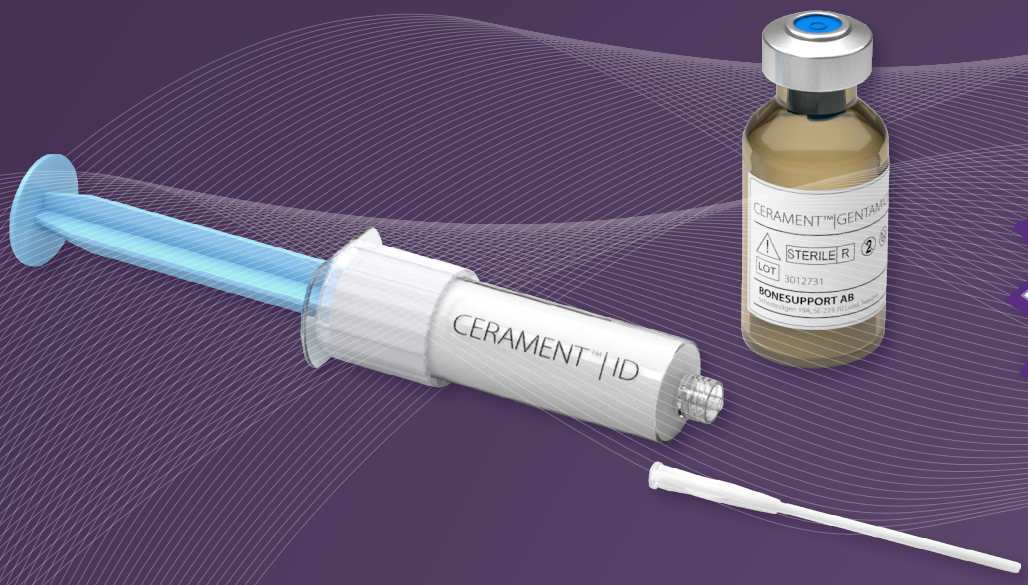
CERAMENT® G
with Gentamicin

OUTPATIENT CODING GUIDE

Outpatient Coding & Billing Guide

CERAMENT® G with Gentamicin Synthetic Bone Void Filler
Device-drug matrix, absorbable, antimicrobial-eluting Bone Void Filler



Transitional Pass-Through (TPT) payment available in 2026

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PR-01427-04 en US 01-2026

REIMBURSEMENT PROGRAM

REIMBURSEMENT PROGRAM: TRANSITIONAL PASS-THROUGH PAYMENT (TPT)[1]

The Transitional Pass-Through (TPT) Payment is an additional payment that can be made to hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs)for the incremental cost of a device (such as CERAMENT® G) when the cost of the device exceeds the current device-related portion of the ambulatory payment classification (APC) payment for the associated procedure as determined by CMS. This incremental payment helps to support access to a new technology while the claims-based cost data are collected to incorporate the cost for the device (e.g., CERAMENT G) into the APC rates for the associated procedures.

ACTIVE TRANSITIONAL PASS-THROUGH (TPT) PAYMENT FOR CERAMENT® G[1]

Effective January 1, 2024, CERAMENT® G is eligible for separate payment under the Medicare Hospital Outpatient Prospective Payment System (OPPS).

In the 2024 OPPS Final Rule, the Centers for Medicare and Medicaid Services (CMS) approved a new device category for CERAMENT® G to get a Transitional Pass-Through (TPT) Payment. CMS agreed that CERAMENT® G met all criteria to qualify for this additional cost-based payment when billed with an associated procedure code, as defined by CMS.

HIGHLIGHT OF CHANGES FOR 2026

CMS has removed the inpatient-only status restriction from 5 relevant procedures for 2026. All of these codes are valid primary procedures to bill with the TPT for CERAMENT G.

- 21510 - Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess), thorax
- 26992 - Incision, bone cortex, pelvis and/or hip joint (e.g., osteomyelitis or bone abscess)
- 27070 - Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (e.g., osteomyelitis or bone abscess); superficial
- 27071 - Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (e.g., osteomyelitis or bone abscess); deep (subfascial or intramuscular)
- 27303 - Incision, deep, with opening of bone cortex, femur or knee (e.g., osteomyelitis or bone abscess)

CMS will pay TPT when CG is used with the primary procedure code HCPCS 11012 for treating Open Fracture outpatient.

