SpeedFLEX™ Implant

2026 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions regarding arthroscopic procedures completed with the products in this guide, the following information is shared for educational and strategic planning purposes only. It is the sole responsibility of the treating health care professional to diagnose and treat the patient, and to and confirm coverage, coding, and claim submission guidance with the patient's health insurance plan to ensure claims are accurate, complete, and supported by 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

The SpeedFLEX™ implant is intended for use in general surgical procedures for reinforcement of soft tissue where weakness exists. The SpeedFLEX implant is also intended for reinforcement of soft tissues that are repaired by suture or suture anchors, during tendon repair surgery including but not limited to reinforcement of rotator cuff, patellar, Achilles, biceps, or quadriceps tendons. The SpeedFLEX implant is not intended to replace normal body structures or provide the full mechanical strength to support the rotator cuff, patellar, Achilles, biceps, or quadriceps tendons. Sutures used to repair the tear, and sutures or bone anchors used to attach the tissue to bone, provide mechanical strength for the tendon repair (K251690).

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 procedure determined by the surgeon may include:

2026 Medicare National Average Payment Rates (Not Adjusted for Geography)		**Physician**[b,c]		**Hospital Outpatient**[d]		**ASC**[e]
CPT®[a] Code HCPCS Code	Code Description	Work RVUs	Medicare National Average	APC and APC Description	Medicare National Average	Medicare National Average
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	15.20	$981.18	5114 – Level 4 Musculoskeletal (MSK) procedures	$7413.38	$3695.53
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	11.11	$768.70	5114 – Level 4 MSK procedures	$7413.38	$3695.53
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	11.63	$795.89	5114 – Level 4 MSK procedures	$7413.38	$3695.53
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	13.20	$911.02	5114 – Level 4 MSK procedures	$7413.38	$3695.53

[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 2026 and CMS PFS 2026 Final Rule

[c] CMS Conversion Factor (CF) effective January 1, 2026: $33.5675

[d] CMS 2026 OPPS Final Rule @ www.cms.gov

[e] CMS 2026 ASC Final Rule @ www.cms.gov

Facility Coding		
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 voids 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). 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.
C1762	**Connective tissue, human** These tissues include a natural, cellular collagen or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia Lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue.	
L8699	**Prosthetic implant, no otherwise specified** This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	
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 AskMarketAccess@arthrex.com.