SwiveLock® ACL Repair Kit

2024 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the SwiveLock ACL Repair Kit, 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

SwiveLock suture anchors are intended to be used for fixation of suture (soft tissue) to the bone in the knee, including anterior cruciate ligament repair (4.75-5.5 mm SwiveLock anchor only), medial collateral ligament repair, lateral collateral ligament repair, patellar tendon repair, posterior oblique ligament repair, iliotibial band tenodesis, and quadriceps tendon repair. Secondary or adjunct fixation for ACL/PCL reconstruction or repair (4.75-5.5 mm SwiveLock anchor only). (K191226)

Value Analysis Significance

ACL primary repair with the SwiveLock ACL Repair Kit involves reattaching a torn ACL using SwiveLock anchors and high-strength FiberWire® and TigerWire® sutures. The repair uses an *Internal*Brace™ ligament augmentation, which enables patients to return to activity more quickly while protecting the repaired ligament. ACL primary repair preserves native neurovascular anatomy and proprioception while eliminating graft site morbidity. It also restores biomechanical strength, normal kinematics, and knee stability to improve functional outcomes. The kit is convenient and contains all the surgical products needed for the ACL repair technique.

Coding Considerations

Codes provide a uniform language for describing services performed by health care 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 health care provider to correctly prepare claims submitted to insurance carriers.

Physician's Professional Fee

The primary arthroscopic procedure determined by the surgeon may include:

2024 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		**Physician**[b]		**Hospital Outpatient**[c]		**ASC**[d]
		Medicare National Average				
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
Knee						
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	$963.33	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$6823.42	$4499.61
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	$1212.85	N/A	5115 - Level 5 MSK Procedures	$12,552.87	$8190.60

[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 2024 and CMS PFS 2024 Final Rule

[c] CMS 2024 OPPS Final Rule @ www.cms.gov

[d] CMS 2024 ASC Final Rule @ www.cms.gov

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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).	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).
L8699	**Prosthetic implant, not otherwise specified** This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	For non-Medicare (eg, commercial) patients, depending on contractual terms and general stipulations of the payer, direct invoicing by the facility 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 HCPCS 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 arthrexRSP@arthrex.com.

The *Interna*/Brace surgical technique is intended only to augment the primary repair/reconstruction by expanding the area of tissue approximation during the healing period and is not intended as a replacement for the native ligament. The *Interna*/Brace technique is for use during soft tissue-to-bone fixation procedures and is not cleared for bone-to-bone fixation. 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.

This information 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 information in this handout or through the Arthrex Coding Helpline. This guide does not constitute legal, coding, coverage, reimbursement, business, clinical, or other advice and no warranty regarding completeness or accuracy is implied.

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