

CeMend™ Shoulder Spacer Mold

2026 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions regarding arthroscopic procedures completed with the products in this guide, the following information is shared for educational and strategic planning purposes only. It is the sole responsibility of the treating health care professional to diagnose and treat the patient, and to confirm coverage, coding, and claim submission guidance with the patient's health insurance plan to ensure claims are accurate, complete, and supported by documentation in the patient's medical record. Any determination regarding if and how to seek reimbursement should be made only by the appropriate members of the staff, in consultation with the physician, and in consideration of the procedure performed or therapy provided to a specific patient. Arthrex does not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy and legislation are subject to continual change.

FDA Regulatory Clearance

SpaceFlex Shoulder (K202338), G3 40 Radiopaque Bone Cement (K193061), G3A 40 Bone Cement (K181282).

VALUE ANALYSIS SIGNIFICANCE

CeMend Shoulder Spacer Mold

Consists of two plastic half-molds and a stainless-steel stem with two centering pins and low-viscosity polymethylmethacrylate (PMMA) bone cement. The temporary spacer is then inserted into the humeral medullary canal and glenoid cavity of the shoulder following removal of the existing humeral and glenoid cavity implants and debridement (SpaceFlex Shoulder [K202338]).

Arthrex Bone Cement MVG

A self-curing, radiopaque, PMMA-based cement used for securing a metal or polymeric prosthesis to living bone in arthroplasty revision procedures such as hip replacement, knee replacement, ankle replacement, shoulder replacement and other joint replacements. It contains and releases the aminoglycoside antibiotic gentamicin to protect the cured cement and contiguous tissue against contamination by microbes sensitive to gentamicin (G3A 40 Bone Cement [K181282]).

Arthrex Bone Cement MV

A self-curing, radiopaque, PMMA-based cement used for securing a metal or polymeric prosthesis to living bone in arthroplasty procedures. The hardened bone cement secures the fixation of the grafted artificial joint, improving the transfer of forces at the interface of the implant-bone (G3 40 Radiopaque Bone Cement [K193061]).

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 procedure(s) 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						
23334	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component	15.11	\$981.18	5114 – Level 4 Musculoskeletal (MSK) procedures	\$7413.38	\$3695.53
23335	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
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	17.44	\$1093.29	5115 – Level 5 MSK procedures	\$13,116.76	\$9694.41



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
23472	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
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	\$9390.23
23474	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
(+)20704	Manual preparation and insertion of drug-delivery device(s), intra-articular (list separately in addition to code for primary procedure)	2.54	\$129.23 (HOPD and ASC) \$156.42 (Office)	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
(+)20705	Removal of drug-delivery device(s), intra-articular (list separately in addition to code for primary procedure)	2.10	\$106.74 (HOPD and ASC) \$128.90 (Office)	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
11981	Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, nonbiodegradable)	1.11	\$55.05 (HOPD and ASC) \$108.09 (Office)	5734 – Level 4 Minor procedures	\$135.93	Packaged service/item; no separate payment made
11982	Removal, nonbiodegradable drug delivery implant	1.31	\$63.44 (HOPD and ASC) \$115.47 (Office)	51735 – Level 5 Minor procedures	\$456.04	Packaged service/item; no separate payment made

^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
C1602	Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable) Implantable orthopedic/device/drug matrix/absorbable bone void fillers with antimicrobial-eluting traits. These materials are used as components in orthopedic procedures to reduce risk of postprocedure infection or to treat an active infection of the bone or joint.	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.
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 tissue 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 plate 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).	
C1776	Joint device (implantable)	
C1889	Implantable / insertable device for device-intensive procedure, not otherwise classified	
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 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.