Foot/Ankle Soft-Tissue Anchors

2025 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the Foot/Ankle soft-tissue anchors, 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® 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, and bunionectomy (K151342).

Value Analysis Significance

Soft-tissue anchor fixation has been a large part of Arthrex's success over the years. We have developed a multitude of anchor options across the foot and ankle platform. Arthrex is equipped to respond to customer needs by providing a portfolio of anchors that leverage our latest product innovations in sizing, versatility, and materials for all patients and procedures.

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] **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
Leg (Tibia and Fibula) and Ankle Joint						
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	$652.11	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$7143.73	$3510.84
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	$657.28	N/A	5114 - Level 4 MSK Procedures	$7143.73	$4628.28
27654	Repair, secondary, Achilles tendon, with or without graft	$709.36	N/A	5114 - Level 4 MSK Procedures	$7143.73	$4440.78
27658	Repair, flexor tendon, leg; primary, without graft, each tendon	$368.10	N/A	5113 - Level 3 MSK Procedures	$3244.61	$1579.16
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon	$467.08	N/A	5114 - Level 4 MSK Procedures	$7143.73	$3510.84
27664	Repair, extensor tendon, leg; primary, without graft, each tendon	$354.52	N/A	5114 - Level 4 MSK Procedures	$7143.73	$3510.84
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	$413.39	N/A	5114 - Level 4 MSK Procedures	$7143.73	$4438.66

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27675	Repair, dislocating peroneal tendons; without fibular osteotomy	$491.67	N/A	5113 - Level 3 MSK Procedures	$3244.61	$1579.16
27676	Repair, dislocating peroneal tendons; with fibular osteotomy	$603.91	N/A	5114 - Level 4 MSK Procedures	$7143.73	$3510.84
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	$632.70	N/A	5114 - Level 4 MSK Procedures	$7143.73	$3510.84
27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	$735.24	N/A	5114 - Level 4 MSK Procedures	$7143.73	$3510.84
27692	Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon (list separately in addition to code for primary procedure)	$99.30	N/A	Packaged service/item; no separate payment made		Packaged service/ item; no separate payment made
27695	Repair, primary, disrupted ligament, ankle; collateral	$482.29	N/A	5114 - Level 4 MSK Procedures	$7143.73	$4676.75
27696	Repair, primary, disrupted ligament, ankle; both collateral ligaments	$541.48	N/A	5114 - Level 4 MSK Procedures	$7143.73	$4511.06
27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	$630.11	N/A	5114 - Level 4 MSK Procedures	$7143.73	$4580.12
Foot and Toes						
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	$323.47	$478.73	5113 - Level 3 MSK Procedures	$3244.61	$1579.16
28202	Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft)	$425.36	$584.18	5114 - Level 4 MSK Procedures	$7143.73	$4731.58
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	$317.00	$468.08	5113 - Level 3 MSK Procedures	$3244.61	$1579.16
28210	Repair, tendon, extensor, foot; secondary with free graft, each tendon (includes obtaining graft)	$414.68	$569.30	5114 - Level 4 MSK Procedures	$7143.73	$4838.51
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner procedure)	$477.11	$645.31	5114 - Level 4 MSK Procedures	$7143.73	$3510.84
28313	Reconstruction, angular deformity of toe, soft-tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	$360.66	$516.57	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 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 content provided in this guide is for informational purposes only. The Arthrex Coding Helpline does not guarantee reimbursement by third-party payers.

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