# 2026 HCPCS Level II Coding Reference Guide

## 2026 Coding and Reimbursement Guidelines

**Purpose**

This guide is designed to help facility billing, coding, reimbursement, and clinical teams evaluate potential HCPCS Level II and revenue code categories associated with surgical devices, biologics, supplies, and related Arthrex products. It provides a practical reference for understanding how these codes may be considered across hospital outpatient departments under OPPS, ambulatory surgery centers, and inpatient settings, where device, supply, or revenue code reporting may be required. The guide supports informed coding review, chargemaster evaluation, payer research, and reimbursement planning; however, it does not assign or recommend a code for any specific product, procedure, claim, or patient encounter. Final code selection must reflect the product used, procedure performed, setting of care, payer requirements, contractual provisions, claim instructions, and documentation in the patient's medical record.

**Coding Considerations**

The Healthcare Common Procedure Coding System (HCPCS) is divided into two primary code sets. HCPCS Level I consists of CPT®[a] codes, which are five-digit numeric codes maintained by the American Medical Association and used primarily to describe medical procedures and professional services. HCPCS Level II consists of alphanumeric codes maintained by the Centers for Medicare & Medicaid Services and used primarily to identify products, supplies, equipment, drugs, biologicals, devices, and certain services not included in CPT. Within HCPCS Level II, code families have different purposes and reporting rules. For example, C-codes are primarily used by hospitals under Medicare's Outpatient Prospective Payment System (OPPS) to report certain drugs, biologicals, devices, and other items, while other HCPCS categories may describe supplies, implants, prosthetics, or miscellaneous items. The existence of an HCPCS Level II code does not establish that a product is covered, separately payable, or appropriate to report in every setting. HCPCS Level II and revenue code reporting may vary across hospital outpatient, ASC, and inpatient facility billing based on the payer, claim type, payment methodology, and contract terms. Revenue codes are separate from HCPCS codes and categorize facility charges on institutional claims; they should align with the facility's chargemaster, payer policy, and billing requirements.

**How to Use This Guide**

Use the table below as a reference when evaluating potential HCPCS Level II device, implant, biologic, and supply code categories, as well as related revenue code considerations. The table is not product-specific and should not be interpreted as a coding directive; instead, it is intended to support review of potential code categories, documentation considerations, and payer or facility billing requirements.

Arthrex products may fall under different HCPCS Level II code categories depending on product type, clinical use, claim setting, payer requirements, and supporting documentation. When reporting is appropriate, facilities should select the most specific code that accurately describes the item or service and is applicable to the setting of care and payer requirements. CPT and HCPCS Level II codes may describe different components of an encounter and should be evaluated independently. Miscellaneous or not otherwise classified codes should generally be considered only after confirming that no more specific applicable code exists and that payer guidance, facility policy, and documentation support their use.

**Coding, Coverage, and Payment Considerations**

- HCPCS code availability does not guarantee coverage, separate payment, or payer acceptance.
- Facilities should confirm whether an item is separately reportable, packaged into the procedure or facility payment, or addressed through contract-specific terms.
- Claims using miscellaneous codes may require supporting documentation, such as the product name, invoice, operative note, implant log, description of use, and medical necessity rationale.
- Final coding, revenue code, coverage, and claim submission decisions remain the responsibility of the billing provider or facility.

[a] CPT (Current Procedural Terminology) is a registered trademark of the American Medical Association.

