

# Foot/Ankle *Internal/Brace*™ Ligament Augmentation System

2024 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the *Internal/Brace* ligament augmentation 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

SwiveLock® anchors are intended for fixation of suture (soft tissue) to bone in the foot/ankle in the following procedures: lateral stabilization, medial stabilization, Achilles tendon repair, hallux valgus reconstruction, midfoot reconstruction, metatarsal ligament repair/tendon repair, and bunionectomy (K151342).

## Value Analysis Significance

*Internal/Brace* ligament augmentation is a minimally invasive procedure that allows surgeons to approximate injured soft tissue back to bone, supporting the primary repair during the healing process. The procedure is designed to help speed up the recovery process and allow for accelerated rehabilitation,<sup>1,2</sup> acting as a “seat belt” by securing ligaments to bone and helping limit excess range of motion during the healing phase. Additionally, the *Internal/Brace* procedure with Broström provides a stronger repair than a Broström procedure alone.<sup>3</sup>

## 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 arthroscopic procedure determined by the surgeon may include:

2024 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician <sup>b,e</sup>		Hospital Outpatient <sup>c</sup>		ASC <sup>d</sup>
		Medicare National Average				
CPT <sup>®a</sup> Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Non-Facility Setting (Office)	APC and APC Description	Medicare National Average	Medicare National Average
<b>Leg (Tibia and Fibula) and Ankle Joint</b>						
<b>27690</b>	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	\$643.78	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	\$6823.42	\$3393.01
<b>27691</b>	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	\$749.63	N/A	5114 - Level 4 MSK Procedures	\$6823.42	\$3393.01
<b>27692</b>	Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon (list separately in addition to code for primary procedure)	\$100.86	N/A	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
<b>27695</b>	Repair, primary, disrupted ligament, ankle; collateral	\$492.32	N/A	5114 - Level 4 MSK Procedures	\$6823.42	\$4,441.28
<b>27696</b>	Repair, primary, disrupted ligament, ankle; both collateral ligaments	\$552.91	N/A	5114 - Level 4 MSK Procedures	\$6823.42	\$4,853.30
<b>27698</b>	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	\$642.78	N/A	5114 - Level 4 MSK Procedures	\$6823.42	\$4,332.30



# Foot/Ankle *Internal/Brace*™ Ligament Augmentation System

2024 Coding and Reimbursement Guidelines

Foot and Toes						
<b>28200</b>	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	\$329.88	\$493.99	5113 - Level 3 MSK Procedures	\$3087.24	\$1518.96
<b>28313</b>	Reconstruction, angular deformity of toe, soft-tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	\$365.50	\$528.94	5113 - Level 3 MSK Procedures	\$3087.24	\$1518.96

<sup>a</sup> 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.

<sup>b</sup> AMA CPT 2024 and CMS PFS 2024 Final Rule

<sup>c</sup> CMS 2024 OPPS Final Rule @ [www.cms.gov](http://www.cms.gov)

<sup>d</sup> CMS 2024 ASC Final Rule @ [www.cms.gov](http://www.cms.gov)

<sup>e</sup> CMS Conversion Factor (CF) effective March 9, 2024: \$33.2875

HCPCS Code	Code Description	Notes
<b>C1713</b>	<b>Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)</b> 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).	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).
<b>L8699</b>	<b>Prosthetic implant, no otherwise specified</b> 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 the facility's payer contract for further information.
<b>A4649</b>	<b>Surgical supplies; miscellaneous</b> 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](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](mailto:arthrexRSP@arthrex.com).

The *Internal/Brace* surgical technique is intended only to augment the primary repair/reconstruction by expanding the area of tissue approximation during the healing period and is not intended as a replacement for the native ligament. The *Internal/Brace* technique is for use during soft tissue-to-bone fixation procedures and is not cleared for bone-to-bone fixation. 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.

## References

- Coetzee JC, Ellington JK, Ronan JA, Stone RM. Functional results of open Broström ankle ligament repair augmented with a suture tape. *Foot Ankle Int.* 2018;39(3):304-310. doi:10.1177/1071100717742363
- Kulwin R, Watson TS, Rigby R, Coetzee JC, Vora A. Traditional modified Broström vs suture tape ligament augmentation. *Foot Ankle Int.* 2021;42(5):554-561. doi:10.1177/1071100720976071
- Viens NA, Wijdicks CA, Campbell KJ, Laprade RF, Clanton TO. Anterior talofibular ligament ruptures, part 1: biomechanical comparison of augmented Broström repair techniques with the intact anterior talofibular ligament. *Am J Sports Med.* 2014;42(2):405-411. doi:10.1177/0363546513510141

