BioSurge™ Convenience Kit

2025 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 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 arthroscopic procedure determined by the surgeon may include:

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		**Physician**[b,c] **Medicare National Average**		**Hospital Outpatient**[d]		**ASC**[e]
CPT®[a] Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC and APC Description	Medicare National Average	Medicare National Average
Shoulder						
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	$810.93	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$7143.73	$3510.84
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	$842.63	N/A	5114 - Level 4 MSK Procedures	$7143.73	$3510.84
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	$964.25	N/A	5114 - Level 4 MSK Procedures	$7143.73	$3510.84
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)	$1414.84	N/A	5115 - Level 5 MSK Procedures	$18,390.05	$14,519.98
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	$1572.69	N/A	5115 - Level 5 MSK Procedures	$12,866.82	N/A
29806	Arthroscopy, shoulder, surgical, capsulorrhaphy	$1042.20	N/A	5114 - Level 4 MSK Procedures	$7143.73	$3510.84
29827	With rotator cuff repair	$1050.29	N/A	5114 - Level 4 MSK Procedures	$7143.73	$3510.84

arthrex.com

Femur and Knee						
27405	Repair, primary, torn ligament and/or capsule, knee; collateral	$671.51	N/A	5114 – Level 4 MSK Procedures	$7143.73	$3510.84
27407	Cruciate	$791.20	N/A	5114 – Level 4 MSK Procedures	$7143.73	$4966.63
27409	Collateral and cruciate ligaments	$954.87	N/A	5114 – Level 4 MSK Procedures	$7143.73	$3510.84
27415	Osteochondral allograft, knee, open	$1350.47	N/A	5115 – Level 5 MSK Procedures	$12,866.82	$11,001.72
27416	Osteochondral allograft(s), knee, open (eg, mosaicplasty), including harvesting of autograft)	$967.81	N/A	5114 – Level 4 MSK Procedures	$7143.73	$3510.84
27418	Anterior tibial tubercleplasty (eg, Maquet-type procedure)	$808.02	N/A	5114 – Level 4 MSK Procedures	$7143.73	$3510.84
Tibia, Fibula, and Ankle Joint						
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula	$571.56	N/A	5113 – Level 3 MSK Procedures	$3244.61	$1579.16
27638	With allograft	$736.53	N/A	5114 – Level 4 MSK Procedures	$7143.73	$3510.84
27705	Osteotomy; tibia	$733.94	N/A	5114 – Level 4 MSK Procedures	$7143.73	$4428.66
27707	Fibula	$404.65	N/A	5113 – Level 3 MSK Procedures	$33244.61	$1579.16
27709	Tibia and fibula	$1120.48	N/A	5115 – Level 5 MSK Procedures	$12,866.82	$8624.91
27726	Repair of fibula nonunion and/or malunion with internal fixation	$943.55	N/A	5114 – Level 4 MSK Procedures	$7143.73	$4740.36
27758	Open treatment of tibial shaft fracture (with or without fibular fracture) with plate/screws, with or without cerclage	$885.65	N/A	5115 – Level 5 MSK Procedures	$12,866.82	$8900.76
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	$983.01	N/A	5115 – Level 5 MSK Procedures	$12,866.82	$8817.21
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	$601.64	N/A	5114 – Level 4 MSK Procedures	$7143.73	$3510.84
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	$719.06	N/A	5114 – Level 4 MSK Procedures	$7143.73	$4720.98
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	$703.86	N/A	5114 – Level 4 MSK Procedures	$7143.73	$3510.84
27792	Open treatment of distal fibular fracture (lateral malleolus, includes internal fixation, when performed)	$637.55	N/A	5114 – Level 4 MSK Procedures	$7143.73	$4596.18

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	$754.64	N/A	5114 – Level 4 MSK Procedures	$7143.73	$4567.40
27829	Open treatment of distal tibiofibular (syndesmosis) disruption, includes internal fixation, when performed	$695.45	N/A	5114 – Level 4 MSK Procedures	$7143.73	$4781.86
27870	Arthrodesis, ankle, open	$990.45	N/A	5115 – Level 5 MSK Procedures	$12,866.82	$9589.26
27871	Arthrodesis, tibiofibular joint, proximal or distal	$681.22	N/A	5115 – Level 5 MSK Procedures	$12,866.82	$9504.55
Foot and Ankle						
28320	Repair, nonunion or malunion, tarsal bone	$607.47	N/A	5115 – Level 5 MSK Procedures	$12,866.82	$8513.31
28322	Metatarsal, with or without bone graft (includes obtaining graft)	$569.95	$763.70	5114 – Level 4 MSK Procedures	$7143.73	$4782.19
20999	Unlisted procedure, musculoskeletal system, general	Contractor priced		5111 – Level 1 MSK Procedures	$239.88	N/A
0232T	Injection(s), platelet-rich plasma, any site (including image guidance, harvesting, and preparation, when performed)	Contractor priced		5735 – Level 5 Minor Procedures	$399.04	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 2025 and CMS PFS 2025 Final Rule

[c] CMS Conversion Factor (CF) effective January 1, 2025: $32.3465

[d] CMS 2025 OPPS Final Rule @ www.cms.gov

[e] CMS 2025 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, implantable bone graft materials 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).
L8699	**Prosthetic implant, no otherwise specified** This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	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 contract for further information.
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		

BioSurge™ Convenience Kit

2025 Coding and Reimbursement Guidelines

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.

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.

arthrex.com