2023 Coding and Reimbursement Guidelines for the IntraOsseous BioPlasty® Technique

To help answer common coding and reimbursement questions about arthroscopic procedures completed with IntraOsseous BioPlasty (IOBP®) technique, 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 IntraOsseous BioPlasty (IOBP) surgical technique is for the treatment for bone pathologies resulting from acute or chronic injury, including bone marrow lesions associated with insufficiency fractures, persistent bone bruises, osteoarthritis, and early stages of avascular necrosis. Arthrex offers options for the treatment of these pathologies by performing a core decompression of the lesion and a direct application of platelet-rich plasma concentrate (cPRP) from bone marrow aspirate (BMA) using the Arthrex Angel® cPRP and bone marrow processing system. The IOBP procedure is the biologic treatment of bone marrow lesions with techniques that encourage physiologic bone remodeling and repair.

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 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						
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedures)	$416.13	$561.85	5113 - Level 3 MSK Procedures	$2976.66	$1414.89
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)	$547.62	N/A	5113 - Level 3 MSK Procedures	$2976.66	$1414.89
29876	Arthroscopy, knee, surgical; synovectomy, major, two or more compartments (eg, medial or lateral)	$665.88	N/A	5113 - Level 3 MSK Procedures	$2976.66	$1414.89
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)	$634.37	N/A	5113 - Level 3 MSK Procedures	$2976.66	$1414.89
29886	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion	$650.63	N/A	5113 - Level 3 MSK Procedures	$2976.66	$1414.89
29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation	$768.56	N/A	5114 - Level 4 MSK Procedures	$6614.63	$3138.05
27509	Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or	$693.67	N/A	5114 - Level 4 MSK Procedures	$6614.63	$4408.20

	transcondylar, with or without intercondylar extension, or distal femoral epiphyseal separation					

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		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
Repair, Revision, and/or Reconstruction						
Foot and Ankle						
28320	Repair, nonunion or malunion, tarsal bone	$620.81	N/A	5115 – Level 5 Musculoskeletal (MSK) Procedures	$13048.08	$8270.67
28322	Metatarsal, with or without bone graft (includes obtaining graft)	$587.60	$798.04	5114 – Level 4 MSK Procedures	$6614.63	$4209.17
20999	Unlisted procedure, musculoskeletal system, general	Contractor priced		5111 – Level 1 MSK Procedures	$207.01	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**
A4649	**Surgical Supplies** 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 refer to the facility's payer contract for more information.

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 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.

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