Hammertoe Correction Using DynaNite® FlexWire

2025 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic, endoscopic, or surgical procedures completed with the products described in this guide, the following information is shared for educational and strategic planning purposes only. Information described in this guide is intended solely for use as a resource tool to assist physician office and ambulatory surgical center billing staff regarding potential reimbursement challenges. It is the sole responsibility of the treating health care professional to diagnose and treat the patient, and to confirm coverage, coding, and claim submission guidance with the patient's health insurance plan to ensure claims are accurate, complete, and supported documentation in the patient's medical record. Any determination regarding if and how to seek reimbursement should be made only by the appropriate members of the staff, in consultation with the physician, and in consideration of the procedure performed or therapy provided to a specific patient. Arthrex does not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy and legislation are subject to continual change.

FDA Regulatory Clearance

DynaNite FlexWire is indicated for fixation of osteotomies and reconstruction of the lesser toes following correction procedure for hammertoe (K190287, K200068).

Value Analysis Significance

Postoperatively and until healing is complete, fixation provided by this device should be considered as temporary and may not withstand weightbearing or other unsupported stress. The fixation provided by this device should be protected. The postoperative regimen prescribed by the physician should be strictly followed to avoid adverse stresses applied to the device.

Physician's Professional Fee

The surgical foot procedure determined by the surgeon may include:

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		**Physician**[b,c] **Medicare National Average**		**Hospital Outpatient**[d]		**ASC**[e]
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
Foot / Toes						
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	$384.28	$525.31	5113 - Level 3 Musculoskeletal (MSK) Procedures	$3244.61	$1579.16
28286	Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)	$291.77	$424.39	5113 - Level 3 MSK Procedures	$3244.61	$1579.16

[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 2025 and CMS PFS 2025 Final Rule

[c] CMS Conversion Factor (CF) effective January 1, 2025: $32.3465

[d] CMS 2025 OPPS Final Rule @ www.cms.gov

[e] CMS 2025 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)** 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, no 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 the facility's payer contract for further 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 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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