



WHITE PAPER

A. BACKGROUND

US reimbursement arrangements influence healthcare providers' willingness and ability to purchase AROA's products. Providers purchase the products used in a patient's treatment and seek payment (reimbursement) from the patient's insurer. That payment may include the product's cost within an overall payment for care or reimburse it separately. Whether payment is available, and how much the provider receives, depends on the insurer's requirements, the patient's condition and the setting in which treatment takes place.

This primer explains the reimbursement pathways relevant to Myriad Matrix™ and Myriad Morcells™ products used in inpatient care and Symphony™ products used in outpatient care, and is intended to help investors understand how these arrangements affect purchasing decisions and product adoption.

Important notes

- Patients in the US may obtain health insurance in various ways depending on factors such as age, income, employment, and disability. This primer primarily explains payment arrangements under traditional Medicare, also known as Original Medicare (the federal health insurance programme primarily for people aged 65 and over and some younger people with disabilities), while also referring to other insurers. Coverage requirements and provider payment arrangements may differ under Medicare Advantage plans and other insurance arrangements.
- The reimbursement amount paid to the healthcare provider is separate from the price it pays for the product, which may differ from AROA's selling price if the product was purchased through a distributor.
- FDA clearance and reimbursement are separate. FDA clearance allows a product to be marketed in the US for specified uses but does not automatically mean that Medicare or a private health insurer will reimburse providers for using the product in treatment.
- Similarly, product-specific billing codes enable a product to be identified on an insurance claim. The fact that a product has been granted a code does not automatically establish insurance coverage or entitlement to separate payment.
- This document is provided as part of the AROA Biosurgery Investor Presentation dated 25 November 2026. The Important Notice and Disclaimer set out in that presentation applies to this document.
- This information is current as at 25 November 2026.

B. MYRIAD AND INPATIENT REIMBURSEMENT

1. How hospitals are paid for inpatient care

When a patient is admitted to hospital, Medicare generally pays the hospital a predetermined amount for that admission. The payment is based on a *Diagnosis-Related Group* code, or DRG, which groups cases according to the patient's condition, treatment and complexity.

Private health insurers pay hospitals under negotiated contracts. These contracts may also use DRG-based or similar payments that provide an agreed amount for an inpatient admission. The amount is negotiated between the insurer and the hospital. Other contracts use daily rates or other payment arrangements. Under bundled payment arrangements, medical products are generally paid for within the hospital's overall reimbursement, unless the contract provides for separate payment.

This type of bundled payment generally covers the services and supplies typically provided and used by the hospital throughout the admission (except doctors' professional fees which are generally billed separately). The types of services and supplies that are generally covered include:

- Accommodation, meals and nursing care.
- Operating theatre facilities and recovery room care.
- Medicines, medical supplies and surgical products, including tissue matrices.
- Laboratory tests and diagnostic imaging.
- Rehabilitation and other hospital support services.

The hospital manages these costs within its overall payment. This gives hospitals a financial incentive to select treatments that are competitively priced and deliver good clinical outcomes, helping control the total cost of the admission. For example, a more expensive medical device may reduce the hospital's margin unless its cost is offset by savings elsewhere in the patient's care or additional reimbursement. Similarly, postoperative complications resulting from use of a medical device can require additional treatment and extend the hospital stay, increasing costs and potentially reducing the hospital's margin.

2. How Myriad Matrix™ and Myriad Morcells™ fit into the reimbursement picture

A separate CMS product-specific billing code is not generally required for use within this bundled DRG payment. The adoption of Myriad Matrix and Myriad Morcells devices is subject to the hospital's own approval process, typically through a Value Analysis Committee. This committee assesses a product's clinical benefits, safety and cost before approving it for use. Treatment must also meet applicable insurer coverage and medical necessity requirements.

When Myriad Matrix or Myriad Morcells is used during an inpatient admission paid on a DRG or other bundled basis, the device costs are generally included within that payment. The hospital

purchases the product and pays for it from the overall payment it receives for the admission. For AROA, this means hospital purchasing decisions are heavily influenced by evidence about the products' clinical benefits and their value within the overall cost of care. Evidence that a product can help reduce post-operative complications, further procedures or length of hospital stay can strengthen that value proposition.

C. SYMPHONY AND OUTPATIENT REIMBURSEMENT

1. The basic reimbursement pathway

Outpatient care takes place without a formal inpatient admission. It includes treatment in hospital outpatient departments, ambulatory surgical centres and physicians' offices. The relevant reimbursement pathway in these settings depends on three related factors:

- Coding: The specific billing codes used to identify the product and the procedure in which it was applied.
- Coverage: Whether the patient's insurer covers the product for the condition being treated and what requirements must be met (e.g. whether standard wound care has been tried first).
- Payment: How much the provider is reimbursed for the product and procedure.

2. The move to standardized skin substitute payments

In January 2026, Medicare introduced a standardized base rate of approximately **US$127 per square centimetre** for eligible sheet-form skin substitute products in the principal outpatient settings (hospital outpatient departments, ambulatory surgical centres and physician offices), with a separate payment for the procedure to apply the skin substitute product. [1]

In November 2026, CMS confirmed that the US$127.14 per square centimetre rate for eligible sheet-form skin substitutes would continue in 2027 for those settings. From 1 January 2027 the payment methodology will also extend to eligible non-sheet skin substitute products used in the physicians' office setting. [2]

The existence of this payment rate does not establish nationwide coverage for Symphony. Coverage depends on the policies of the relevant Medicare contractor or other insurer and the circumstances of treatment. In addition, payment is subject to the applicable coverage and billing requirements, and actual payment can vary with applicable geographic and other adjustments.

