# 2021 Coding and Reimbursement Guidelines for the Syndesmosis TightRope® Implant System

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the Syndesmosis TightRope implant 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 Arthrex TightRope syndesmosis device is intended as an adjunct in fracture repair involving metaphyseal and periarticular small bone fragments where screws are not indicated, and as an adjunct in external and intramedullary fixation systems involving plates and rods, with fracture braces and casting. Specifically, the Arthrex TightRope syndesmosis device is intended to provide fixation during the healing process following a syndesmotic trauma, such as fixation of syndesmosis (syndesmosis disruptions) in connection with Weber B and C ankle fractures. (K043248, February 16, 2005)

## Value Analysis Significance:
The Syndesmosis TightRope implant system, comprised of 2 metallic buttons and #5 UHMWPE, is intended to provide physiologic syndesmosis fixation during the healing process following a syndesmotic injury. The Syndesmosis TightRope fixation system mimics the natural micro-motion of the fibula and prevents the need for a second surgery to remove a rigid syndesmotic screw.

## 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 primary open and/or arthroscopic procedure determined by the surgeon may include:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Code Description</th>
<th>Physician Facility Setting (HOPD and ASC)</th>
<th>Hospital Outpatient APC &amp; APC Description</th>
<th>ASC APC &amp; APC Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27829</td>
<td>Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed</td>
<td>$732.01</td>
<td>N/A</td>
<td>$2,944.24</td>
</tr>
<tr>
<td>29898</td>
<td>Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive</td>
<td>$575.39</td>
<td>N/A</td>
<td>$1,335.09</td>
</tr>
</tbody>
</table>

1 CPT is the 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.

2 Source: AMA CPT 2021 and CMS PFS 2021 Final Rule

3 Source: CMS 2021 OPPS Final Rule @ www.cms.gov

4 Source: CMS 2021 ASC Final Rule @ www.cms.gov
# Hospital and Facility Coding

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Code Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1713</td>
<td>Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)</td>
<td>For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (eg, hospital, ASC, office). These costs are absorbed by the facility via the appropriate reimbursement mechanism (eg, MS-DRG, APC, etc.)</td>
</tr>
</tbody>
</table>

- 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 (ie, bone substitute implanted into a bony defect created from trauma or surgery.)

(List of Pass Through Payment Device Category Codes – Updated July 2020)
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Complete-list-DeviceCats-OPPS.pdf

For non-Medicare (eg, 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.

For more information about the primary procedure, please speak with your admitting surgeon. You may also call Arthrex’s Reimbursement Helpline at 1-877-734-6289 or e-mail us at arthrex@mcra.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.

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