2021 Coding and Reimbursement Guidelines for CuffMend™ Rotator Cuff Repair Augmentation System

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the CuffMend technique, 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.

Value Analysis Significance

CuffMend rotator cuff repair augmentation provides a straightforward approach for augmenting partial- and full-thickness rotator cuff tears using a decellularized dermal allograft to provide mechanical strength[1] and added biology to the repair construct. The system includes a graft spreader for introducing the ArthroFlex decellularized dermal allograft and TissueTak™ tendon anchors for medial soft-tissue fixation to the rotator cuff tendon. Lateral bony fixation is accomplished with PushLock® anchors spanning the graft over the footprint. The scientific literature supports the use of a decellularized dermal allograft as an option for augmentation in rotator cuff repair[2,3]. This has led to significant clinical interest, particularly for challenging repairs such as revisions or when retears are a concern due to suboptimal tendon quality.

Coding Considerations

Codes provide a uniform language for describing services performed by healthcare 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. Please note that the CuffMend™ system does not have its own CPT®[a] code.

Physician's Professional Fee

The primary arthroscopic procedure determined by the surgeon may include:

2021 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[b]		Hospital Outpatient[c]		ASC[d]
		Medicare National Average				
CPT Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC & APC Description	Medicare National Average	Medicare National Average
Arthroscopy						
Shoulder						
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	$1,100.53	N/A	5114 - Level 4 MSK Procedures	$6,264.95	$2,944.24
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	$845.11	N/A	5114 - Level 4 (MSK) Procedures	$6,264.95	$2,944.24
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	$877.91	N/A	5114 - Level 4 MSK Procedures	$6,264.95	$2,944.24
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	$1,002.83	N/A	5114 - Level 4 MSK Procedures	$6,264.95	$2,944.24

[a] CPT is the 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] Source: AMA CPT 2021 and CMS PFS 2021 Final Rule
[c] Source: CMS 2021 OPPS Final Rule @ www.cms.gov
[d] Source: CMS 2021 ASC Final Rule @ www.cms.gov

Hospital and Facility Coding		
HCPCS Code	**Code Description**	**Notes**
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.*	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).
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.)*	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.
Q4125	**ArthroFlex** *ArthroFlex, per sq centimeter*	
L8699	**Prosthetic implant, not otherwise specified** *(List of Pass Through Payment Device Category Codes – Updated July 2020)* *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Complet-list-DeviceCats-OPPS.pdf*	

For more information about the primary procedure, please speak with your admitting surgeon. You may also call Arthrex's Coding Helpline at 1-844-604-6359 or e-mail us at arthrex@cmcopilot.com.

This content 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 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 healthcare 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 which 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.

References

1. Ely EE, Figueroa NM, Gilot GJ. Biomechanical analysis of rotator cuff repairs with extracellular matrix graft augmentation. *Orthopedics*. 2014;37(9):608-614. doi:10.3928/01477447-20140825-05
2. Gilot GJ, Alvarez-Pinzon AM, Barcksdale L, Westerdahl D, Krill M, Peck E. Outcome of large to massive rotator cuff tears repaired with and without extracellular matrix augmentation: a prospective, comparative study. *Arthroscopy*. 2015;31(8):1459-1465. doi:10.1016/j.arthro.2015.02.032
3. Hirahara AM, Andersen WJ, Panero AJ. Superior capsular reconstruction: clinical outcomes after minimum 2-year follow-up. *Am J Orthop*. 2017;46(6):266-278.

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