1) The Final Rule which documents the TPT is found here: https://www.cms.gov/newsroom/fact-sheets/cy-2024-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

PRODUCT OVERVIEW

PRODUCT DESCRIPTION[2]

CERAMENT® G is the first combination bone graft substitute and antibiotic indicated as part of the management of osteomyelitis and open fractures. Unlike other treatment options, CERAMENT® G is injectable and can be delivered in a more patient-friendly single-stage surgical procedure because of its unique ability to simultaneously remodel into bone and elute an antibiotic to protect bone healing. With a 96% success rate in reducing chronic osteomyelitis, healthcare resources and costs could be reduced while clinical outcomes are improved[3]. CERAMENT® G received breakthrough device designation from the FDA for the indications of bone infection and open fractures.

INDICATIONS FOR USE[2]

CERAMENT® G is a resorbable, gentamicin-eluting ceramic bone void filler intended for use in defects in the extremities of skeletally mature patients as an adjunct to systemic antibiotic therapy and surgical debridement as part of the standard treatment approach to a bone infection and open fractures. By eluting gentamicin, CERAMENT® G can reduce the occurrence and recurrence of bone infection from gentamicin-sensitive microorganisms in order to protect bone healing. CERAMENT® G can augment provisional hardware to help support bone fragments during the surgical procedure. The cured paste acts only as a temporary support media and is not intended to provide structural support during the healing process. CERAMENT® G resorbs and is replaced by bone during the healing process.

CONTRAINDICATIONS[2]

- Hypersensitivity to any amino-glycoside antibiotics
- Myasthenia gravis
- Severe renal impairment
- Pre-existing calcium metabolism disorder
- Pregnancy
- Breastfeeding

2) For detailed information on indications, contraindications, warnings and precautions see Instructions for Use.

3) Ferguson, J et al., 'Radiographic and Histological Analysis of a Synthetic Bone Graft Substitute Eluting Gentamicin in the Treatment of Chronic Osteomyelitis', Journal of Bone and Joint Infection, 4.2 (2019), 76-84.

