Chondrofix® Osteochondral Allograft Coding Reference Guide

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Chondrofix® Osteochondral Allograft is a decellularized allograft consisting of hyaline cartilage and cancellous bone. As a minimally manipulated human tissue graft, the Chondrofix Osteochondral Allograft undergoes a proprietary processing protocol resulting in a shelf-stable graft that retains relevant inherent structural properties and provides an effective alternative to fresh allograft or autograft for the repair of osteochondral lesions.

Physician – Knee	
CPT® Code	**CPT Description**
27415	Osteochondral allograft, knee, open
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)

Physician – Ankle	
CPT Code	**CPT Description**
27899	Unlisted procedure, leg or ankle
29999	Unlisted procedure, arthroscopy

Hospital Outpatient and Ambulatory Surgery Center (ASC)				
CPT Code	**CPT Description**	**OPPS Status Indicator**	**APC**	**ASC Payment Indicator**
27415	Osteochondral allograft, knee, open	J1	5115	J8
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	J1	5115	NA
27899	Unlisted procedure, leg or ankle	T	5111	NA
29999	Unlisted procedure, arthroscopy	T	5111	NA

OPPS – Outpatient Prospective Payment System; APC – Ambulatory Payment Classification
Status Indicator J1 – Hospital Part B services paid through a comprehensive APC; Status Indicator T – Multiple procedure reduction applies
APC 5111 – Level 1 Closed Treatment Fracture and Related Services; APC 5115 – Level 5 Musculoskeletal Procedures.
Payment Indicator J8 - Device-intensive procedure; paid at adjusted rate.
NA – This procedure is not on Medicare's List of ASC Covered Surgical Procedures.

HCPCS (Healthcare Common Procedure Coding System)	
HCPCS Code	**HCPCS Description**
C1889	Implantable/insertable device for device intensive procedure, not otherwise classified
L8699	Prosthetic implant, not otherwise specified

Note: HCPCS codes report devices used in conjunction with outpatient procedures billed and paid for under Medicare's Outpatient Prospective Payment System.

Hospital Inpatient			
ICD-10-PCS Code	**Description**	**MS-DRG and Description***	
Knee			
ØSQCØZZ	Repair right knee joint, open approach	MS-DRG 488	Knee Procedures without PDX of Infection with CC/MCC
ØSQDØZZ	Repair left knee joint, open approach	MS-DRG 489	Knee Procedures without PDX of Infection without CC/MCC
ØSQC4ZZ	Repair right knee joint, percutaneous endoscopic approach		
ØSQD4ZZ	Repair left knee joint, percutaneous endoscopic approach		
Ankle			
ØSQFØZZ	Repair right ankle joint, open approach	MS-DRG 492	Lower Extremity & Humerus Procedure Except Hip, Foot, Femur with MCC
ØSQGØZZ	Repair left ankle joint, open approach	MS-DRG 493	Lower Extremity & Humerus Procedure Except Hip, Foot, Femur with CC
ØSQF4ZZ	Repair right ankle joint, percutaneous endoscopic approach	MS-DRG 494	Lower Extremity & Humerus Procedure Except Hip, Foot, Femur without CC/MCC
ØSQG4ZZ	Repair left ankle joint, percutaneous endoscopic approach		

CC – Complication and/or Comorbidity, MCC – Major Complication and/or Comorbidity

*MS-DRG – Medicare Severity Diagnosis Related Group. Other MS-DRGs may apply

For further assistance with reimbursement questions, contact the Zimmer Biomet Reimbursement Hotline at 866-946-0444 or reimbursement@zimmerbiomet.com, or visit our reimbursement web site at reimbursement.zimmerbiomet.com.

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