## HCPCS Level II Device, Biologic, and Supply Coding Reference

| HCPCS Code | Code Description | Notes |
|---|---|---|
| **C1713** | **Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)**<br>Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissue 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 an orthopedic plate 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). | Generally packaged into the facility payment for Medicare. Confirm treatment under the applicable MS-DRG, APC, ASC, payer, and contract requirements. |
| **C1762** | **Connective tissue, human**<br>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. | Confirm the tissue type, product characteristics, intended use, code descriptor, documentation, and payer requirements align. |
| **C1763** | **Nonhuman connective tissue (includes synthetic)**<br>A natural collagen matrix typically obtained from porcine or bovine small intestinal submucosa, or pericardium. The material is acellular as all cells are removed leaving only a matrix or scaffold. This tissue is intended to promote the growth of the patient's cells within the implanted matrix. It is intended to repair or support damaged or inadequate soft tissue. | Confirm the non-human tissue, intended use, code descriptor, documentation, and payer requirements align. |
| **C1769** | **Guidewire**<br>A guidewire is a thin, flexible piece of material that is guided into a desired blood vessel or hollow organ. The guidewire may be utilized for access, to maneuver to a specific target location, or to provide a platform for device exchanges, stent insertions, and other procedures. A needle (eg, single-wall, trocar, Chiba, echo-tip, micro puncture set, vascular sheath) is inserted and the guidewire is advanced to the target location under radiological guidance. | May apply when separately reported and supported by payer or facility requirements. |
| **C1776** | **Joint device, implantable**<br>Describes an artificial joint or joint substitute and is not typically used for fixation hardware. | Confirm the device function, code descriptor, documentation, and payer requirements align. |
| **C1889** | **Implantable or insertable device for a device-intensive procedure, not otherwise classified**<br>Report C1889 for a miscellaneous device that is implanted or inserted during a device-intensive OPPS procedure that is not described by a specific HCPCS Level II category C code. | Use only when device-intensive criteria are met, no more specific code applies, and payer requirements support reporting. |
| **C9359** | **Porous purified collagen matrix bone void filler putty, per 0.5 cc**<br>A synthetic type of bone void filler (brand names Integra Mozaik Osteoconductive Scaffold Putty and Integra OS Osteoconductive Scaffold Putty) that is used for the treatment of gaps or osseous defects of the skeletal system in the extremities, spine, and pelvis. This filler is made from a purified collagen matrix, and its chemical composition allows it to be absorbed and replaced with growing host bone during the healing process. The filler is supplied in powder form and mixed with the bone marrow of the host to form a putty-like substance. This putty is often used as a substitute for harvesting bone graft material from the patient's iliac crest. | Confirm the product composition and code descriptor match. |
| **C9362** | **Porous purified collagen matrix bone void filler strip, per 0.5 cc**<br>Porous purified collagen matrix bone void filler is a resorbable bone filler designed to mimic the structure and composition of natural human bone. | Confirm the product composition and code descriptor match. |
| **C9399** | **Unclassified drugs or biologicals**<br>This code should be used to report drugs and biologicals that have been approved by the FDA, but do not have a product-specific, drug/biological HCPCS Level II code assigned. | Use only when no more specific code applies and payer requirements support reporting. Documentation may be required. |
| **L8699** | **Prosthetic implant, not otherwise specified**<br>Reports prosthetic implants that are not otherwise described by a more specific HCPCS Level II code. | Reporting varies by benefit category, claim type, setting, payer, contract, and facility policy. Do not use a miscellaneous code solely because the item is implanted or lacks a product-specific code. |
| **A4649** | **Surgical supplies; miscellaneous**<br>Reports on miscellaneous surgical supplies. Consider only after confirming that no more specific applicable HCPCS Level II supply code describes the item and that payer or facility requirements support use; it should not be treated as a default alternative for an implant or biologic. | |

**Current as of October 1, 2026:** Code information should be validated against the CMS October 2026 Alpha-Numeric HCPCS File and the applicable CMS OPPS Quarterly Addendum B, status indicators, ASC payment files, CMS claims-processing guidance, payer policies, and provider contracts. HCPCS Level II files and OPPS addenda are updated quarterly.

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.

This guide is for informational and educational purposes only and does not constitute legal, coding, coverage, reimbursement, business, clinical, or other professional advice. Arthrex does not recommend a particular code or claim-submission approach and does not guarantee coverage, coding, reimbursement, or payment by third-party payers.

The information in this guide was obtained from multiple sources and is subject to change without notice as a result of changes in reimbursement laws, regulations, rules, policies, and other coding or payment guidance. The information is general in nature and does not address all situations or all payer rules and policies. Final decisions should reflect the specific product, procedure, setting of care, medical record documentation, current coding guidance, payer policy, contract terms, and facility compliance requirements.

This guide is not intended to instruct medical providers on how to use or bill for healthcare procedures, including new technologies outside of Medicare national guidelines. A determination of medical necessity is a prerequisite and is assumed to have been made before codes are assigned or payment is requested. Medical providers should consult appropriate payers, including Medicare fiscal intermediaries and carriers, for specific information regarding coding, billing, coverage, and payment. It is the sole responsibility of the medical provider to determine the appropriate coding.

Arthrex and the Arthrex Coding Helpline make no promise or guarantee regarding coverage, coding, billing, reimbursement, or payment and disclaim liability or responsibility for the results or consequences of actions taken in reliance on information provided in this guide or through the Arthrex Coding Helpline.

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