

# DeNovo® NT Natural Tissue Graft Coding Reference Guide



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	
CPT® Code	Description
<b>Lower Joints</b>	
<b>27310*</b>	Arthrotomy, knee, with exploration, drainage, or removal of foreign body (eg, infection)
<b>27610*</b>	Arthrotomy, ankle, including exploration, drainage, or removal of foreign body
<b>28020*</b>	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint
<b>28022*</b>	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; metatarsophalangeal joint
<b>28024*</b>	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; interphalangeal joint
<b>27599</b>	Unlisted procedure, femur or knee
<b>27899</b>	Unlisted procedure, leg or ankle
<b>28899</b>	Unlisted procedure, foot or toes
<b>29999</b>	Unlisted procedure, arthroscopy
<b>Upper Extremities</b>	
<b>23040*</b>	Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body
<b>24000*</b>	Arthrotomy, elbow, including exploration, drainage, or removal of foreign body
<b>23929</b>	Unlisted procedure, shoulder
<b>24999</b>	Unlisted procedure, humerus or elbow
<b>29999</b>	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 Inpatient: ICD-10-PCS Code and Description			
<b>Supplement - Lower Joints</b>			
<b>Ø</b> Medical and Surgical <b>S</b> Lower Joints <b>U</b> Supplement			
Body Part	Approach	Device	Qualifier
<b>C</b> Knee Joint, Right <b>D</b> Knee Joint, Left <b>F</b> Ankle Joint, Right <b>G</b> Ankle Joint, Left <b>H</b> Tarsal Joint, Right <b>J</b> Tarsal Joint, Left <b>K</b> Tarsometatarsal Joint, Right <b>L</b> Tarsometatarsal Joint, Left <b>M</b> Metatarsal-Phalangeal Joint, Right <b>N</b> Metatarsal-Phalangeal Joint, Left <b>P</b> Toe Phalangeal Joint, Right <b>Q</b> Toe Phalangeal Joint, Left	<b>Ø</b> Open <b>4</b> Percutaneous Endoscopic	<b>K</b> Nonautologous Tissue Substitute	<b>Z</b> No Qualifier
<b>Supplement - Upper Joints</b>			
<b>Ø</b> Medical and Surgical <b>R</b> Upper Joints <b>U</b> Supplement			
Body Part	Approach	Device	Qualifier
<b>J</b> Shoulder Joint, Right <b>K</b> Shoulder Joint, Left <b>L</b> Elbow Joint, Right <b>M</b> Elbow Joint, Left	<b>Ø</b> Open <b>4</b> Percutaneous Endoscopic	<b>K</b> Nonautologous Tissue Substitute	<b>Z</b> No Qualifier

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

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.

<b>Hospital Outpatient and Ambulatory Surgery Center (ASC)</b>				
<b>CPT® Code</b>	<b>Description</b>	<b>OPPS Status Indicator</b>	<b>Ambulatory Payment Classification</b>	<b>ASC Payment Indicator</b>
<b>23040</b>	Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body	J1	5113	A2
<b>23929</b>	Unlisted procedure, shoulder	T	5111	NA
<b>24000</b>	Arthrotomy, elbow, including exploration, drainage, or removal of foreign body	J1	5113	A2
<b>24999</b>	Unlisted procedure, humerus or elbow	T	5111	NA
<b>27310</b>	Arthrotomy, knee, with exploration, drainage, or removal of foreign body (eg, infection)	J1	5113	A2
<b>27599</b>	Unlisted procedure, femur or knee	T	5111	NA
<b>27610</b>	Arthrotomy, ankle, including exploration, drainage, or removal of foreign body	J1	5113	A2
<b>27899</b>	Unlisted procedure, leg or ankle	T	5111	NA
<b>28020</b>	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint	J1	5113	A2
<b>28022</b>	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; metatarsophalangeal joint	J1	5113	A2
<b>28024</b>	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; interphalangeal joint	J1	5112	A2
<b>28899</b>	Unlisted procedure, foot or toes	T	5111	NA
<b>29999</b>	Unlisted procedure, arthroscopy	T	5111	NA

OPPS – Outpatient Prospective Payment System

APC 5111 – Level 1 Musculoskeletal Procedures; APC 5112 – Level 2 Musculoskeletal Procedures; APC 5113 – Level 3 Musculoskeletal Procedures

Status Indicator J1 - Hospital Part B services paid through a comprehensive APC; T – Multiple procedure reduction applies

Payment Indicator A2 – Payment based on OPPS relative payment weight; NA – This procedure is not on Medicare’s ASC Covered Procedures List (CPL).

HCPCS (Healthcare Common Procedure Coding System)	
Code	Description
<b>C1734</b>	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)
<b>L8699</b>	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.

**For further assistance with reimbursement questions, contact the Zimmer Biomet Reimbursement Hotline at 866-946-0444 or [reimbursement@zimmerbiomet.com](mailto:reimbursement@zimmerbiomet.com), or visit our reimbursement web site at [zimmerbiomet.com/reimbursement](http://zimmerbiomet.com/reimbursement).**

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