2022 Coding and Reimbursement Guidelines for Hand/Wrist Anchors Soft Tissue Implants

To help answer common coding and reimbursement questions about procedures completed with the Hand/Wrist Anchors Soft Tissue Implants, 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 SwiveLock® anchors are intended for fixation of suture (soft tissue) to bone in the foot/ankle in the following procedures: Lateral Stabilization Medial Stabilization, Achilles Tendon Repair, Hallux Valgus Reconstruction, Mid-foot Reconstruction, Metatarsal Ligament Repair/Tendon Repair, Bunionectomy. (K151342, March 24, 2016)

Value Analysis Significance:

The Arthrex SwiveLock soft tissue anchors offer the ultimate flexibility in soft-tissue repairs and reconstructions by allowing multiple suture or SutureTape configurations as well as graft incorporation. The forked-tip eyelet of the DX SwiveLock SL anchor allows repairs that incorporate various suture materials, biologic grafts, or combinations of both. The combination of suture materials along with the biologic graft provides the advantage of augmenting the biologic repair with immediate stability from InternalBrace™ ligament augmentation technology.

Coding Considerations:

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

Physician's Professional Fee

The primary open procedure determined by the surgeon may include:

2022 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	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC & APC Description	Medicare National Average	Medicare National Average
Repair, Revision, and/or Reconstruction						
Wrist						
25320	Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	$1,010.85	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$6,397.05	$3,000.95
25447	Arthroplasty, interposition, intercarpal or carpometacarpal joints	$854.08	N/A	5113 - Level 3 MSK Procedures	$2,892.28	$1,361.61
Repair, Revision, and/or Reconstruction						
Hand						
26433	Repair of extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger)	$602.49	N/A	5113 - Level 3 MSK Procedures	$2,892.28	$1,361.61
26498	Transfer of tendon to restore intrinsic function; all 4 fingers	$1,230.94	N/A	5113 - Level 3 MSK Procedures	$2,892.28	$1,361.61
26499	Correction claw finger, other methods	$912.91	N/A	5113 - Level 3 MSK Procedures	$2,892.28	$1,361.61
26516	Capsulodesis, metacarpophalangeal joint; single digit	$780.02	N/A	5113 - Level 3 MSK Procedures	$2,892.28	$1,361.61
26530	Arthroplasty, metacarpophalangeal joint; each joint	$558.54	N/A	5114 - Level 4 MSK Procedures	$6,397.05	$3,948.28
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint	$734.34	N/A	5113 - Level 3 MSK Procedures	$2,892.28	$1,361.61
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	$766.87	N/A	5113 - Level 3 MSK Procedures	$2,892.28	$1,361.61
26548	Repair and reconstruction, finger, volar plate, interphalangeal joint	$836.09	N/A	5113 - Level 3 MSK Procedures	$2,892.28	$1,361.61

[1] CPT is the 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 2022 and CMS PFS 2022 Final Rule
[3] Source: CMS 2022 OPPS Final Rule @ www.cms.gov
[4] Source: CMS 2022 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 July 2020)* 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 the facility's payer contract for further 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 which 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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