Univers Revers™ Total Shoulder System

2026 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroplasty procedures completed with the Univers Revers total shoulder system, 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 Univers Revers total shoulder system is indicated for use in a grossly rotator cuff-deficient glenohumeral joint with severe arthropathy or a previously failed joint replacement with a gross rotator cuff deficiency. The Univers Revers system is indicated for primary, fracture, or revision total shoulder replacement (K130129).

Value Analysis Significance

The Univers Revers total shoulder system provides the option to implant a traditional Grammont-style configuration, which follows the principles of a constrained environment that medializes the center of rotation and lengthens the deltoid, resulting in increased torque with forward flexion. In addition, this unique implant design offers the option to create a more anatomic center of rotation by altering the neck-shaft angle from 155° to 135° and using a lateralized glenosphere. This more lateralized center of rotation decreases the risk of scapular notching, while increasing the external rotator torque by lengthening the intact posterior cuff musculature. This adjustable neck-shaft angle, in combination with the wide range of offset options available in the humeral and glenoid components, allows the surgeon to tailor the implant specific to each patient's anatomy and disease process.

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 arthroplasty 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
Shoulder						
20902	Bone graft, any donor area; major or large	4.47	$243.03	5114 – Level 4 Musculoskeletal (MSK) procedures	$7413.38	$3695.53
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, imageless (list separately in addition to code for primary procedure)	2.44	$124.54	Packaged service/item; no separate payment made		Packaged service/ item; no separate payment made
23334	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component	15.11	$981.18	5073 – Level 3 Excision/Biopsy/ Incision and Drainage	$2862.05	$1201.90
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)	$18.53	$1154.05	5114 – Level 4 MSK procedures	$7413.38	$4996.77
23395	Muscle transfer, any type, shoulder or upper arm; single	18.08	$1183.59	5114 – Level 4 MSK procedures	$7413.38	$3695.53
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	17.44	$1093.29	5115 – Level 5 MSK Procedures	$13,116.76	$9694.41

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CPT®[a] Code HCPCS Code	Code Description	Work RVUs	Medicare National Average	APC and APC Description	Medicare National Average	Medicare National Average
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement [eg, total shoulder])	21.58	$1306.78	5116 – Level 6 MSK Procedures	$17,913.59	$13,911.66
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	24.38	$1447.43	5115 – Level 5 MSK Procedures	$13,116.76	$9390.23
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	26.53	$1559.88	5115 – Level 5 MSK Procedures	$13,116.76	$9995.66
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed	11.99	$827.77	5115 – Level 5 MSK Procedures	$13,116.76	$9193.89
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement	17.91	$1127.20	5116 – Level 6 MSK procedures	$17,913.59	$13,437.31
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	11.82	$826.43	5115 – Level 5 MSK procedures	$13,116.76	$8818.21

[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

HCPCS Code	Code Description	Notes
C1776	**Joint device (implantable)** An artificial joint that is implanted in a patient. Typically, a joint device functions as a substitute to its natural counterpart and is not used (as are anchors) to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone.	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.
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.

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