

Cartiform® Viable Osteochondral Allograft Reimbursement Guide 2021

Cartiform Patient Support Hotline: 1-866-988-3491 • FAX: 1-866-304-6692 • Customer Support: 1-866-352-4540

Osiris Reimbursement Support Services

Cartiform Patient Support Hotline

For assistance with reimbursement questions, contact the Cartiform Patient Support Hotline at **866-988-3491**. Normal business hours are 8:00 am - 7:00 pm eastern time Monday through Friday.

Cartiform Patient Support Hotline staff can assist with the following:

- Patients younger than 50 years old with a chief complaint of pain limiting their desired activities
- Patient-specific insurance verifications
- Payer policy and Medicare Local Coverage Determination (LCD) information
- Nurse Case Manager review of documentation and coding
- Prior authorization and pre-determination support
- General coding and reimbursement questions



Provider Responsibility:

The provider is responsible for verifying individual contract or reimbursement rates with each payer. The Cartiform Patient Support Hotline is not able to confirm contracted or reimbursable rates on your behalf.

Note: Private payer coverage and payment policies will vary. Payers should be consulted in regard to their specific policies. Most payers closely monitor Medicare fee schedules.

How to Request Support for Patients?

To initiate insurance verification support for your patients, please submit a complete **Insurance Verification Request Form (IVR)** with a signed practitioner authorization and fax to **866-304-6692**.

Reimbursement Disclaimer

Reimbursement guidance included in this billing guide, including coding information, is supplied for informational purposes only and does not represent a statement, promise, or guarantee by Osiris that these codes will be appropriate or that reimbursement will be made. Coding practice will vary by site of care, patient condition, services provided, local payer instructions, and other factors. Coding requirements are subject to change at any time; please check with your local payer regularly for updates.

Reimbursement Disclaimer (Cont.)

The decision as to how to complete a reimbursement form, including amount to bill, is exclusively the responsibility of the provider. The provider is ultimately responsible for verifying coverage with the patient's payer source and billing appropriately for services provided.

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Coding Guidelines

The following HCPCS codes are associated with Cartiform® Viable Osteochondral Allograft:

There are no HCPCS codes specifically assigned to identify Cartiform viable osteochondral allograft. CPT code 27415 and CPT code 29867 are designated as device-intensive procedures. Medicare requires that facilities submit a device HCPCS code when device intensive procedures are reported. When a device used in a device-intensive procedure does not have a specific HCPCS code, Medicare recommends that the HCPCS code C1889 may be reported.

| HCPCS | Code Description |
|-------|--|
| L8699 | Prosthetic Implant, not otherwise specified |
| C1889 | Implantable/insertable device not otherwise classified |

Common Physician Procedure Coding

The physician's professional reimbursement for an unlisted service is typically determined on a case-by-case basis. The post-service determination includes a review of documentation submitted with the claim and payment is based on a determination of medical necessity for the service provided.

CPT codes are used by hospital outpatient departments, ambulatory surgery centers, and physicians to describe professional services and procedures.

Based on CY2021 Medicare Physician Fee Schedule national payment amount averages as follows:

| CPT | Description | Payment |
|-------|---|-----------|
| 27415 | Osteochondral allograft, knee, open | \$1412.12 |
| 29867 | Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty) | \$1315.82 |

Coding Guidelines (Cont.)

Common Hospital Outpatient Coding

Under the Hospital Outpatient Prospective Payment System, CMS generally assigns the unlisted procedure or service to the lowest level Ambulatory Payment Classification (APC) code within the most appropriate clinically related series of APCs. Payment for items reported with unlisted codes is often packaged. Hospital outpatient payment will vary by each private payer. Please contact the payer regarding questions on hospital outpatient payment.

CPT codes are used by hospital outpatient departments, ambulatory surgery centers, and physicians to describe professional services and procedures.

