Syndesmosis TightRope® Implant System

2024 Coding and Reimbursement Guidelines

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 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).

Value Analysis Significance

The Syndesmosis TightRope implant system, comprised of 2 metallic buttons and #5 ultra-high-molecular-weight polyethylene (UHMWPE) suture, is intended to provide physiologic syndesmosis fixation during the healing process following a syndesmotic injury. The Syndesmosis TightRope fixation system mimics the natural micromotion 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:

2024 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		**Physician**[b,e] **Medicare National Average**		**Hospital Outpatient**[c]		**ASC**[d]
CPT®[a] Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC and APC Description	Medicare National Average	Medicare National Average
Ankle Joint - Fracture and/or Dislocation (Open)						
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	$715.02	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	$6823.42	$4551.97
Ankle Joint - Arthroscopic						
29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive	$564.56	N/A	5113 - Level 3 MSK Procedures	$3087.24	$1518.96

[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 2024 and CMS PFS 2024 Final Rule

[c] CMS 2024 OPPS Final Rule @ www.cms.gov

[d] CMS 2024 ASC Final Rule @ www.cms.gov

[e] CMS Conversion Factor (CF) effective March 9, 2024: $33.2875

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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.	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).
L8699	**Prosthetic implant, no otherwise specified** This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	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 refer to the facility's payer contract for more information.
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 arthrexRSP@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.

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