2023 Coding and Reimbursement Guidelines for Meniscal Allograft Transplant Procedure

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the Dovetail Meniscal Allograft Set, 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 dovetail technique simplifies graft preparation with a time-saving series of cuts preparing the bone component of the graft to sit securely in the recipient semi-trapezoidal slot created in the tibia. A matching semi-trapezoidal shaped recipient slot created in the tibia with a series of step drills, rasps and dilators matches the bone block preparation. Subsequent peripheral graft fixation to the capsular rim with 2-0 FiberWire® achieves the goal of creating a solid meniscal allograft construct. Preferably performed for lateral meniscal incompetence, the dovetail technique anatomically recreates the normal lateral meniscal relationships within the knee.

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. Typically, insurance carriers require a specific amount of the meniscus to be affected (eg, >50% of the meniscus). Please check with insurance carriers for specific requirements.

Physician's Professional Fee

The primary arthroscopic procedure determined by the surgeon may include:

2023 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[b]		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 & APC Description	Medicare National Average	Medicare National Average
Arthroscopy						
Knee						
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	$1690.29	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$6614.63	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] Source: AMA CPT 2023 and CMS PFS 2023 Final Rule
[c] Source: CMS 2023 OPPS Final Rule @ www.cms.gov
[d] Source: CMS 2023 ASC Final Rule @ www.cms.gov

Hospital and Facility Coding		
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.* *List of Pass-Through Payment Device Category Codes (Updated September 2022)* *https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf*	For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (eg, hospital, ASC, office). These costs are absorbed by the facility via the appropriate reimbursement mechanism (eg, MS-DRG, APC, etc). For non-Medicare (eg, commercial) patients, depending on contractual terms and general stipulations of the payer, direct invoicing may be allowed. Contact the patient's insurance company or the facility's payer contract for further information.

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

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.

The information provided in this handout represents no promise or guarantee concerning coverage, coding, billing, and payment levels. Arthrex specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on this information. It does not constitute legal advice and no warranty regarding completeness or accuracy is implied. The essential components which determine appropriate payment for a procedure, or a product are site of service/coding/coverage/ payment system/geographical location/national and local medical review policies and/or payer edits.

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