Based on CY2021 Medicare Hospital Outpatient Fee Schedule national payment amount averages as follows:

| CPT Cross Reference | APC / Status* | Description | Payment |
|---------------------|---------------|------------------------------------|------------|
| 27415, 29867 | 5115/J1 | Level IV musculoskeletal procedure | \$12314.76 |

* Status Key: J1 = Hospital Part B services paid through a comprehensive APC

See above: **OPPS HCPCS Codes - L8699 or C1889**

Common ASC Coding

Based on CY2021 Medicare Ambulatory (ASC) Fee Schedule national payment amount averages as follows:

| CPT | Description | Payment |
|-------|---|------------|
| 27415 | Osteochondral allograft, knee, open | \$10163.92 |
| 29867 | Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty) | \$9556.74 |

Private payers should be contacted for their specific ASC coverage and payment guidelines; J8 - Device-intensive procedure; paid at adjusted rate.

Common Inpatient Coding

Medicare Severity-Diagnosis Related Groups (commonly referred to as DRGs) are used to reimburse hospitals for inpatient stays. Each inpatient stay is assigned a DRG that is determined according to the principal diagnosis, major procedures, discharge status, and complicating secondary diagnoses. Each DRG is assigned a flat payment rate, which is adjusted according to the individual hospital's teaching status, disproportionate share services for treating low-income patients, and location in urban versus rural regions, etc. Note that DRGs do not include payment for physician services, which are coded and reimbursed separately.

There are three levels of severity in most DRG categories:

1. MCC—Major Complication/Comorbidity, which reflect the highest level of severity;
2. CC—Complication/Comorbidity, which is the next level of severity; and
3. Non-CC—Non-Complication/Comorbidity, which do not significantly affect severity of illness and resource use.

Coding Guidelines (Cont.)

Based on CY2021 Medicare DRG national payment rates are as follows:

| DRG | DRG Description | Payment |
|-----|--|------------|
| 515 | Other Musculoskeletal system and connective tissue OR procedures with MCC | \$20163.13 |
| 516 | Other musculoskeletal system and connective tissue OR procedures with CC | \$12605.01 |
| 517 | Other musculoskeletal system and connective tissue OR procedures with CC/MCC | \$8977.32 |

L8699 *Prosthetic implant, not otherwise specified*
 C1889 *Implantable/insertable device, not otherwise classified*

Private Insurers

Private insurers cover hospital inpatient services that are considered medically necessary and within the benefit structure of the patient's health insurance coverage. Payment for Knee procedures may be based on a percentage of the billed or allowed charges, per diem, or on a negotiated payment rate. Check with your payer organizations to determine the payment methodology for knee procedures.

ICD10-PCS Procedural Codes Crosswalk

The International Classification of Disease tenth revision Procedure Coding System (ICD10-PCS) is a system of medical classification used for procedural codes that track various health interventions taken by medical professionals effective October 1, 2015. Below you will find the most common ICD10-PCS that may apply to patients undergoing knee procedures:

| | | |
|-------|---------|--|
| 27415 | 0SUC0KZ | Supplement right knee joint with nonautologous tissue substitute, open approach |
| | 0SUD0KZ | Supplement left knee joint with nonautologous tissue substitute, open approach |
| 29867 | 0SUC4KZ | Supplement right knee joint with nonautologous tissue substitute, percutaneous endoscopic approach |
| | 0SUD4KZ | Supplement left knee joint with nonautologous tissue sSubstitute, percutaneous endoscopic approach |

This pricing information is taken directly from the CMS website <https://www.CMS.gov>, and is supplied as is for informational purposes only. Osiris makes no opinion, statement, promise, or guarantee that reimbursement will be made by a payer.

* Always refer to the insurer-specific coverage policy or contact the insurer for instructions. The ICD-10 and HCPCS codes are supplied for informational purposes only and do not represent a statement, promise, or guarantee by Osiris that these codes will be appropriate or that reimbursement will be made. Coding practice will vary by site of care, patient condition, range of service provided, local payer instructions, and other factors. The decision as to how to complete a reimbursement form, including amount to bill, is exclusively the responsibility of the provider. The provider is ultimately responsible for verifying coverage with the patient's payer source.

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