

Autograft OATS[®] Technique

2025 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the OATS technique, the following information is shared for educational and strategic planning purposes only. While Arthrex believes this information to be correct, coding and reimbursement decisions by AMA, CMS, and leading payers are subject to change without notice. As a result, providers are encouraged to speak regularly with their payers.

Value Analysis Significance

The disposable donor and recipient cutting tube sets of the single-use osteochondral autograft transplant system (OATS) kit facilitate harvesting of various diameter osteochondral/hyaline cartilage cylinders from a donor site superior and lateral to the femoral notch or above the sulcus terminalis. A recipient socket, sized to the proper depth, is created in the chondral defect to accept the donor graft. The bone cylinder is inserted with a collared pin delivery system for press-fit fixation.

Coding Considerations

Codes provide a uniform language for describing services performed by health care providers. The actual selection of codes depends upon the primary surgical procedure, supported by details in the patient's medical record about medical necessity. It is the sole responsibility of the health care provider to correctly prepare claims submitted to insurance carriers.

Physician's Professional Fee

The primary arthroscopic procedure determined by the surgeon may include:

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician ^{b,c}		Hospital Outpatient ^d		ASC ^e
CPT ^a Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC and APC Description	Medicare National Average	Medicare National Average
Knee						
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	\$1040.26	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	\$7143.73	\$1579.16
27415	Osteochondral allograft, knee, open	\$1350.47	N/A	5115 - Level 5 MSK Procedures	\$12,866.82	\$11,001.72
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])	\$967.81	N/A	5114 - Level 4 MSK Procedures	\$7143.73	\$3510.84
Foot/Ankle						
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	\$646.11	N/A	5114 - Level 4 MSK Procedures	\$6823.42	\$3393.01
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	\$1205.88	N/A	5114 - Level 4 MSK Procedures	\$7143.73	\$4449.87

^a CPT (Current Procedural Terminology) is a registered trademark of the American Medical Association. Health care providers and their professional coders must closely review this primary citation along with the patient's medical record before selecting the appropriate code.

^b AMA CPT 2025 and CMS PFS 2025 Final Rule

^c CMS Conversion Factor (CF) effective January 1, 2025: \$32.3465

^d CMS 2025 OPFS Final Rule @ www.cms.gov

^e CMS 2025 ASC Final Rule @ www.cms.gov



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HCPCS Code	Code Description	Notes
C1762	Connective tissue, human These tissues include a natural, cellular collagen or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue.	For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (eg, hospital, ASC). These costs are absorbed by the facility via the appropriate reimbursement mechanism (eg, MS-DRG, APC, etc).
L8699	Prosthetic implant, no otherwise specified This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	For non-Medicare (eg, commercial) patients, depending on contractual terms and general stipulations of the payer, direct invoicing by the facility may be allowed. Contact the patient's insurance company or refer to the facility's payer contract for more information.
A4649	Surgical supplies; miscellaneous This code reports miscellaneous surgical supplies and should only be reported if a more specific HCPCS Level II or CPT code is not available.	

List of Pass-Through Payment Device Category Codes (Updated September 2022) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment

For more information about the primary procedure, please speak with your admitting surgeon. You may also call the Arthrex Coding Helpline at 1-844-604-6359 or email arthrexRSP@arthrex.com.

The content provided in this guide is for informational purposes only. The Arthrex Coding Helpline does not guarantee reimbursement by third-party payers.

The information provided in this handout was obtained from many sources and is subject to change without notice as a result of changes in reimbursement laws, regulations, rules, and policies. All content on this website is informational only, general in nature, and does not cover all situations or all payers' rules and policies. This content is not intended to instruct medical providers on how to use or bill for health care procedures, including new technologies outside of Medicare national guidelines. A determination of medical necessity is a prerequisite that we assume will have been made prior to assigning codes or requesting payments. Medical providers should consult with appropriate payers, including Medicare fiscal intermediaries and carriers, for specific information on proper coding, billing, and payment levels for health care procedures. It is the sole responsibility of the medical provider to determine the appropriate coding.

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