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[1] Centers for Medicare & Medicaid Services, *CY 2026 Medicare Physician Fee Schedule Final Rule*, "Skin Substitutes" (link); *Hospital Outpatient Prospective Payment System: January 2026 Update*, MM14361, pp. 8–9 (link); and *April 2026 Update of the Ambulatory Surgical Center Payment System*, Transmittal 13704, section 5 (link).

[2] Centers for Medicare & Medicaid Services, *CY 2027 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule* (CMS-1850-FC); and *CY 2027 Medicare Physician Fee Schedule Final Rule*, subsection "National Payment for Non-Sheet Form Skin Substitutes", 91 FR 71090–71091 (9 November 2026) (link).

The new approach outlined above replaced product-specific pricing in physician offices and the bundled (product-and-procedure) payments in hospital outpatient departments[3] that had created an incentive for providers to select products that offered higher financial margins (particularly in the physician's office). Under this payment framework, Medicare spending on skin substitute products experienced a period of rapid growth. The reform aims to control spending and create more consistent payment across products and treatment settings. oig.hhs.gov

For providers, the changes reduce the financial attraction of products previously associated with high reimbursement rates.

We set out how covered procedures involving skin substitute products are reimbursed by Medicare in various outpatient settings below. Private insurers pay according to their coverage policies and contracts with the specific providers.

3. Symphony in the hospital outpatient department

Hospital outpatient departments provide procedures and treatments without admitting the patient as an inpatient. These include many hospital-based wound care centres.

Medicare generally makes two key payments to hospitals for covered skin substitute application procedures in this setting:

- A payment for the procedure performed, covering resources such as facilities, nursing and routine supplies.
- A separate payment for eligible sheet-form skin substitute products. Payment for Symphony depends on the applicable coverage requirements, the patient's clinical circumstances and appropriate documentation. www.cms.gov

The hospital uses the second payment above to contribute to the acquisition cost of the product.

Fees for doctors' professional services are generally billed separately from these hospital payments.

4. Symphony in Ambulatory Surgical Centres

An ambulatory surgical centre performs surgical procedures for patients who generally return home the same day.

Putting doctors' professional fees to one side, Medicare generally pays the centre:

[3] Department of Health & Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS), Calendar Year (CY) *2026 Medicare Physician Fee Schedule Final Rule* (CMS-1832-F), Oct 31, 2025. https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f

- A facility fee for eligible procedures performed, covering resources such as facilities, nursing, equipment and routine supplies.
- A separate amount for eligible sheet-form skin substitute products when used during a qualifying procedure. Payment for Symphony's use depends on the applicable coverage and billing requirements.

5. Symphony in physician offices

Physician offices include community-based specialist practices that provide wound care (e.g. podiatry practices). For covered skin substitute application procedures, Medicare generally pays the practice:

- A fee for the procedure performed, reflecting the clinician's work and practice expenses.
- A separate amount for eligible skin substitute products. Payment for Symphony's use depends on the applicable coverage and billing requirements.

6. What this Means for AROA and Symphony

AROA believes that the fact that Symphony has a product-specific billing code and published randomized clinical evidence puts Symphony in a good position in terms of provider confidence and pursuing broader Symphony coverage. Neither guarantees payment, but both address important components of the outpatient reimbursement pathway.

- **Greater emphasis on reimbursement confidence**: Medicare's payment reforms and heightened scrutiny of skin substitute billing have increased the importance of a clear reimbursement pathway. Providers need confidence that treatment meets coverage requirements and that paid claims can withstand subsequent audit. In a physician-owned practice, the costs of responding to audits and repaying amounts paid for disallowed claims can directly affect the practice and its owner. www.cms.gov

  Symphony's product-specific billing code, A2009, allows providers to identify the product directly on a claim, rather than use an unspecified product code. This provides greater clarity when billing for the product, although payment remains subject to applicable coverage and other requirements.

- **Clinical evidence to support coverage**: Medicare coverage reviews have historically highlighted the importance of high-quality clinical evidence, particularly randomized controlled trials, when assessing skin substitutes. Requirements vary between insurers but a product's billing code and FDA clearance alone do not demonstrate its effectiveness in healing a particular wound. www.cms.gov Symphony has published randomized controlled trial evidence evaluating treatment using Symphony plus standard care against standard care alone in patients with diabetic foot ulcers.[4] AROA believes that this product-specific

[4] Armstrong DG, Orgill DP, Galiano RD, Lantis JC, Glat P, Reyzelman AM, Snyder RJ, Isaac AL, Carter MJ, Zelen CM. A Composite Ovine Forestomach Matrix and Hyaluronic Acid CAMP for the Treatment of Full Thickness Wounds of the

clinical evidence will help support coverage submissions and payer reviews. onlinelibrary.wiley.com Coverage decisions remain subject to each payer's assessment of the evidence and its applicable policies.

Foot in People With Diabetes: A Randomized Controlled Trial. Int Wound J. 2026 Oct;23(10):e71056. doi: 10.1111/iwj.71056.