AutoCart™ Technique Using GraftNet™ Autologous Tissue Collector and BioCartilage® Extracellular Matrix

2026 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic procedures for treatment of articular cartilage defects, 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 AutoCart surgical technique is for the treatment of symptomatic articular cartilage defects. This surgical approach is a single-stage, matrix-augmented, autologous chondrocyte transplantation that combines articular cartilage collected using the GraftNet device with BioCartilage extracellular matrix. The ability to augment microfracture procedures with a low-cost, high-value approach that is minimally invasive and supported by clinical evidence makes the AutoCart procedure an important technique for surgeons to include in their joint preservation algorithm.

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 endoscopic/arthroscopic procedure determined by the surgeon may include:

2026 Medicare National Average Payment Rates (Not Adjusted for Geography)		**Physician**[b,c]		**Hospital Outpatient**[d]		**ASC**[e]
CPT®[a] Code HCPCS Code	Code Description	Work RVUs	Medicare National Average	APC and APC Description	Medicare National Average	Medicare National Average
Knee						
27415	Osteochondral allograft, knee open	19.50	$1264.49	5115 – Level 5 MSK Procedures	$13,116.76	$10,492.07
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	17.93	$1184.60	5115 – Level 5 MSK Procedures	$13,116.76	$8621.29
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy	5.06	(HOPD & ASC): $401.80 (Office): $605.89	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
29871	For infection, lavage, and drainage	6.52	$494.11	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
29874	Removal of loose body or foreign body	7.01	$508.55	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
29875	Synovectomy, limited	6.29	$476.66	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
29876	Synovectomy, major, 2 or more compartments (eg, medial or lateral)	8.65	$617.98	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
29877	Debridement/shaving of articular cartilage (chrondoplasty)	8.09	$589.78	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
29879	Abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	8.77	$626.37	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
29880	With meniscectomy (medial and lateral, includes meniscal shaving) includes debridement/shaving of articular cartilage	7.21	$535.74	5113 – Level 3 MSK Procedures	$3342.87	$1644.87

2026 Medicare National Average Payment Rates (Not Adjusted for Geography)		**Physician**[b,c]		**Hospital Outpatient**[d]		**ASC**[e]
CPT®[a] Code HCPCS Code	Code Description	Work RVUs	Medicare National Average	APC and APC Description	Medicare National Average	Medicare National Average
29881	With meniscectomy (medial OR lateral, includes meniscal shaving) includes debridement/shaving of articular cartilage (chondroplasty, same or separate compartment[s], when performed)	6.85	$518.62	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
29885	Drilling for osteochrondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)	9.95	$716.33	5114 – Level 4 MSK Procedures	$7413.38	$4990.40
29886	Drilling for intact osteochondritis dissecans lesion	8.28	$607.57	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
29887	Drilling of intact osteochrondritis dissecans lesion with internal fixation	9.91	$713.98	5114 – Level 4 MSK Procedures	$7413.38	$5298.84
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	13.94	$893.90	5114 – Level 4 MSK Procedures	$7413.38	$4817.25
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	16.97	$1138.27	5115 – Level 5 MSK Procedures	$13,116.76	$9934.11
0232T	Injection(s), platelet-rich plasma, any site (including image guidance, harvesting, and preparation, when performed)	0.0	$0 (carrier-priced)	5735 – Level 5 Minor Procedures	$456.40	$0 (carrier-priced)

[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 2026 and CMS PFS 2026 Final Rule

[c] CMS Conversion Factor (CF) effective January 1, 2026: $33.5675

[d] CMS 2026 OPPS Final Rule @ www.cms.gov

[e] CMS 2026 ASC Final Rule @ www.cms.gov

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). 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 the facility's payer contract for further information.
L8699	**Prosthetic implant, no otherwise specified** This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	

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 AskMarketAccess@arthrex.com.