2021 Coding and Reimbursement Guidelines for the Arthrex Biceps Implant Systems

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the Arthrex Biceps 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 biceps tenodesis implant systems are intended to be used for fixation of suture (soft tissue) to bone in the shoulder and elbow. Procedures include, but are not limited to: biceps tendon reattachment, biceps tenodesis, and ulnar or radial collateral ligament reconstruction. (K151230, June 19, 2015) (K191426, November 26, 2019) (K071176, May 31, 2007) (K123341, December 21, 2015)

Value Analysis Significance

The Arthrex family of biceps tenodesis implant systems provides various implants and techniques to tenodese the proximal biceps tendon (high in the groove, suprapectoral, subpectoral) or to tenodese the distal biceps tendon. The tenodesis family consists of tenodesis screws, SwiveLock® anchors, cortical buttons, and FiberTak® anchors, and can be used alone or combined for inlay or onlay tenodesis techniques.

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 or arthroscopic procedure determined by the surgeon may include:

2021 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[2]		Hospital Outpatient[3]		ASC[4]
		Medicare National Average				
CPT®[1] Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC & APC Description	Medicare National Average	Medicare National Average
Open						
Biceps						
23430	Tenodesis of long tendon of biceps	$767.30	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$6,264.95	$2,944.24
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft	$800.10	N/A	5114 - Level 4 MSK Procedures	$6,264.95	$2,944.24
Arthroscopy						
Biceps						
29822	Arthroscopy, shoulder, surgical; debridement, limited	$559.34	N/A	5113 - Level 3 Musculoskeletal (MSK) Procedures	$2,830.40	$1,335.09
29823	Arthroscopy, shoulder, surgical; debridement, extensive	$611.68	N/A	5113 - Level 3 MSK Procedures	$2,830.40	$1,335.09
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	$944.56	N/A	5114 - Level 4 MSK Procedures	$6,264.95	$2,944.24

[1] 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.
[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		
HCPCS Code	**Code Description**	**Notes**
C1713	**Anchor/screw for opposing bone-to-bone or soft tissue to bone (implantable)** *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/Complet-list-DeviceCats-OPPS.pdf)*	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). 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 Coding Helpline at 1-844-604-6359 or e-mail us at arthrex@cmcopilot.com.

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 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.

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