

# Eclipse™ Total Shoulder System

## 2026 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroplasty procedures completed with the Eclipse 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 Eclipse shoulder prosthesis is indicated for severely painful and/or disabled joint resulting from osteoarthritis or traumatic arthritis (K183194).

### Value Analysis Significance

The Eclipse anatomic shoulder arthroplasty system provides bone-preserving humeral head replacement. A novel cage screw and trunnion provide fixation of the implant without removing bone from the proximal humerus or the canal. The cage screw gains fixation in the metaphyseal bone while compressing the trunnion to the cortical rim, thereby reducing stress shielding. The device also provides bony growth surfaces, fenestrations in the cage screw, and calcium-phosphate coating of the trunnion, which all yield a stable construct with multiple modes of fixation.

### 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 <sup>b,c</sup>		Hospital Outpatient <sup>d</sup>		ASC <sup>e</sup>
CPT <sup>a</sup> Code HCPCS Code	Code Description	Work RVUs	Medicare National Average	APC and APC Description	Medicare National Average	Medicare National Average
<b>Shoulder</b>						
<b>20902</b>	Bone graft, any donor area; major or large	4.47	\$243.03	5114 – Level 4 Musculoskeletal (MSK) procedures	\$7413.38	\$3695.53
<b>20985</b>	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
<b>23334</b>	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component	15.11	\$981.18	5114 – Level 4 MSK procedures	\$7413.38	\$3695.53
<b>23335</b>	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
<b>23395</b>	Muscle transfer, any type, shoulder or upper arm; single	18.08	\$1183.59	5114 – Level 4 MSK procedures	\$7413.38	\$3695.53
<b>23470</b>	Arthroplasty, glenohumeral joint; hemiarthroplasty	17.44	\$1093.29	5115 – Level 5 MSK procedures	\$13,116.76	\$9694.41
<b>23472</b>	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
<b>23473</b>	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
<b>23474</b>	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



2026 Medicare National Average Payment Rates (Not Adjusted for Geography)		Physician <sup>b,c</sup>		Hospital Outpatient <sup>d</sup>		ASC <sup>e</sup>
CPT <sup>a</sup> Code HCPCS Code	Code Description	Work RVUs	Medicare National Average	APC and APC Description	Medicare National Average	Medicare National Average
<b>23615</b>	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
<b>23616</b>	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	\$13,473.31
<b>24515</b>	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

<sup>a</sup> 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.

<sup>b</sup> AMA CPT 2026 and CMS PFS 2026 Final Rule

<sup>c</sup> CMS Conversion Factor (CF) effective January 1, 2026: \$33.5675

<sup>d</sup> CMS 2026 OPPS Final Rule @ [www.cms.gov](http://www.cms.gov)

<sup>e</sup> CMS 2026 ASC Final Rule @ [www.cms.gov](http://www.cms.gov)

HCPCS Code	Code Description	Notes
<b>C1776</b>	<b>Joint device (implantable)</b> 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).
<b>L8699</b>	<b>Prosthetic implant, no otherwise specified</b> 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.
<b>A4649</b>	<b>Surgical supplies; miscellaneous</b> This code reports miscellaneous surgical supplies and should only be reported if a more specific HCPCS Level II or CPT code is not available.	Contact the patient's insurance company or the facility's payer contract for further 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 [AskMarketAccess@arthrex.com](mailto: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.

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