Subchondroplasty® (SCP®) Procedure Coding Reference Guide

The Subchondroplasty® Procedure is a minimally-invasive, fluoroscopically-assisted procedure that targets and fills chronic subchondral bone defects - also known as bone marrow lesions - using AccuFill® BSM, a hard-setting bone substitute. The procedure is usually performed with arthroscopy to evaluate and treat findings inside the joint. Some procedures may be performed using an open or mini-open approach, as needed.

It is important to note that "Subchondroplasty" is a marketing tradename, and is not recognized as standard diagnosis or generic procedure terminology.

Physician	
CPT® Code	**Description**
0707T	Injection(s), bone-substitute material (eg, calcium phosphate) into subchondral bone defect (ie, bone marrow lesion, bone bruise, stress injury, microtrabecular fracture), including imaging guidance and arthroscopic assistance for joint visualization

Coding and Billing Guidance

- Note that the nomenclature for the code states that "imaging guidance and arthroscopic assistance for joint visualization" is included and thus not separately reportable.
- Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy (CPT 2022 Professional Edition, p. 212). Therefore, diagnostic arthroscopy is not separately reportable if performed during the same operative session as the injection procedure/other surgical arthroscopy.
- Other surgical arthroscopy procedures may be reported in addition to the above-listed injection procedure. Check relevant coding edits and with your payer(s) for guidance. Because Category III CPT codes (such as 0707T) do not have Relative Value Units (RVUs) assigned, it is recommended that the CPT codes for the reported procedures be listed on the claim in descending order based on their RVUs/payment amounts. Payers should process any multiple procedure payment reduction discounts based on this hierarchy, regardless of the order codes are listed on the claim.
- The most common way payers determine payment for unlisted/Category III CPT codes is using a comparison to a similar procedure with a similar approach and similar anatomical site. Whenever reporting a service using one of these codes, use the freeform field of the claim form (61 characters in length) to present a crosswalk to another procedure believed to be fairly equivalent, or to offer a comparison to a code for which there is an existing valuation. For example, "0707T comparable to XXXXX, payment of $XXX.XX expected." It is instrumental to provide the RVUs for the similar procedure and provide an explanation of how the procedure described by the unlisted/Category III CPT code is more or less difficult than the comparable procedure. For example, provide a cover letter that outlines the difference in the amount of time, work, technical expertise and use of equipment necessary to perform the procedures. Recognize that payers will commonly make the payment decision based on comparisons to their fee schedule and not necessarily the submitted charge.

Hospital Inpatient: ICD-10-PCS Code and Description			
Introduction *(Putting in or on a therapeutic, diagnostic, nutritional, physiological, or prophylactic substance except blood or blood products)*			
3 Administration **E** Physiological Systems and Anatomical Regions **Ø** Introduction			
Body Part	**Approach**	**Device**	**Qualifier**
V Bones	**Ø** Open **3** Percutaneous **4** Percutaneous Endoscopic	**G** Other Therapeutic Substance	**C** Other Substance

Hospital Inpatient: Medicare Severity-Diagnosis Related Group (MS-DRG)*	
MS-DRG	**Description**
480	Hip and Femur Procedures Except Major Joint with MCC
481	Hip and Femur Procedures Except Major Joint with CC
482	Hip and Femur Procedures Except Major Joint without CC/MCC
492	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC
493	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with CC
494	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur without CC/MCC
503	Foot Procedures with MCC
504	Foot Procedures with CC
505	Foot Procedures without CC/MCC
510	Shoulder, Elbow or Forearm Procedures, Except Major Joint Procedures with MCC
511	Shoulder, Elbow or Forearm Procedures, Except Major Joint Procedures with CC
512	Shoulder, Elbow or Forearm Procedures, Except Major Joint Procedures without CC/MCC
513	Hand or Wrist Procedures, Except Major Thumb or Joint Procedures with CC/MCC
514	Hand or Wrist Procedures, Except Major Thumb or Joint Procedures without CC/MCC
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures without CC/MCC

CC – Complication and/or Comorbidity. MCC – Major Complication and/or Comorbidity.
*Other MS-DRGs may be applicable. MS-DRG will be determined by the patient's diagnosis and any procedure(s) performed.

Hospital Outpatient and Ambulatory Surgical Center (ASC)				
CPT® Code	**Description**	**OPPS Status Indicator**	**APC Assignment**	**ASC Payment Indicator**
0707T	Injection(s), bone-substitute material (eg, calcium phosphate) into subchondral bone defect (ie, bone marrow lesion, bone bruise, stress injury, microtrabecular fracture), including imaging guidance and arthroscopic assistance for joint visualization	J1	5113	J8

OPPS - Outpatient Prospective Payment System; **APC** - Ambulatory Payment Classification; **ASC** - Ambulatory Surgical Center
Status Indicator: J1 - Hospital Part B services paid through a comprehensive APC. Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service, with limited exceptions
APC: 5113 – Level 3 Musculoskeletal Procedures
Payment Indicator: J8 – Device-intensive procedure paid at adjusted rate

HCPCS (Healthcare Common Procedure Coding System)	
Code	**Description**
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)

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

Anchor for opposing bone-to-bone or soft tissue-to-bone (C1713) - Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissues 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 plates with accompanying washers and nuts. This category also applies to synthetic bone substitutes that may be used to fill bony voids or gaps (i.e., bone substitute implanted into a bony defect created from trauma or surgery).

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Complet-list-DeviceCats-OPPS.pdf

Clarification of Device Kits:

Some devices may be packaged within a device kit which contains both the device and a number of associated supplies used in a particular procedure. For the kit itself, no HCPCS code may have been established. However, if the kit contains individual items that separately qualify for transitional pass-through payments, these items should be separately reported with the applicable HCPCS codes. [Please note, the supplies contained in the kit will not be separately reported]. *AHA Coding Clinic® for HCPCS Volume 16, Number 3, Third Quarter 2016.*

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 zimmerbiomet.com/reimbursement.

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