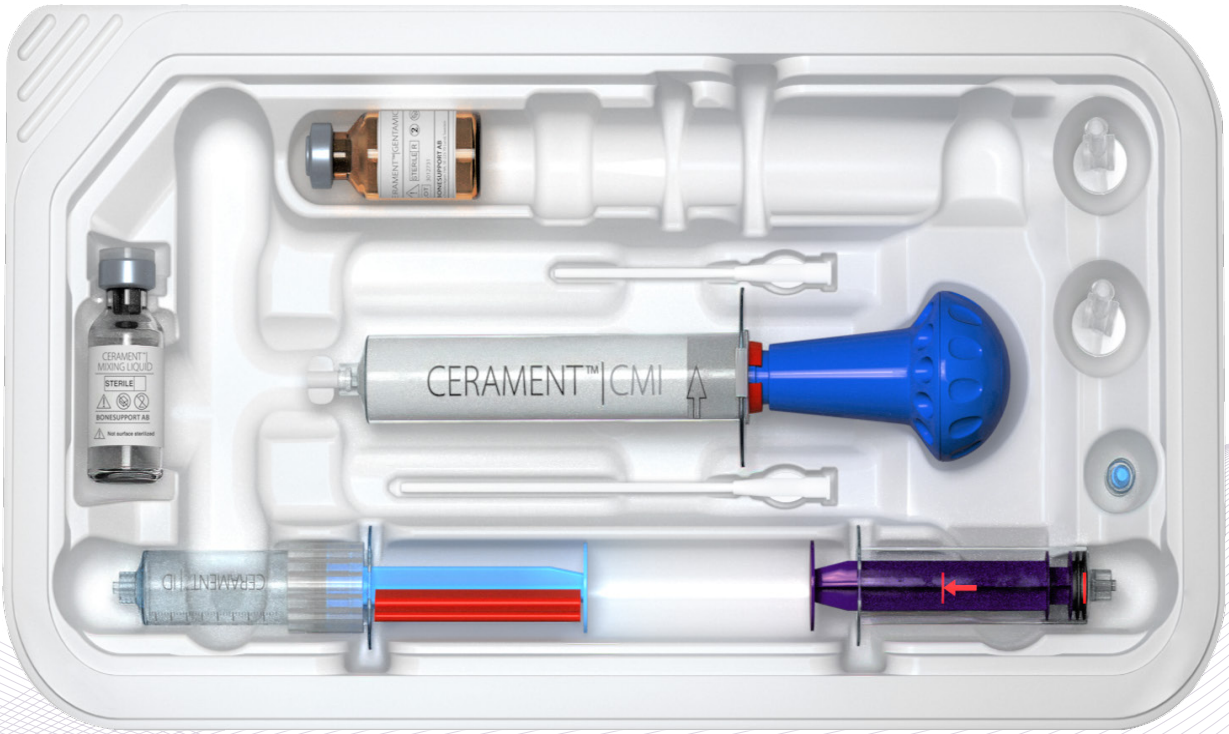
COVERAGE

MEDICARE COVERAGE DETERMINATIONS (NCD/LCD)

Currently, there is no National Coverage Determination (NCD) related to CERAMENT® G. Check with your local Medicare Administrative Contractor (MAC) regarding any Local Coverage Determinations (LCDs) related to CERAMENT® G. Medicare may cover CERAMENT® G on a case-by-case basis, with evidence of medical necessity. While traditional Medicare does not require or allow prior authorization or prior approval for procedures, Medicare Advantage plans are managed by commercial payers who may require prior authorization for Medicare Advantage patients. Check with your plan administrator for any prior authorization requirements.

COMMERCIAL COVERAGE DETERMINATIONS

Commercial insurance coverage policies vary, and many require prior authorization for any procedure. We encourage health care professionals to contact payer(s) directly with questions regarding coverage policies or guidelines for CERAMENT® G.



Disclaimer: CMS makes it clear that Medicare TPT status and assignment of a HCPCS code does not imply or guarantee Medicare coverage. Medical necessity decisions will be made separately by the Medicare Administrative Contractors (MACs) based on the patient condition and service provided; the provider is responsible for submitting accurate claims for products and services rendered.

CODING AND PAYMENT IN THE HOSPITAL OUTPATIENT DEPARTMENT (HOPD) AND AMBULATORY SURGICAL CENTER (ASC) SETTINGS

When used in the hospital outpatient department (HOPD) or ASC, the facility may report certain devices by using the appropriate HCPCS Level II billing codes. This is true when a device is described by an eligible TPT category. Medicare will recognize the device codes for separate payment, as long as the device is billed in addition to a code recognized by CMS instructions for the associated procedure performed.

See Table 1: Effective January 1, 2024, Medicare established a unique HCPCS Level II code (C1602) to describe a new category of devices eligible for a cost-based transitional pass-through payment (TPT). This code is appropriate for billing CERAMENT® G in the HOPD and ASC settings.

The creation of this TPT will allow Medicare to provide an additional payment for CERAMENT G above the base APC payment so that patients can have access to new technology, while CMS gathers claims data for future payment system updates.

CMS specifies which CPT code pairs its claims-processing software will accept as an associated procedure to bill with C1602 (Transmittal #R12552CP (cms.gov)). The TPT will be denied if not paired with a recognized code from Table 3.

There are several CPT codes that may be applicable to procedures performed in cases for which CERAMENT® G is indicated. It is up to the provider to bill appropriately to reflect the procedures performed. Table 3 also includes code descriptions, APC assignments, and the Medicare national unadjusted payment amounts3

Note: Physician services are billed on a separate claim and paid under the Medicare Physician Fee Schedule (MPFS.)

Payment may vary for private payers and Medicare Advantage plans.

Table 1. HCPCS II CODE TO BILL FOR CERAMENT® G

HCPCS Code	Description	APC	SI	HOPD Payment	PI	ASC Payment
C1602	Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)	2043	H	"Costs" based on line-item charge X (CCR), minus a device offset.	J7	Contractor priced (e.g. invoice), minus a device offset.

Table 2. Hospital Outpatient Status Indicators and ASC Payment Indicators	
Hospital Outpatient Status Indicators	
J1	Hospital part B services paid through a comprehensive APC
H	Pass though device category; separate cost-based pass-through payment
ASC Payment Indicators	
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor priced.
J8	Device-intensive procedure; paid at adjusted rate
N1	Packaged service/item; no separate payment made.
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.

