Meniscal Allograft Transplant Procedure

2025 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the Dovetail Meniscal Allograft Set, 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 dovetail technique simplifies graft preparation with a time-saving series of cuts preparing the bone component of the graft to sit securely in the recipient semi-trapezoidal slot created in the tibia. A matching semi–trapezoidal-shaped recipient slot created in the tibia with a series of step drills, rasps, and dilators matches the bone block preparation. Subsequent peripheral graft fixation to the capsular rim with 2-0 FiberWire® suture achieves the goal of creating a solid meniscal allograft construct. Preferably performed for lateral meniscal incompetence, the dovetail technique anatomically recreates the normal lateral meniscal relationships within the knee.

Coding Considerations

Codes provide a uniform language for describing services performed by health care 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 health care provider to correctly prepare claims submitted to insurance carriers. Typically, insurance carriers require a specific amount of the meniscus to be affected (eg, >50% of the meniscus). Please check with insurance carriers for specific requirements.

Physician's Professional Fee

The primary arthroscopic procedure determined by the surgeon may include:

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		**Physician**[b,c]		**Hospital Outpatient**[d]		**ASC**[e]
		Medicare National Average				
CPT®[a] Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC and APC Description	Medicare National Average	Medicare National Average
Knee						
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	$1636.41	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$7143.73	$3510.84

[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 2025 and CMS PFS 2024 Final Rule

[c] CMS Conversion Factor (CF) effective January 1, 2025: $32.3465

[d] CMS 2025 OPPS Final Rule @ www.cms.gov

[e] CMS 2025 ASC Final Rule @ www.cms.gov

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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).
L8699	**Prosthetic implant, not otherwise specified** This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	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 refer to the facility's payer contract for more information.
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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