

FastThread™ Interference Screws

2025 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the FastThread interference screws, 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

FastThread interference screws are intended to be used for fixation of tissue, including ligament or tendon to bone, or a bone/tendon to bone. Interference fixation is appropriate for surgeries of the knee where the sizes offered are patient appropriate; specifically, anterior cruciate ligament repair, posterior cruciate ligament repair, medial collateral ligament repair, lateral collateral ligament repair, patellar tendon repair, posterior oblique ligament repair, and iliotibial band tenodesis (K180662).

Value Analysis Significance

The family of FastThread interference screws is made of proven, reliable materials and engineered to improve screw performance during insertion and the early postoperative period.¹ Prominent leading thread and large thread pitch facilitate screw engagement and advancement, leading to faster insertion. Optimized screw threads improve pullout strength, and thread design minimizes friction against the graft, while rounded end protects the graft at the aperture.¹

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 primary arthroscopic procedure determined by the surgeon may include:

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician ^{b,c}		Hospital Outpatient ^d		ASC ^e
		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	\$957.46	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	\$7143.73	\$4628.28
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	\$1207.82	N/A	5115 - Level 5 MSK Procedures	\$12,866.82	\$8478.4

^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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HCPSC 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, not otherwise specified This code reports prosthetic implants that are not otherwise described in more specific HCPSC 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 supply, miscellaneous This code reports miscellaneous surgical supplies and should only be reported if a more specific HCPSC 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 AskMarketAccess@arthrex.com.

Reference

1. Arthrex, Inc. LA1-00099-EN_A. Naples, FL; 2018.

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.

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