

# 2022 Coding and Reimbursement Guidelines for the SwiveLock® ACL Repair Kit

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the SwiveLock ACL Repair 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 Arthrex SwiveLock Suture Anchors are intended to be used for fixation of suture (soft tissue) to the bone in the knee, including Anterior Cruciate Ligament Repair(4.75-5.5SwiveLockOnly), Medial Collateral Ligament Repair, Lateral Collateral Ligament Repair, Patellar Tendon Repair, Posterior Oblique Ligament Repair, Iliotibial Band Tenodesis, and Quadriceps Tendon Repair. Secondary or adjunct fixation for ACL/PCL reconstruction or repair (4.75-5.5 SwiveLock only). (K191226, June 11, 2019)

## Value Analysis Significance

ACL primary repair with the SwiveLock® ACL Repair Kit involves reattaching a torn ACL utilizing SwiveLock® anchors and high-strength FiberWire® and TigerWire® sutures. The repair utilizes an InternalBrace™ ligament augmentation, which enables patients to return to activity more quickly while protecting the repaired ligament. ACL primary repair preserves native neurovascular anatomy and proprioception while eliminating graft site morbidity. It also restores biomechanical strength, normal kinematics, and knee stability to improve functional outcomes. The kit is convenient and contains all the surgical products needed for the ACL repair technique.

## Coding Considerations

Codes provide a uniform language for describing services performed by healthcare 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 healthcare provider to correctly prepare claims submitted to insurance carriers.

## Physician's Professional Fee

The primary arthroscopic procedure determined by the surgeon may include:

2022 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician <sup>2</sup>		Hospital Outpatient <sup>3</sup>		ASC <sup>4</sup>
		Medicare National Average				
CPT <sup>®1</sup> Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC & APC Description	Medicare National Average	Medicare National Average
Arthroscopy						
Knee						
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	\$1,003.23	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	\$6,397.05	\$4,126.78
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	\$1,256.55	N/A	5115 - Level 5 MSK Procedures	\$12,593.29	\$8,255.98

<sup>1</sup> CPT is the registered trademark of the American Medical Association. Healthcare providers and their professional coders must closely review this primary citation along with the patient's medical record before selecting the appropriate code.

<sup>2</sup> Source: AMA CPT 2022 and CMS PFS 2022 Final Rule

<sup>3</sup> Source: CMS 2022 OPPS Final Rule @ www.cms.gov

<sup>4</sup> Source: CMS 2022 ASC Final Rule @ www.cms.gov

Hospital and Facility Coding

HCPCS Code	Code Description	Notes
C1713	<p><b>Anchor/screw for opposing bone-to-bone or soft tissue to bone (implantable)</b></p> <p><i>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. This category also applies to synthetic bone substitutes that may be used to fill bony void or gaps (i.e., bone substitute implanted into a bony defect created from trauma or surgery.)</i></p> <p><i>(List of Pass Through Payment Device Category Codes – Updated July 2020)</i>  <a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Compleat-list-DeviceCats-OPPS.pdf">https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Compleat-list-DeviceCats-OPPS.pdf</a></p>	<p>For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (e.g. hospital, ASC, office). These costs are absorbed by the facility via the appropriate reimbursement mechanism (e.g. MS-DRG, APC, etc.)</p> <hr/> <p>For non-Medicare (e.g. Commercial) patients, depending on contractual terms and general stipulations of the payer, direct invoicing may be allowed. Contact the patient's insurance company or the facility's payer contract for further information.</p>

For more information about the primary procedure, please speak with your admitting surgeon. You may also call Arthrex's Coding Helpline at 1-844-604-6359 or e-mail us at [arthrex@cmcpilot.com](mailto:arthrex@cmcpilot.com).

This content is not intended to instruct medical providers on how to use or bill for healthcare 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 healthcare procedures.

The information provided in this handout 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 this information. It does not constitute legal advice and no warranty regarding completeness or accuracy is implied. The essential components which determine appropriate payment for a procedure or a product are site of service/coding/coverage/payment system/geographical location/national and local medical review policies and/or payer edits.

