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BIO⁴® – Viable Bone Matrix
2019 reimbursement information

Overview

BIO⁴ is an allogeneic viable bone matrix that retains the osteoconductive, osteoinductive, osteogenic and angiogenic characteristics involved in bone repair and regeneration.[1]

BIO⁴ is a Human Cell, Tissue, and Cellular and Tissue-based product or HCT/P: BIO⁴ is limited to homologous use for the repair, replacement or reconstruction of bone defects.

Possible HCPCS codes

Code	Description
C1762	Connective tissue, human (includes fascia lata)

CPT codes

BIO⁴ may be used in a variety of different orthopaedic procedures. The codes listed in the table below are representative of some of the possible procedures that may be performed utilizing BIO⁴. This is not a complete listing of codes. It is always the provider's responsibility to determine and submit appropriate codes, charges, and modifiers that best reflect the actual service(s) furnished to a particular patient. Providers should consult with the appropriate payer(s) if they have any questions regarding billing and coding and follow the payer's guidelines.

The implantation of bone allografts in conjunction with most musculoskeletal defect procedures is considered bundled or packaged into the primary procedure.

2019 Medicare physician and hospital outpatient coding and payment (Possible coding options)

CPT Code[2]	Descriptor	Physician payment[3]	Hospital outpatient payment[4]	ASC payment[4]
23146	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft	$635.37	$5,699.59	$2,744.32
23156	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft	$701.32	$5,699.59	$2,744.32
24116	Excision or curettage of bone cyst or benign tumor, humerus; with allograft	$893.77	$5,699.59	$2,744.32
24126	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with allograft	$667.44	$5,699.59	$4,126.25
25126	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with allograft	$616.63	$2,623.34	$1,750.43
25136	Excision or curettage of bone cyst or benign tumor of carpal bones; with allograft	$506.71	$5,699.59	$2,744.32
27638	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft	$794.66	$5,699.59	$2,744.32
28103	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft	$405.44	$5,699.59	$2,744.32
28107	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft	$361.47	$5,699.59	$2,744.32

1. BIO⁴ Technical Summary_AGFT-BR-1
2. 2018 CMS PFS Final Rule, Addendum B, Conversion Factor 35.9996 (updated 11-6-17).
3. 2018 CMS OPPS Final Rule Correction Notice, Addendum B, (published 12-27-17).
4. 2019 CMS IPPS Final Rule, Tables 1B, 1D and 5 (available on CMS website) 83 Fed. Reg. 160 (Aug. 17, 2018; CN Oct 1, 2018). Payments calculated assuming full update using the following national standardized amounts.

2019 Medicare inpatient hospital coding and payment information (Possible MS-DRGs)

	Code description	Inpatient payment[4]
485	Knee procedures with principal diagnosis of infection with MCC	$20,173.15
486	Knee procedures with principal diagnosis of infection with CC	$13,544.42
487	Knee procedures with principal diagnosis of infection without CC/MCC	$10,075.28
488	Knee procedures without principal diagnosis of infection with CC/MCC	$12,897.85
489	Knee procedures without principal diagnosis of infection without CC/MCC	$7,921.26
492	Lower extremity and humerus procedures except hip, foot, femur with MCC	$20,700.66
493	Lower extremity and humerus procedures except hip, foot, femur with CC	$13,713.54
494	Lower extremity and humerus procedures except hip, foot, femur without CC/MCC	$10,708.42
503	Foot procedures with MCC	$15,643.49
504	Foot procedures with CC	$10,559.44
505	Foot procedures without CC/MCC	$9,645.45
513	Hand or wrist procedures, except major thumb or joint procedures with CC/MCC	$10,010.56
514	Hand or wrist procedures, except major thumb or joint procedures without CC/MCC	$6,104.27
515	Other musculoskeletal system & connective tissue O.R. procedure with MCC	$18,817.12
516	Other musculoskeletal system & connective tissue O.R. procedure with CC	$11,511.29
517	Other musculoskeletal system & connective tissue O.R. procedure without CC/MCC	$8,431.07

**Payments calculated assuming full update using the following national standardized amounts and rounded to the nearest dollar.

Payment rates to individual hospitals will vary based on type of hospital (academic/non academic), geographic location and compliance with reporting overall quality measures required by Medicare.

Stryker cannot guarantee coverage or payment for products or procedures. Coverage determinations are made based on individual patient conditions and can vary depending on local payer policies. For more specific information, please contact your Medicare Administrative Contractor or Private Payer.

Every reasonable effort has been made to ensure the accuracy of the information in this guide. However, the ultimate responsibility for coding and claims submission lies with the provider of services (e.g., physician, hospital or other facility). Stryker makes no representation, guarantee or warranty, expressed or implied, that this report is error-free or that the use of this information will prevent differences of opinion with third-party payers and will bear no responsibility or liability for the results or consequences of its use. Our recommendations do not guarantee coverage or payment of the technology or procedure. Providers should accurately report the patient's condition and the services and supplies they provide to their patients. Reimbursement is dynamic. Coding and payment rates may change from time to time. Providers should also consult with payers and follow their guidelines as appropriate.

1. Current Procedural Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2019 AMA. All rights reserved
2. 2019 CMS PFS Final Rule, Addendum B (available on CMS website), 83 Fed. Reg. 226 (Nov. 23, 2018).
3. 2019 CMS OPPS and ASC Final Rule, Addenda AA and B (available on CMS website), 83 Fed. Reg. 225 (Nov. 21, 2018), and Correction Notice, 83 Fed. Reg. 248 (Dec. 28, 2018).
4. 2019 CMS IPPS Final Rule, Tables 1B, 1D and 5 (available on CMS website) 83 Fed. Reg. 160 (Aug. 17, 2018; CN Oct 1, 2018). Payments calculated assuming full update using the following national standardized amounts.

Note: Payment rates to individual providers will vary based on geographic location, compliance with reporting quality measures required by Medicare, among other things.

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