2021 Coding and Reimbursement Guidelines for Arthrex Amnion™ Matrix and Viscous

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the Arthrex Amnion Matrix and Viscous, 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.

FDA Regulatory Clearance

Amniotic tissues are allografts, regulated by the FDA as a human cell, tissue, and cellular and tissue-based product (HCT/P) under 21 CFR Part 1271 and Section 361 of the Public Health Service Act. Tissues and fluids are minimally manipulated and intended for homologous use only. *Homologous use is defined as repair, reconstruction, replacement, or supplementation of a tissue with an HCT/P that performs the same basic function in the recipient as in the donor.* Final products are tested for sterility and indicated usage is single patent, one-time use.

Value Analysis Significance

Arthrex Amnion matrix and Arthrex Amnion viscous are rich in growth factors and contain regenerative qualities and growth factors that maintain the natural healing properties of amnion. Used as an anatomical barrier or wrap in a variety of orthopedic applications, Arthrex Amnion matrices provide biological and mechanical protection to strengthen the repair while helping prevent adhesion.

Coding Considerations

Codes provide a uniform language for describing services performed by healthcare 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 healthcare provider to correctly prepare claims submitted to insurance carriers.

Physician's Professional Fee

The primary arthroscopic procedure determined by the surgeon may include:

2021 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[2]		Hospital Outpatient[3]		ASC[4]
		Medicare National Average				
CPT®[1] Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC & APC Description	Medicare National Average	Medicare National Average
Soft Tissue						
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	$85.49	$158.76	5054 - Level 4 Skin Procedures	$1,715.36	$871.28
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	$17.45	$25.82	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm	$202.73	$326.60	5054 - Level 4 Skin Procedures	$3,522.15	$1,788.99

	wound surface area, or 1% of body area of infants and children					
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	$46.06	$85.14	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	$164.00	$95.61	5054 - Level 4 Skin Procedures	$1,715.36	$871.28
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	$33.50	$25.47	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	$229.95	$356.96	5054 - Level 4 Skin Procedures	$1,715.36	$871.28

[1] CPT is the registered trademark of the American Medical Association. Healthcare providers and their professional coders must closely review this primary citation along with the patient's medical record before selecting the appropriate code.
[2] Source: AMA CPT 2021 and CMS PFS 2021 Final Rule
[3] Source: CMS 2021 OPPS Final Rule @ www.cms.gov
[4] Source: CMS 2021 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 July 2020)* *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Complet-list-DeviceCats-OPPS.pdf*	For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (e.g. hospital, ASC, office). These costs are absorbed by the facility via the appropriate reimbursement mechanism (e.g. MS-DRG, APC, etc.) For non-Medicare (e.g. 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 Reimbursement Helpline at 1-877-734-6289 or e-mail us at arthrex@mcra.com.

This content is not intended to instruct medical providers on how to use or bill for healthcare 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 healthcare procedures.

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