2020 Coding and Reimbursement Guidelines for Achilles Soft-Tissue Implants

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the Achilles 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, Midfoot Reconstruction, Metatarsal Ligament Repair/Tendon Repair, Bunionectomy. (K151342, March 24, 2016)

Value Analysis Significance:

Arthrex has developed multiple systems for both insertional and ruptured Achilles pathologies. These systems were designed to be minimally invasive techniques and using innovative, cutting-edge technology for fixation with a variety of suture options. The development improves stability such that immediate postoperative weightbearing and range of motion are possible.

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:

2020 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 and APC Description	Medicare National Average	Medicare National Average
Repair, Revision, and/or Reconstruction						
Leg (Tibia and Fibula) and Ankle Joint						
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon;	$683.90	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$5,981.95	$2,803.36
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	$691.48	N/A	5114 - Level 4 MSK Procedures	$5,981.95	$2,803.36
27654	Repair, secondary, Achilles tendon, with or without graft	$741.28	N/A	5114 - Level 4 MSK Procedures	$5,981.95	$2,803.36

[1] CPT is the registered trademark of the American Medical Association. Healthcare 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 2020 and CMS PFS 2020 Final Rule
[3] Source: CMS 2020 OPPS Final Rule @ www.cms.gov
[4] Source: CMS 2020 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 January 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 Reimbursement Helpline at 1-877-734-6289 or e-mail us at arthrex@mcra.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 that 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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