BioSurge™ Convenience Kit

2026 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about endoscopic, arthroscopic, or open procedures completed with the BioSurge convenience kit, 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 Angel® concentrated platelet-rich plasma (cPRP) system is to be used in the clinical laboratory or intraoperatively at the point of care for the safe and rapid preparation of platelet-poor plasma and platelet concentrate (platelet-rich plasma) from a small sample of whole blood or a small mixture of blood and bone marrow. The platelet-rich plasma can be mixed with autograft and/or allograft bone prior to application to an orthopedic site (BK110046).

Value Analysis Significance

The BioSurge system combines the matrices of the AlloSync™ bone grafting solutions line with the Angel system's proprietary technology to prepare customized cPRP from bone marrow aspirate (BMA). Hydrated AlloSync bone grafts provide the optimal scaffold for cPRP from BMA, which is a rich source of platelets and nucleated and progenitor cells.

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 arthroscopic 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						
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	11.11	$768.70	5114 – Level 4 Musculoskeletal (MSK) procedures	$7413.38	$3695.53
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	11.63	$795.89	5114 – Level 4 MSK procedures	$7413.38	$3695.53
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	13.20	$911.02	5114 – Level 4 MSK procedures	$7413.38	$3695.53
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement [eg, total shoulder])	21.58	$1306.78	5115 – Level 5 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	$0 (carrier priced)
29806	Arthroscopy, shoulder, surgical, capsulorrhaphy	14.76	$977.82	5114 – Level 4 MSK procedures	$7413.38	$3695.53
29827	With rotator cuff repair	15.20	$981.18	5114 – Level 4 MSK procedures	$7413.38	$3695.53

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Femur and Knee						
27405	Repair, primary, torn ligament and/or capsule, knee; collateral	8.85	$640.47	5114 – Level 4 MSK procedures	$7413.38	$3695.53
27407	Cruciate	10.58	$751.91	5114 – Level 4 MSK procedures	$7413.38	$5256.83
27409	Collateral and cruciate ligaments	13.37	$900.62	5114 – Level 4 MSK procedures	$7413.38	$3695.53
27415	Osteochondral allograft, knee, open	19.50	$1264.49	5115 – Level 5 MSK procedures	$13,116.76	$10,492.07
27416	Osteochondral allograft(s), knee, open (eg, mosaicplasty, including harvesting of autograft)	13.81	$906.99	5114 – Level 4 MSK procedures	$7413.38	$3695.5
27418	Anterior tibial tubercleplasty (eg, Maquet-type procedure)	11.31	$767.02	5114 – Level 4 MSK procedures	$7413.38	$3695.5
Tibia, Fibula, and Ankle Joint						
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	7.83	$548.49	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
27638	With allograft	10.72	$702.23	5114 – Level 4 MSK Procedures	$7413.38	$3695.53
27705	Osteotomy; tibia	10.59	$696.19	5114 – Level 4 MSK Procedures	$7413.38	$5157.52
27707	Fibula	4.66	$394.42	5113 – Level 3 MSK Procedures	$3342.87	$1644.87
27709	Tibia and fibula	17.04	$1056.37	5115 – Level 5 MSK Procedures	$13,116.76	$8873.30
27726	Repair of fibula nonunion and/or malunion with internal fixation	13.98	$879.47	5114 – Level 4 MSK Procedures	$7413.38	$4746.58
27758	Open treatment of tibial shaft fracture (with or without fibular fracture) with plate/screws, with or without cerclage	12.23	$837.51	5115 – Level 5 MSK Procedures	$13,116.76	$8872.72
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	14.09	$922.77	5115 – Level 5 MSK Procedures	$13,116.76	$8846.34
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	7.69	$582.73	5114 – Level 4 MSK Procedures	$7413.38	$3695.53
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	9.89	$679.07	5114 – Level 4 MSK Procedures	$7413.38	$4682.29
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	9.43	$676.39	5114 – Level 4 MSK Procedures	$7413.38	$3695.53
27792	Open treatment of distal fibular fracture (lateral malleolus, includes internal fixation, when performed)	8.53	$610.93	5114 – Level 4 MSK Procedures	$7413.38	$4813.11
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	10.35	$718.34	5114 – Level 4 MSK Procedures	$7413.38	$4843.35
27829	Open treatment of distal tibiofibular (syndesmosis) disruption, includes internal fixation, when performed	8.58	$676.39	5114 – Level 4 MSK Procedures	$7413.38	$4876.77
27870	Arthrodesis, ankle, open	15.02	$932.51	5115 – Level 5 MSK Procedures	$13,116.76	$9693.82
27871	Arthrodesis, tibiofibular joint, proximal or distal	9.30	$650.54	5115 – Level 5 MSK Procedures	$13,116.76	$9492.21

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Foot and Ankle						
28320	Repair, nonunion or malunion, tarsal bone	9.14	$580.72	5115 – Level 5 MSK procedure	$13,116.76	$9557.85
28322	Metatarsal, with or without bone graft (includes obtaining graft)	8.32	$543.79	5114 – Level 4 MSK procedure	$7413.38	$4734.49
20999	Unlisted procedure, musculoskeletal system, general	0.0	$0 (carrier priced)	5111 – Level 1 MSK procedure	$252.01	$0 (carrier priced)
0232T	Injection(s), platelet-rich plasma, any site (including image guidance, harvesting, and preparation, when performed)	0.0	$0 (carrier priced)	5115 – Level 5 MSK procedure	$456.40	Packaged service/ item; no separate payment

[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
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). 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.