Table 3. POTENTIAL CPT CODES THAT CMS HAS RECOGNIZED AS VALID PRIMARY PROCEDURES FOR CERAMENT G AND CORRESPONDING MEDICARE 2026 OPPS PAYMENT						
HCPCS Code	**DESCRIPTION**	**APC**	**SI**	**Unadjusted HOPD Payment**	**ASC PI**	**Unadjusted ASC Payment**
Debridement						
11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (e.g., excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone	5073	J1	$2,967.63	A2	$1,248.36
Shoulder/Clavicle						
21510	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess), thorax	5113	J1	$3,342.87	G2	$1,644.87
23035	Incision, bone cortex (e.g., osteomyelitis or bone abscess), shoulder area	5112	J1	$1,642.82	A2	$872.87
23140	Excision or curettage of bone cyst or benign tumor of clavicle or scapula	5113	J1	$3,342.87	A2	$1,644.87
23170	Sequestrectomy (e.g., for osteomyelitis or bone abscess), clavicle	5113	J1	$3,342.87	J8	$2,310.78
23172	Sequestrectomy (e.g., for osteomyelitis or bone abscess), scapula	5113	J1	$3,342.87	J8	$2,171.33
23174	Sequestrectomy (e.g., for osteomyelitis or bone abscess), humeral head to surgical neck	5114	J1	$7,413.38	A2	$3,695.53

HCPCS Code	DESCRIPTION	APC	SI	Unadjusted HOPD Payment	ASC PI	Unadjusted ASC Payment
Shoulder/Clavicle						
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), clavicle	5114	J1	$7,413.38	A2	$3,695.53
23182	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), scapula	5114	J1	$7,413.38	A2	$3,695.53
23184	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), proximal humerus	5114	J1	$7,413.38	A2	$3,342.87
Arm/Elbow						
23935	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess), humerus or elbow	5113	J1	$3,342.87	A2	$1,644.87
24110	Excision or curettage of bone cyst or benign tumor, humerus, with allograft	5113	J1	$3,342.87	A2	$1,644.87
24134	Sequestrectomy (e.g., for osteomyelitis or bone abscess), shaft or distal humerus	5114	J1	$7,413.38	A2	$3,695.53
24136	Sequestrectomy (e.g., for osteomyelitis or bone abscess), radial head or neck	5113	J1	$3,342.87	A2	$1,644.87
24138	Sequestrectomy (e.g., for osteomyelitis or bone abscess), olecranon process	5114	J1	$7,413.38	A2	$3,695.53
24140	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), humerus	5113	J1	$3,342.87	A2	$1,644.87
24145	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	5114	J1	$7,413.38	A2	$3,695.53

HCPCS Code	DESCRIPTION	APC	SI	Unadjusted HOPD Payment	ASC PI	Unadjusted ASC Payment
Arm/Elbow						
25035	Incision, deep, bone cortex, forearm and/or wrist (e.g., osteomyelitis or bone abscess)	5114	J1	$7,413.38	A2	$3,695.53
25130	Excision or curettage of bone cyst or benign tumor of carpal bones; with autograft (includes obtaining graft)	5113	J1	$3,342.87	A2	$1644.87
25136	Excision or curettage of bone cyst or benign tumor of carpal bones with allograft	5113	J1	$3,342.87	A2	$1,644.87
25145	Sequestrectomy (e.g., for osteomyelitis or bone abscess), forearm and/or wrist	5113	J1	$3,342.87	A2	$1,644.87
25150	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); ulna	5113	J1	$3,342.87	A2	$1,644.87
25151	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); radius	5113	J1	$3,342.87	A2	$1,644.87
Hand/Fingers						
26034	Incision, bone cortex, hand or finger (e.g., osteomyelitis or bone abscess)	5112	J1	$1,642.87	A2	$872.87
26200	Excision or curettage of bone cyst or benign tumor of metacarpal	5112	J1	$1,642.82	A2	$872.87
26230	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis); metacarpal	5113	J1	$3,342.87	A2	$1,644.87
26236	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis); distal phalanx of finger	5112	J1	$1,642.82	A2	$872.87

