FiberTak® Anchors

2024 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions regarding arthroscopic procedures completed with the products in this guide, the following information is shared for educational and strategic planning purposes only. It is the sole responsibility of the treating health care professional to diagnose and treat the patient, and to and confirm coverage, coding, and claim submission guidance with the patient's health insurance plan to ensure claims are accurate, complete, and supported by documentation in the patient's medical record. Any determination regarding if and how to seek reimbursement should be made only by the appropriate members of the staff, in consultation with the physician, and in consideration of the procedure performed or therapy provided to a specific patient. Arthrex does not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy and legislation are subject to continual change.

FDA Regulatory Clearance

FiberTak anchor is intended to be used for suture fixation of soft tissue to bone in the shoulder. Procedures include, but are not limited to: rotator cuff repair, Bankart repair, SLAP lesion repair, biceps tenodesis, acromioclavicular separation repair, deltoid repair, capsular shift, or capsulolabral reconstruction (K200341, K151230, K130458).

Value Analysis Significance

The family of FiberTak suture anchors was designed for maximum bone fixation using a soft-bodied anchor and sutures for knotless and knotted soft-tissue fixation. These implants are available in multiple sizes and suture configurations.

Physician's Professional Fee

The arthroscopic procedure determined by the surgeon may include:

2024 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		**Physician**[b,e]		**Hospital Outpatient**[c]		**ASC**[d]
		Medicare National Average				
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
Decompression						
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	$827.53	N/A	Level 4 Musculoskeletal (MSK) Procedures	$6823.42	$3393.01
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	$860.15	N/A	5114 - Level 4 MSK Procedures	$6823.42	$3393.01
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	$982.98	N/A	5114 - Level 4 MSK Procedures	$6823.42	$3393.01
23430	Tenodesis of long tendon of biceps	$753.30	N/A	5114 - Level 4 MSK Procedures	$6823.42	$4441.00
23455	Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)	$991.97	N/A	5114 - Level 4 MSK Procedures	$6823.42	$3393.01
29806	Arthroscopy, shoulder, surgical, capsulorrhaphy	$1065.87	N/A	5114 - Level 4 MSK Procedures	$6823.42	$3393.01
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion	$1040.90	N/A	5114 - Level 4 MSK Procedures	$6823.42	$3393.01
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	$1073.85	N/A	5114 - Level 4 MSK Procedures	$6823.42	$3393.01

[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)** 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).
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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