

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

Hospital Inpatient: ICD-10-PCS Code and Description			
Repair (Restoring, to the extent possible, a body part to its normal anatomic structure and function)			
Ø Medical and Surgical P Upper Bones Q Repair			
Body Part	Approach	Device	Qualifier
5 Scapula, Right 6 Scapula, Left 7 Glenoid Cavity, Right 8 Glenoid Cavity, Left 9 Clavicle, Right B Clavicle, Left C Humeral Head, Right D Humeral Head, Left F Humeral Shaft, Right G Humeral Shaft, Left H Radius, Right J Radius, Left K Ulna, Right L Ulna, Left M Carpal, Right N Carpal, Left P Metacarpal, Right Q Metacarpal, Left R Thumb Phalanx, Right S Thumb Phalanx, Left T Finger Phalanx, Right V Finger Phalanx, Left	Ø Open 3 Percutaneous 4 Percutaneous Endoscopic	Z No Device	Z No Qualifier

Hospital Inpatient: ICD-10-PCS Code and Description (cont.)

Repair (Restoring, to the extent possible, a body part to its normal anatomic structure and function)

Ø Medical and Surgical
Q Lower Bones
Q Repair

Body Part	Approach	Device	Qualifier
4 Acetabulum, Right 5 Acetabulum, Left 6 Upper Femur, Right 7 Upper Femur, Left 8 Femoral Shaft, Right 9 Femoral Shaft, Left B Lower Femur, Right C Lower Femur, Left D Patella, Right F Patella, Left G Tibia, Right H Tibia, Left J Fibula, Right K Fibula, Left L Tarsal, Right M Tarsal, Left N Metatarsal, Right P Metatarsal, Left Q Toe Phalanx, Right R Toe Phalanx, Left	Ø Open 3 Percutaneous 4 Percutaneous Endoscopic	Z No Device	Z No Qualifier

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

V Bones 3 Percutaneous 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 void 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/Compleat-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 an applicable HCPCS codes. [Please note, the supplies contained in the kit would 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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