To help answer common coding and reimbursement questions about arthroscopic procedures completed with the Syndesmosis TightRope implant 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 TightRope syndesmosis device is intended as an adjunct in fracture repair involving metaphyseal and periartricular small bone fragments where screws are not indicated, and as an adjunct in external and intramedullary fixation systems involving plates and rods, with fracture braces and casting. Specifically, the Arthrex TightRope syndesmosis device is intended to provide fixation during the healing process following a syndesmotic trauma, such as fixation of syndesmosis (syndesmosis disruptions) in connection with Weber B and C ankle fractures (K043248).

**Value Analysis Significance**
The Syndesmosis TightRope implant system, comprised of 2 metallic buttons and #5 ultra-high-molecular-weight polyethylene (UHMWPE) suture, is intended to provide physiologic syndesmosis fixation during the healing process following a syndesmotic injury. The Syndesmosis TightRope fixation system mimics the natural micromotion of the fibula and prevents the need for a second surgery to remove a rigid syndesmotic screw.

**Coding Considerations**
Codes provide a uniform language for describing services performed by health care providers. The actual selection of codes depends upon 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 open and/or arthroscopic procedure determined by the surgeon may include:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Code Description</th>
<th>Physician Medicare National Average</th>
<th>Hospital Outpatient Medicare National Average</th>
<th>ASC Medicare National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>27829</td>
<td>Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed</td>
<td>$723.15</td>
<td>N/A</td>
<td>$6614.63</td>
</tr>
<tr>
<td>29898</td>
<td>Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive</td>
<td>$570.32</td>
<td>N/A</td>
<td>$2976.66</td>
</tr>
</tbody>
</table>

* 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.
* AMA CPT 2023 and CMS PFS 2023 Final Rule
* CMS 2023 OPPS Final Rule @ www.cms.gov
* CMS 2023 ASC Final Rule @ www.cms.gov
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Code Description</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 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. | 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).  
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 refer to the facility’s payer contract for more information. |

List of Pass-Through Payment Device Category Codes (Updated September 2022) [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment](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.

The information provided in this handout was obtained from many sources and is subject to change without notice as a result of changes in reimbursement laws, regulations, rules, and policies. All content on this website is informational only, general in nature, and does not cover all situations or all payers’ rules and policies. This content is not intended to instruct medical providers on how to use or bill for health care 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 health care procedures. It is the sole responsibility of the medical provider to determine the appropriate coding.

This information 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 information in this handout or through the Arthrex Coding Helpline. This guide does not constitute legal, coding, coverage, reimbursement, business, clinical, or other advice and no warranty regarding completeness or accuracy is implied.