HCPCS Code	DESCRIPTION	APC	SI	Unadjusted HOPD Payment	ASC PI	Unadjusted ASC Payment
Hip/Pelvis						
26992	Incision, bone cortex, pelvis and/or hip joint (e.g., osteomyelitis or bone abscess)	5113	J1	$3,342.87	G2	$1,644.87
27065	Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; superficial, includes autograft, when performed	5114	J1	$7,413.38	A2	$3,695.53
27066	Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; deep (subfascial), includes autograft, when performed	5113	J1	$3,342.87	A2	$1,644.87
27067	Excision of bone cyst or benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; with autograft requiring seperate incision	5114	J1	$7,413.38	J8	$5,244.73
27070	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (e.g., osteomyelitis or bone abscess); superficial	5113	J1	$3,342.87	J8	$2,685.62
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (e.g., osteomyelitis or bone abscess); deep (subfascial or intramuscular)	5113	J1	$3,342.87	G2	$1,644.87
Knee/Leg						
27303	Incision, deep, with opening of bone cortex, femur or knee (e.g., osteomyelitis or bone abscess)	5113	J1	$3,342.87	J8	$2,084.06
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (e.g., osteomyelitis or bone abscess)	5113	J1	$3,342.87	A2	$1,644.87
27607	Incision (e.g., osteomyelitis or bone abscess), leg or ankle	5113	J1	$3,342.87	A2	$1,644.87

HCPCS Code	DESCRIPTION	APC	SI	Unadjusted HOPD Payment	ASC PI	Unadjusted ASC Payment
Knee/Leg						
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	5113	J1	$3,342.87	A2	$1,644.87
27640	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis); tibia	5113	J1	$3,342.87	A2	$1,644.87
27641	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis); fibula	5113	J1	$3,342.87	A2	$1,644.87
Foot/Toes						
28005	Incision, bone cortex (e.g., osteomyelitis or bone abscess), foot	5113	J1	$3,342.87	A2	$1,644.87
28110	Partial excision of the fifth metatarsal head (bunionette estectomy)	5113	J1	$3,342.87	A2	$1,644.87
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); talus or calcaneus	5113	J1	$3,342.87	A2	$1,644.87
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	5113	J1	$3,342.87	A2	$1,644.87
28124	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); phalanx of toe	5113	J1	$3,342.87	J1	$297.07

DEVICE OFFSET

CMS has specified a device offset amount for each associated CPT code when billed with the TPT; this is the amount that will be deducted from the total payment to reflect previous device costs. A TPT calculator tool is available upon request with the device offset amounts and showing how hospital charges are converted to cost by Medicare. CMS has modified the device offset amounts for some CPT codes for CY 2026.

For HOPD device offsets for CY2026: See the January 2026 Integrated Outpatient Code Editor (I/OCE) page 98 to 100. Found at https://www.cms.gov/medicare/coding-billing/outpatient-code-editor-oce/quarterly-release-files r13575cp.pdf

For ASC: Look for the ASC Code Pair at https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc

FREQUENTLY ASKED QUESTIONS

1. What is a transitional pass-through (TPT) and what is it intended to do?

TPT is a pathway created by CMS to allow Medicare patients access to new and innovative technology while claims data is collected. The TPT is designed to reimburse for the incremental cost of a qualifying device (such as CERAMENT® G) when the cost of the device exceeds the current device-related portion of the Ambulatory Payment Classification (APC) for the associated procedure as determined by CMS. A TPT allows an HOPD or ASC to receive additional cost-based payment for the use of qualified technology for a period of 3 years.

2. What are the criteria to qualify for TPT?

There are four criteria: new technology that is surgically inserted or implanted; clinically reasonable and necessary; provides a substantial clinical improvement over the current standard of care; "not insignificant" cost.

3. Is CERAMENT G eligible for a separate transitional pass-through (TPT) payment? If so, when does the payment go into effect?

Yes, CMS has officially acknowledged that CERAMENT® G does meet the criteria to create a new pass-through device category and is eligible for a separate cost-based payment in the HOPD and ASC settings. The TPT payment for CERAMENT® G will be effective from January 1, 2024, and last for 3 years.

