

ACL Reconstruction With BioACL™ Technique

2025 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic, endoscopic, or surgical procedures completed with the products described in this guide, the following information is shared for educational and strategic planning purposes only. Information described in this guide is intended solely for use as a resource tool to assist physician office and ambulatory surgical center billing staff regarding potential reimbursement challenges. It is the sole responsibility of the treating health care professional to diagnose and treat the patient, and to confirm coverage, coding, and claim submission guidance with the patient's health insurance plan to ensure claims are accurate, complete, and supported by documentation in the patient's medical record. Any determination regarding if and how to seek reimbursement should be made only by the appropriate members of the staff, in consultation with the physician, and in consideration of the procedure performed or therapy provided to a specific patient. Arthrex does not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy and legislation, are subject to continual change.

FDA Regulatory Clearance

The Angel® concentrated platelet-rich plasma (cPRP) system is to be used in the clinical laboratory or intraoperatively at the point of care for the safe and rapid preparation of platelet-poor plasma and platelet concentrate (platelet-rich plasma) from a small sample of whole blood or a small mixture of blood and bone marrow. The platelet-rich plasma can be mixed with autograft and/or allograft bone prior to application to an orthopedic site (BK110046).

The TightRope® II devices are intended to be used for fixation of bone to bone or soft tissue to bone, and are intended for fixation posts, a distribution bridge, or for distributing suture tension over areas of ligament or tendon repair, including ACL/PCL repair and reconstruction for the adult and pediatric patient population (K241235).

The SwiveLock® anchor is intended for fixation of suture (soft tissue) to bone in the shoulder, foot/ankle, knee, hand/wrist, elbow, and hip in skeletally mature pediatric and adult patients (K203495).

Value Analysis Significance

The BioACL system combines the matrices of the AlloSync™ bone grafting solutions line with the Angel system's proprietary technology to prepare customized cPRP from bone marrow aspirate (BMA). Hydrated AlloSync bone grafts provide the optimal scaffold for cPRP from BMA, which is a rich source of platelets and nucleated and progenitor cells. This technique harnesses the patient's own biology and combines it with the highest quality biologic scaffolds to maximize the healing potential of anterior cruciate ligament (ACL) and posterior cruciate ligament (PCL) reconstructions.

Coding Considerations

Codes provide a uniform language for describing services performed by health care providers. The actual selection of codes depends on the primary surgical procedure, supported by details in the patient's medical record about medical necessity. It is the sole responsibility of the health care provider to correctly prepare claims submitted to insurance carriers.



ACL Reconstruction With BioACL™ Technique

2025 Coding and Reimbursement Guidelines

Physician's Professional Fee

The primary procedure(s) determined by the surgeon may include:

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician ^{b,c}		Hospital Outpatient ^d		ASC ^e
CPT ^a Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC and APC Description	Medicare National Average	Medicare National Average
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	\$957.46	N/A	5114-Level 4 Musculoskeletal (MSK) Procedures	\$7143.73	\$4628.28
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	\$1207.82	N/A	5115-Level 5 MSK Procedures	\$12,866.82	\$8478.40
0232T	Injection(s), platelet-rich plasma, any site (including image guidance, harvesting, and preparation, when performed)	Contractor - priced	Contractor - priced	5735-Level 5 Minor Procedures	\$399.04	N/A

^a CPT (Current Procedural Terminology) is a registered trademark of the American Medical Association. Health care providers and their professional coders must closely review this primary citation along with the patient's medical record before selecting the appropriate code.

^b AMA CPT 2025 and CMS PFS 2025 Final Rule

^c CMS Conversion Factor (CF) effective January 1, 2025: \$32.3465

^d CMS 2025 OPPS Final Rule @ www.cms.gov

^e CMS 2025 ASC Final Rule @ www.cms.gov



ACL Reconstruction With BioACL™ Technique

2025 Coding and Reimbursement Guidelines

HCPSC Code	Code Description	Notes
C1762	Connective tissue, human These tissues include a natural, cellular collagen, or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue.	For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (eg, hospital, ASC). These costs are absorbed by the facility via the appropriate reimbursement mechanism (eg, MS-DRG, APC, etc).
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable) 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 (ie, bone substitute implanted into a bony defect created from trauma or surgery).	
L8699	Prosthetic implant, not otherwise specified This code reports prosthetic implants that are not otherwise described in more specific HCPSC Level II codes.	For non-Medicare (eg, commercial) patients, depending on contractual terms and general stipulations of the payer, direct invoicing may be allowed. Contact the patient's insurance company or refer to the facility's payer contract for more information.
A4649	Surgical supplies; miscellaneous This code reports miscellaneous surgical supplies and should only be reported if a more specific HCPSC Level II or CPT code is not available.	

List of Pass-Through Payment Device Category Codes (Updated September 2022) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment

For more information about the primary procedure, please speak with your admitting surgeon. You may also call the Arthrex Coding Helpline at 1-844-604-6359 or email AskMarketAccess@arthrex.com.

The content provided in this guide is for informational purposes only. The Arthrex Coding Helpline does not guarantee reimbursement by third-party payers.

The information provided in this handout was obtained from many sources and is subject to change without notice as a result of changes in reimbursement laws, regulations, rules, and policies. All content on this website is informational only, general in nature, and does not cover all situations or all payers' rules and policies. This content is not intended to instruct medical providers on how to use or bill for health care procedures, including new technologies outside of Medicare national guidelines. A determination of medical necessity is a prerequisite that we assume will have been made prior to assigning codes or requesting payments. Medical providers should consult with appropriate payers, including Medicare fiscal intermediaries and carriers, for specific information on proper coding, billing, and payment levels for health care procedures. It is the sole responsibility of the medical provider to determine the appropriate coding.

