Hand and Wrist Soft-Tissue Anchors

2026 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about procedures completed with the Hand/Wrist soft-tissue anchors, 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 Arthrex SwiveLock®, Corkscrew® and PushLock® anchors are intended for fixation of suture (soft tissue) to bone in the hand/wrist in the following procedures: scapholunate ligament reconstruction and ulnar or radial collateral ligament reconstruction (K201749, K173788, K101679).

Value Analysis Significance

SwiveLock soft-tissue anchors offer the ultimate flexibility in soft-tissue repairs and reconstructions by allowing multiple suture or SutureTape configurations as well as graft incorporation. The forked-tip eyelet of the DX SwiveLock SL anchor allows repairs that incorporate various suture materials, biologic grafts, or combinations of both. The combination of suture materials along with the biologic graft provides the advantage of augmenting the biologic repair with immediate stability from *Internal*Brace™ ligament augmentation technology.

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 open 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
Wrist						
25320	Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	12.43	$932.17	5114 – Level 4 Musculoskeletal (MSK) procedures	$7413.38	$3695.53
25447	Arthroplasty, interposition, intercarpal or carpometacarpal joints	10.24	$747.55	5113 – Level 3 MSK procedures	$3342.87	$1644.87
25448	Arthroplasty, intercarpal or carpometacarpal joints; suspension, including transfer or transplant of tendon, with interposition, when performed	11.55	$823.41	5113 – Level 3 MSK procedures	$3342.87	$1644.87
Hand						
26433	Repair of extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger)	4.58	$570.98	5113 – Level 3 MSK procedures	$3342.87	$1644.87
26498	Transfer of tendon to restore intrinsic function; all 4 fingers	13.85	$1125.85	5113 – Level 3 MSK procedures	$3342.87	$1644.87
26499	Correction, claw finger, other methods	8.94	$854.29	5113 – Level 3 MSK procedures	$3342.87	$1644.87
26516	Capsulodesis, metacarpophalangeal joint; single digit	7.14	$721.37	5113 – Level 3 MSK procedures	$3342.87	$1644.87
26530	Arthroplasty, metacarpophalangeal joint; each joint	6.71	$512.24	5113 – Level 3 MSK procedures	$7413.38	$4977.04
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint	6.44	$683.10	5113 – Level 3 MSK procedures	$3342.87	$1644.87

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
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	6.93	$711.63	5113 – Level 3 MSK procedures	$3342.87	$1644.87
26548	Repair and reconstruction, finger, volar plate, interphalangeal joint	8.01	$770.04	5113 – Level 3 MSK procedures	$3342.87	$1644.87

[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, not 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.

The *Internal*Brace surgical technique is intended only to augment the primary repair/reconstruction by expanding the area of tissue approximation during the healing period and is not intended as a replacement for the native ligament. The *Internal*Brace technique is for use during soft tissue-to-bone fixation procedures and is not cleared for bone-to-bone fixation.

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.