

Allograft OATS® Technique With Fresh Osteochondral Allograft

2026 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions regarding arthroscopic procedures completed with the products in this guide, the following information is shared for educational and strategic planning purposes only. It is the sole responsibility of the treating health care professional to diagnose and treat the patient, and to confirm coverage, coding, and claim submission guidance with the patient's health insurance plan to ensure claims are accurate, complete, and supported by documentation in the patient's medical record. Any determination regarding if and how to seek reimbursement should be made only by the appropriate members of the staff, in consultation with the physician, and in consideration of the procedure performed or therapy provided to a specific patient. Arthrex does not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy and legislation are subject to continual change.

Value Analysis Significance

The Allograft OATS instrument set facilitates harvesting of large-diameter osteochondral cartilage cylinders from allograft tissues. The core is recovered by placing the graft (eg, a donor condyle) into the workstation and harvesting with the donor harvester. A recipient socket is created using the appropriately sized recipient reamer. The exact depth of the allograft to match the socket is obtained with the depth measurement guide and the allograft is trimmed to the same depth and obliquity. Final seating of the allograft is achieved with an oversized tamp, resulting in a flush, press-fit graft that does not require additional fixation to ensure graft stability.

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 procedure(s) 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 Musculoskeletal (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
29874	Arthroscopy, knee, surgical; removal of loose/ foreign body (eg, osteochondritis dissecans or chondral fragmentation)	7.01	\$508.55	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)	8.09	\$589.78	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty, multiple drilling, or microfracture)	8.77	\$626.37	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with/without internal fixation (includes debridement of base of lesion)	9.95	\$716.33	5114 – Level 4 MSK procedures	\$7413.38	\$4990.40
27599	Unlisted procedure, femur or knee	0.0	\$0 (carrier-priced)	5111 – Level 1 MSK procedures	\$252.01	\$0 (carrier-priced)



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Foot/Ankle						
29891	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	9.43	\$637.11	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	10.01	\$600.52	5114 – Level 4 MSK procedures	\$7413.38	\$3695.53
27899	Unlisted procedure, leg or ankle	0.0	\$0 (carrier-priced)	5111 – Level 1 MSK procedures	\$252.01	\$0 (carrier-priced)
28899	Unlisted procedure, foot or toes	0.0	\$0 (carrier-priced)	5111 – Level 1 MSK procedures	\$252.01	\$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
C1713	Anchor / screw for opposing bone-to bone or soft tissue-to-bone (implantable) Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissue via drilling as follows: soft tissue-to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone. This may include orthopedic plate with accompanying washers and nuts. This category also applies to synthetic bone substitutes that may be used to fill bony void or gaps (ie, bone substitute implanted into a bony defect created from trauma or surgery).	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).
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 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, not otherwise specified This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	
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.	

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.

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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