TPT was approved by CMS for procedures using CERAMENT G in the HOPD and ASC listed in Table 3 under their HCPCS code. There are five additional CPT procedure codes that can be billed with TPT in 2026.

4. How long will the TPT payment last?

TPT payments will last until the end of 2026. When the pass-through payment expires, CMS will bundle the payment for the product into the relevant procedure APC. By design, CMS will rely on TPT claims data from this 3-year period to calculate the future rates.

5. When is the device eligible for TPT payments?

The CERAMENT® G TPT is effective January 1, 2024, and will last for 3 years.

6. Is there a specific HCPCS code that I will need to bill under?

Yes, CMS created a new HCPCS Level II code to define this TPT device new category:

C1602 - Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable).

This code will allow for billing and payment for CERAMENT® G when medically appropriate and billed with an associated procedure code. CMS has assigned this code an OPPS status indicator (SI) of "H" and an ASC payment indicator (PI) of "J7", meaning that the code is eligible to receive a separate payment in HOPD and ASC settings. According to CMS, this code must be paired with an associated procedure code.

7. How do I report the use of CERAMENT G?

CMS created a new device category and Level II HCPCS code (C1602) effective January 1, 2024. This device-category code should always be billed on the facility claim with an associated CPT procedure code that reflects the procedure performed. Medicare will only recognize the TPT payment with the specified CPT codes that pertain as shown in the billing guide and that pertain to treating bone infection.

8. Does the TPT payment apply to private payers?

No, the TPT payment applies only to fee-for-service Medicare patients. It does not apply to other payers, including Medicare Advantage. Private payer payment is based on a proprietary contract between providers and payers. To the extent that a private payer offers carve-out payments for new technology or for implants, any additional payment, and the requirements for such would be determined by the contract between the payer and the provider. Facilities should check with private payers to determine if there is any supplemental reimbursement.

9. Does the Medicare TPT payment have any impact on the physician payment in any setting?

The TPT payment applies to facility payments under the Hospital Outpatient Prospective Payment System, including ASCs. TPT payment status for CERAMENT® G has no impact on the Medicare Physician Fee Schedule (MPFS) payment to the clinician for the associated procedure.

In the physician office setting, Medicare considers the costs of CERAMENT® G to be inherently part of the physician service and included as part of the MPFS "non-facility" payment amount. Some other payers might treat office-based use of CERAMENT® G differently, but that will depend on contracts between the plan and physicians.

CALCULATING BILLING & PAYMENT AMOUNTS

BONESUPPORT can provide a TPT Calculator tool upon request.

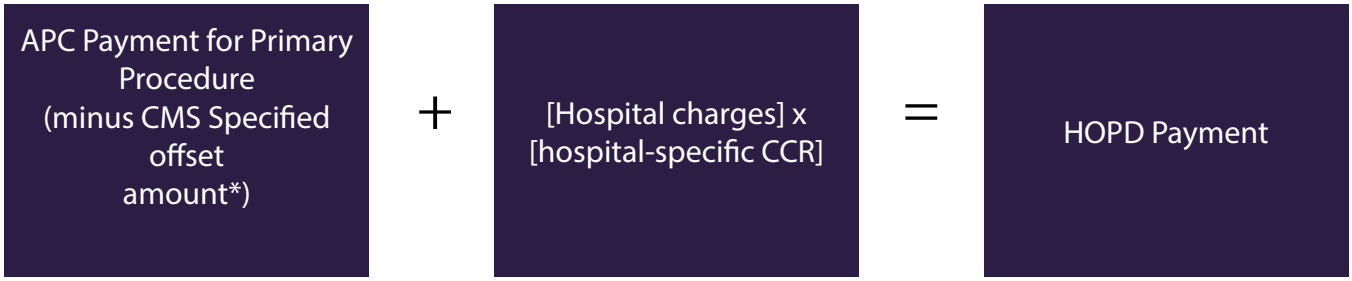
How is the pass-through payment calculated?

The methodology for calculating the TPT payment amount in the HOPD or ASC is slightly different.

HOPD Payment Calculation[4]

For hospitals, the incremental pass-through payment is determined by taking the hospital's charges for CERAMENT G and converting that to "costs" based on the individual hospital's cost to charge (CCR) ratio.

