DeNovo® NT Natural Tissue Graft Coding Reference Guide

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DeNovo NT is a cartilage allograft, comprised of particulated juvenile hyaline cartilage. The tissue is recovered from juvenile donor joints and is applied to the defect site in a single step surgical procedure with fibrin fixation. DeNovo NT Graft is not an autograft.

Physician – Knee	
CPT® Code	**CPT Description**
27310*	Arthrotomy, knee, with exploration, drainage, or removal of foreign body (eg, infection)
27599	Unlisted procedure, femur or knee
29999	Unlisted procedure, arthroscopy

Physician – Ankle	
CPT Code	**CPT Description**
27610*	Arthrotomy, ankle, including exploration, drainage, or removal of foreign body
27899	Unlisted procedure, leg or ankle
29999	Unlisted procedure, arthroscopy

Physician – Foot	
CPT Code	**CPT Description**
28020*	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint
28022*	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; metatarsophalangeal joint
28024*	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; interphalangeal joint
28899	Unlisted procedure, foot or toes
29999	Unlisted procedure, arthroscopy

Physician – Shoulder	
CPT Code	**CPT Description**
23040*	Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body
23929	Unlisted procedure, shoulder
29999	Unlisted procedure, arthroscopy

Physician – Elbow	
CPT Code	**CPT Description**
24000*	Arthrotomy, elbow, including exploration, drainage, or removal of foreign body
24999	Unlisted procedure, humerus or elbow
29999	Unlisted procedure, arthroscopy

*Modifier -22, Increased Procedural Service, should be appended when the physician documents the work associated with the placement of the DeNovo NT graft. This work is above that described by the primary procedure code.

Hospital Outpatient and Ambulatory Surgery Center (ASC)				
CPT Code	**CPT Description**	**OPPS Status Indicator**	**APC**	**ASC Payment Indicator**
23040	Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body	J1	5113	A2
23929	Unlisted procedure, shoulder	T	5111	NA
24000	Arthrotomy, elbow, including exploration, drainage, or removal of foreign body	J1	5113	A2
24999	Unlisted procedure, humerus or elbow	T	5111	NA
27310	Arthrotomy, knee, with exploration, drainage, or removal of foreign body (eg, infection)	J1	5113	A2
27599	Unlisted procedure, femur or knee	T	5111	NA
27610	Arthrotomy, ankle, including exploration, drainage, or removal of foreign body	J1	5113	A2
27899	Unlisted procedure, leg or ankle	T	5111	NA
28020	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint	J1	5113	A2
28022	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; metatarsophalangeal joint	J1	5113	A2
28024	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; interphalangeal joint	J1	5113	A2
28899	Unlisted procedure, foot or toes	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; T – Multiple procedure reduction applies
APC 5111 – Level 1 Musculoskeletal Procedures; APC5113 – Level 3 Musculoskeletal Procedures
ASC Payment Indicator A2 – Payment based on OPPS relative payment weight; NA – This procedure is not on Medicare's List of ASC Covered Surgical Procedures.

Hospital Inpatient

MS-DRG and Description*	
480	Hip & Femur Procedures Except Major Joint with MCC
481	Hip & Femur Procedures Except Major Joint with CC
482	Hip & Femur Procedures Except Major Joint without CC/MCC
488	Knee Procedures without Primary Diagnosis of Infection with CC/MCC
489	Knee Procedures without Primary Diagnosis of Infection without CC/MCC
492	Lower Extremity & Humerus Procedure Except Hip, Foot, Femur with MCC
493	Lower Extremity & Humerus Procedure Except Hip, Foot, Femur with CC
494	Lower Extremity & Humerus Procedure Except Hip, Foot, Femur without CC/MCC
507	Major Shoulder or Elbow Joint Procedures with CC/MCC
508	Major Shoulder or Elbow Joint Procedure without CC/MCC
515	Other Musculoskeletal System and Connective Tissue O.R. Procedure with MCC
516	Other Musculoskeletal System and Connective Tissue O.R. Procedure with CC
517	Other Musculoskeletal System and Connective Tissue O.R. Procedure without CC/MCC

MS-DRG – Medicare Severity Diagnosis Related Group
CC – Complication and/or Comorbidity; MCC – Major Complication and/or Comorbidity
MS-DRG will be determined by the principal procedure performed and diagnoses reported. Other MS-DRGs may be applicable

ICD-10-PCS Code	ICD-10-PCS Description
Knee	
ØSQCØZZ	Repair right knee joint, open approach
ØSQDØZZ	Repair left knee joint, open approach
ØSQC4ZZ	Repair right knee joint, percutaneous endoscopic approach
ØSQD4ZZ	Repair left knee joint, percutaneous endoscopic approach
Ankle	
ØSQFØZZ	Repair right ankle joint, open approach
ØSQGØZZ	Repair left ankle joint, open approach
ØSQF4ZZ	Repair right ankle joint, percutaneous endoscopic approach
ØSQG4ZZ	Repair left ankle joint, percutaneous endoscopic approach
Foot	
ØYQMØZZ	Repair right foot, open approach
ØYQNØZZ	Repair left foot, open approach
ØYQM4ZZ	Repair right foot, percutaneous endoscopic approach
ØYQN4ZZ	Repair left foot, percutaneous endoscopic approach
Shoulder	
ØRQJØZZ	Repair right shoulder joint, open approach
ØRQKØZZ	Repair left shoulder joint, open approach
ØRQJ4ZZ	Repair right shoulder joint, percutaneous endoscopic approach
ØRQK4ZZ	Repair left shoulder joint, percutaneous endoscopic approach
Elbow	
ØRQLØZZ	Repair right elbow joint, open approach
ØRQMØZZ	Repair left elbow joint, open approach
ØRQL4ZZ	Repair right elbow joint, percutaneous endoscopic approach
ØRQM4ZZ	Repair left elbow joint, percutaneous endoscopic approach

HCPCS (Healthcare Common Procedure Coding System)	
HCPCS Code	**HCPCS Description**
L8699	Prosthetic implant, not otherwise specified

There is not a separately reportable HCPCS code available for DeNovo NT Graft.
-AHA Coding Clinic for HCPCS, 4th Quarter, 2010, page 3.
Healthcare Providers are encouraged to check with the specific payer for their recommended HCPCS code assignment.

Access-To-Care (ATC) Program 1-866-946-0444, Option 3

Zimmer offers an Access-To-Care program to assist surgeons and their office staff with prior authorization and denial management for DeNovo® NT Graft. This service is available to facilitate patient access to medically appropriate cartilage repair procedures.

To request assistance with prior authorization or appeals for DeNovo NT cases contact an ATC Specialist via the Zimmer Reimbursement Hotline at 1-866-946-0444, Option 3. The ATC Specialist will evaluate each case on an individual basis to determine the appropriate payer follow up. When requesting ATC to manage the prior authorization, please allow an adequate timeline prior to the scheduled surgery date to accommodate the payers processes and allow them sufficient time to review and respond to the request.

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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