Cartiform® Viable Osteochondral Allograft Reimbursement Guide 2024

Cartiform Patient Support Hotline: 1-866-988-3491 • Fax: 1-866-304-6692 • Customer Support: 1-866-352-4540

Osiris Reimbursement Support Services

Cartiform Patient Support Hotline
For assistance with reimbursement questions, contact the Cartiform Patient Support Hotline at 866-988-3491. Normal business hours are 8 AM - 7 PM ET, Monday through Friday.

Cartiform Patient Support Hotline staff can assist with the following:

- Patients younger than 50 years of age with a chief complaint of pain limiting their desired activities
- Patient-specific insurance verifications
- Payer policy and Medicare Local Coverage Determination (LCD) information
- Nurse Case Manager review of documentation and coding
- Prior authorization and predetermination support
- General coding and reimbursement questions

Provider Responsibility
The provider is responsible for verifying individual contract or reimbursement rates with each payer. The Cartiform Patient Support Hotline is not able to confirm contracted or reimbursable rates on your behalf.

Note: Private payer coverage and payment policies will vary. Payers should be consulted in regard to their specific policies. Most payers closely monitor Medicare fee schedules.

How to Request Support for Patients?
To initiate insurance verification support for your patients, please submit a complete Insurance Verification Request Form (IVR) with a signed practitioner authorization and fax to 866-304-6692.

Reimbursement Disclaimer

Reimbursement guidance included in this billing guide, including coding information, is supplied for informational purposes only and does not represent a statement, promise, or guarantee by Osiris or Arthrex that these codes will be appropriate or that reimbursement will be made. Coding practice will vary by site of care, patient condition, services provided, local payer instructions, and other factors. Coding requirements are subject to change at any time; please check with your local payer regularly for updates.

The decision as to how to complete a reimbursement form, including amount to bill, is exclusively the responsibility of the provider. The provider is ultimately responsible for verifying coverage with the patient's payer source and billing appropriately for services provided.

Coding Guidelines

The following HCPCS codes are associated with Cartiform® viable osteochondral allograft:
There are no HCPCS codes specifically assigned to identify Cartiform viable osteochondral allograft. CPT®[a] code 27415 and CPT code 29867 are designated as device-intensive procedures. Medicare requires that facilities submit a device HCPCS code when device intensive procedures are reported. When a device used in a device-intensive procedure does not have a specific HCPCS code, Medicare recommends that the HCPCS code C1889 is reported.

HCPCS	Code Description
L8699	Prosthetic implant, not otherwise specified
C1889	Implantable/insertable device not otherwise classified

[a] CPT (Currently Procedural Terminology) is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein.

Common Physician Procedure Coding
The physician's professional reimbursement for an unlisted service is typically determined on a case-by-case basis. The post-service determination includes a review of documentation submitted with the claim and payment is based on a determination of medical necessity for the service provided.

CPT codes are used by hospital outpatient departments, ambulatory surgery centers, and physicians to describe professional services and procedures.

Based on CY2024 Medicare Physician Fee Schedule national payment amount averages as follows:

CPT	Code Description[b]	Payment
27415	Osteochondral allograft, knee, open	$1378.10
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	$1285.56

Common Hospital Outpatient Coding
Under the Hospital Outpatient Prospective Payment System, CMS generally assigns the unlisted procedure or service to the lowest level Ambulatory Payment Classification (APC) code within the most appropriate clinically related series of APCs. Payment for items reported with unlisted codes is often packaged. Hospital outpatient payment will vary by each private payer. Please contact the payer regarding questions on hospital outpatient payment.

CPT codes are used by hospital outpatient departments, ambulatory surgery centers, and physicians to describe professional services and procedures.

Based on CY2024 Medicare Hospital Outpatient Fee Schedule national payment amount averages as follows:

CPT Cross-Reference	APC / Status[c]	Description	Payment
27415, 29867	5115/J1	Level V musculoskeletal procedure	$12,552.87

[b] CMS Conversion Factor (CF) effective March 9, 2024: $33.2875
[c] Status Key: J1 = Hospital Part B services paid through a comprehensive APC

See above: OPPS HCPCS Codes - L8699 or C1889

Common ASC Coding

Based on CY2024 Medicare Ambulatory (ASC) Fee Schedule national payment amount averages as follows:

CPT	Code Description	Payment
27415	Osteochondral allograft, knee, open	$9585.12
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	$9719.77

Private payers should be contacted for their specific ASC coverage and payment guidelines; J8 - Device-intensive procedure; paid at adjusted rate.

Common Inpatient Coding

Medicare Severity-Diagnosis Related Groups (commonly referred to as DRGs) are used to reimburse hospitals for inpatient stays. Each inpatient stay is assigned a DRG that is determined according to the principal diagnosis, major procedures, discharge status, and complicating secondary diagnoses. Each DRG is assigned a flat payment rate, which is adjusted according to the individual hospital's teaching status, disproportionate share services for treating low-income patients, and location in urban versus rural regions, etc. Note: DRGs do not include payment for physician services, which are coded and reimbursed separately.

There are three levels of severity in most DRG categories:

- MCC: Major Complication/Comorbidity, which reflects the highest level of severity
- CC: Complication/Comorbidity, which is the next level of severity
- Non-CC—Non-Complication/Comorbidity, which does not significantly affect severity of illness and resource use

Based on CY2024 Medicare DRG national payment rates are as follows:

DRG	DRG Description	Payment
515	Other musculoskeletal system and connective tissue OR procedures with MCC	$22,135.56
516	Other musculoskeletal system and connective tissue OR procedures with CC	$14,288.87
517	Other musculoskeletal system and connective tissue OR procedures with CC/MCC	$10,436.19

L8699 Prosthetic implant, not otherwise specified
C1889 Implantable/insertable device, not otherwise classified

Private Insurers

Private insurers cover hospital inpatient services that are considered medically necessary and within the benefit structure of the patient's health insurance coverage. Payment for knee procedures may be based on a percentage of the billed or allowed charges, per diem, or on a negotiated payment rate. Check with your payer organizations to determine the payment methodology for knee procedures.

ICD10-PCS Procedural Codes Crosswalk

The International Classification of Disease 10th Revision Procedure Coding System (ICD10-PCS) is a system of medical classification used for procedural codes that track various health interventions taken by medical professionals effective October 1, 2015. Below you will find the most common ICD10-PCS that may apply to patients undergoing knee procedures:

27415	0SUC0KZ Supplement right knee joint with nonautologous tissue substitute, open approach 0SUD0KZ Supplement left knee joint with nonautologous tissue substitute, open approach
29867	0SUC4KZ Supplement right knee joint with nonautologous tissue substitute, percutaneous endoscopic approach 0SUD4KZ Supplement left knee joint with nonautologous tissue substitute, percutaneous endoscopic approach

This pricing information is taken directly from the CMS website https://www.CMS.gov, and is supplied as is for informational purposes only. Osiris makes no opinion, statement, promise, or guarantee that reimbursement will be made by a payer.

Always refer to the insurer-specific coverage policy or contact the insurer for instructions. The ICD-10 and HCPCS codes are supplied for informational purposes only and do not represent a statement, promise, or guarantee by Osiris or Arthrex that these codes will be appropriate or that reimbursement will be made. Coding practice will vary by site of care, patient condition, range of service provided, local payer instructions, and other factors. The decision as to how to complete a reimbursement form, including amount to bill, is exclusively the responsibility of the provider. The provider is ultimately responsibility for verifying coverage with the patient's payer source.

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