IntraOsseous BioPlasty® Technique

2024 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic procedures completed with IntraOsseous BioPlasty (IOBP®) 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 IntraOsseous BioPlasty (IOBP) surgical technique is for the treatment of bone pathologies resulting from acute or chronic injury, including bone marrow lesions associated with insufficiency fractures, persistent bone bruises, osteoarthritis, and early stages of avascular necrosis. Arthrex offers options for the treatment of these pathologies by performing a core decompression of the lesion and a direct application of platelet-rich plasma concentrate (cPRP) from bone marrow aspirate (BMA) using the Arthrex Angel® cPRP and bone marrow processing system. The IOBP procedure is the biologic treatment of bone marrow lesions with techniques that encourage physiologic bone remodeling and repair.

Coding Considerations

Codes provide a uniform language for describing services performed by health care providers. The actual selection of codes depends on 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:

2024 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		**Physician**[b,e]		**Hospital Outpatient**[c]		**ASC**[d]
		Medicare National Average				
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						
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedures)	$417.43	$559.23	5113 - Level 3 Musculoskeletal (MSK) Procedures	$3087.24	$1518.96
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)	$545.92	N/A	5113 - Level 3 MSK Procedures	$3087.24	$1518.96
29876	Arthroscopy, knee, surgical; synovectomy, major, two or more compartments (eg, medial or lateral)	$660.76	N/A	5113 - Level 3 MSK Procedures	$3087.24	$1518.96
29877	Arthroscopy, knee, surgical; debridement/ shaving of articular cartilage (chondroplasty)	$628.80	N/A	5113 - Level 3 MSK Procedures	$3087.24	$1518.96
29886	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion	$645.78	N/A	5113 - Level 3 MSK Procedures	$3087.24	$1518.96
29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation	$762.95	N/A	5114 - Level 4 MSK Procedures	$6823.42	$3393.01
27509	Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or transcondylar, with or without intercondylar extension, or distal femoral epiphyseal separation	$684.72	N/A	5114 - Level 4 MSK Procedures	$6823.24	$4600.34

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Foot and Ankle						
28320	Repair, nonunion or malunion, tarsal bone	$621.81	N/A	5115 – Level 5 MSK Procedures	$12,552.87	$8150.81
28322	Metatarsal, with or without bone graft (includes obtaining graft)	$583.53	$788.58	5114 – Level 4 MSK Procedures	$6823.42	$4550.26
20999	Unlisted procedure, musculoskeletal system, general	Contractor priced		5111 – Level 1 MSK Procedures	$224.92	N/A

[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 2024 and CMS PFS 2024 Final Rule

[c] CMS 2024 OPPS Final Rule @ www.cms.gov

[d] CMS 2024 ASC Final Rule @ www.cms.gov

[e] CMS Conversion Factor (CF) effective March 9, 2024: $33.2875

HCPCS Code	Code Description	Notes
L8699	**Prosthetic implant, no otherwise specified** This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	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).
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.	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.
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.

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