2023 Coding and Reimbursement Guidelines for the FiberTak® Anchors

To help answer common coding and reimbursement questions about arthroscopic procedures completed with FiberTak anchors, the following information is shared for educational and strategic planning purposes only. While Arthrex believes this information to be correct, coding and reimbursement decisions by AMA, CMS, and leading payers are subject to change without notice. As a result, providers are encouraged to speak regularly with their payers.

FDA Regulatory Clearance

The Arthrex FiberTak anchor is intended to be used for suture fixation of soft tissue to bone in the shoulder. Procedures include, but are not limited to: rotator cuff repair, Bankart repair, SLAP lesion repair, biceps tenodesis, acromioclavicular separation repair, deltoid repair, capsular shift, or capsulolabral reconstruction. **(K200341, K151230, K130458)**

Value Analysis Significance

The family of FiberTak suture anchors was designed for maximum bone fixation using a soft-bodied anchor and sutures for knotless and knotted soft-tissue fixation. These implants are available in multiple sizes and suture configurations.

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.

Physician's Professional Fee

The endoscopic/arthroscopic procedure determined by the surgeon may include:

2023 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[2]		Hospital Outpatient[3]		ASC[4]
		Medicare National Average				
CPT®[1] Code HCPCS Code		Facility Setting (HOPD & ASC)	Non-Facility Setting (Office)	APC & APC Description	Medicare National Average	Medicare National Average
Endoscopy/Arthroscopy						
Shoulder						
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	$816.27	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$6,614.63	$3,138.05
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	$847.68	N/A	5114 - Level 4 MSK Procedures	$6,614.63	$3,138.05
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	$968.35	N/A	5114 - Level 4 MSK Procedures	$6,614.63	$3,138.05
23430	Tenodesis of long tendon of biceps	$741.55	N/A	5114 - Level 4 (MSK) Procedures	$6,614.63	$4,119.04
23455	Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)	$980.58	N/A	5114 - Level 4 MSK Procedures	$6,614.63	$3,138.05
29806	Arthroscopy, shoulder, surgical, capsulorrhaphy	$1,049.02	N/A	5114 – Level 4 MSK Procedures	$6,614.63	$3,138.05
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion	$1,025.87	N/A	5114 - Level 4 MSK Procedures	$6,614.63	$3,138.05
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	$1,059.60	N/A	5114 - Level 4 MSK Procedures	$6,614.63	$3,138.05

[1] 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.
[2] Source: AMA CPT 2023 and CMS PFS 2023 Final Rule
[3] Source: CMS 2023 OPPS Final Rule @ www.cms.gov
[4] Source: CMS 2023 ASC Final Rule @ www.cms.gov

Hospital and Facility Coding		
HCPCS Code	**Code Description**	**Notes**
C1713	**Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)** *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 (ie, bone substitute implanted into a bony defect created from trauma or surgery).* *List of Pass-Through Payment Device Category Codes – Updated Sept 2022)* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Complet-list-DeviceCats-OPPS.pdf	For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (eg, hospital, ASC, office). These costs are absorbed by the facility via the appropriate reimbursement mechanism (eg, MS-DRG, APC, etc). 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.

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

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.

The information provided in this handout represents no promise or guarantee concerning coverage, coding, billing, and payment levels. Arthrex specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on this information. It does not constitute legal advice and no warranty regarding completeness or accuracy is implied. The essential components that determine appropriate payment for a procedure or a product are site of service/coding/coverage/ payment system/geographical location/national and local medical review policies and/or payer edits.

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