* The HOPD receives payment for the non-device portion of the associated procedure's APC payment rate by subtracting the device offset as specified by CMS [CMS Transmittal 13033]. The latest offset amounts for 2026 can be found at https://www.cms.gov/medicare/coding-billing/outpatient-code-editor-oce/quarterly-release-files. The device offsets can be found in the TPT Calculator Tool also.



ASC Payment Calculation[5]

For ASCs, the incremental pass-through payment is determined by Medicare Administrative Contractor (MAC) specific pricing, typically covering the acquisition cost of the device (e.g., invoice price).

The ASC receives payment for the non-device portion of the associated procedure payment rate. This device portion is usually a percentage of the payment, which is specified by CMS.

How much should my hospital charge for CERAMENT® G?

Each hospital should determine its own charge for CERAMENT® G. However, it is important to understand that CMS will apply the hospital's cost-to-charge ratio (CCR) to the hospital charge to calculate an estimate of the cost of the device. Therefore, to be consistent with its billing practices, a hospital should submit the charges (accounting for their CCRs), not the invoice amount, to CMS on the claim with HCPCS C1602. Otherwise, CMS will calculate an incorrect payment amount for CERAMENT® G. CMS also relies on the charges on claims data for setting payment rates for related procedures when the TPT expires.

Where can a hospital find the relevant hospital outpatient operating cost-to-charge-ratio (CCR) used in the TPT payment calculation?

The CY 2026 CCRs by provider are available at: In the FY 2026 Final Rule Impact File.

References:

1) Ferguson, J et al., 'Radiographic and Histological Analysis of a Synthetic Bone Graft Substitute Eluting Gentamicin in the Treatment of Chronic Osteomyelitis', Journal of Bone and Joint Infection, 4.2 (2019), 76-84 <https://doi.org/10.7150/jbji.31592>

2) For indications, contraindications, warnings and precautions see Instructions for Use

3) Medicare CY2026 Final Rule --CMS–1834–FC and Addenda

4) https://www.cms.gov/files/document/r13575cp.pdf page 98-100

5) Transmittal 12439 (Table 2) and Transmittal 12559 released March 28, 2024; as well as the January 2026 ASC code-pair files.

Additional references:

CERAMENT® G
with Gentamicin

TO ORDER:
1-877-719-6718
US.SALES@BONESUPPORT.COM

BONESUPPORT Reimbursement Support Line Services:

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Product Codes	
CERAMENT® G with Gentamicin 5ml	A0450-11
CERAMENT® G with Gentamicin 10ml	A0450-10
CERAMENT® G with Gentamicin 5ml (updated kit)	A0535-06
CERAMENT® G with Gentamicin 10ml (updated kit)	A0535-05
CERAMENT® BONE VOID FILLER 5ml	A0210-09
CERAMENT® BONE VOID FILLER 10ml	A0210-08
CERAMENT® BONE VOID FILLER 18ml	A0210-11
CERAMENT® Bead Tray	A0513
CERVOS Access/Delivery 8Ga x 250mm	CER-SUB-825
CERVOS Access/Delivery 15Ga x 60mm, Open Tip	CER-SUB-1560
CERVOS Access/Delivery 11Ga x 110mm, Open Tip	CER-SUB-1111-OT
BONESUPPORT Delivery Cannula 11Ga x 120mm, Closed Tip, Side Port Delivery	74389-01M
2-CAN Delivery Cannula 450mm	2CAN450B
2-CAN Delivery Cannula 350mm	2CAN350

Reimbursement Disclaimer: This information is for educational/informational purposes only and should not be construed as authoritative. The information presented here is current as of January 1, 2026, and is based upon publicly available source information. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third-party payers is solely responsible for the accuracy of the codes assigned to the services or items in the medical record. When making coding decisions, we encourage you to seek input from the American Medical Association (AMA), relevant medical societies, Centers for Medicare & Medicaid Services (CMS), your local Medicare Administrative Contractor, (MAC) and other health plans to which you submit claims. Items and services that are billed to payers must be medically necessary and supported by appropriate documentation. It is important to remember that while a code may exist describing certain procedures and/or technologies, it does not guarantee payment by payers. The decision as to how to complete a reimbursement form, including the amount to bill, is exclusively the responsibility of the provider.

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