

Lapidus Bunion Correction

2025 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 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.

Value Analysis Significance

Arthrex implants used for 1st TMT fusion include the following: Plantar Lapidus Plate (K111253), Low-Profile Lapidus Plate (K150456), DynaNite® nitinol staples (K203180, K172052), SuperMX™ nitinol staples (K203180, K172052), DynaNite compression plates (K193345), Compression FT screws (K201132), headless compression screws (K132217), Snap-Off Compression FT pins (K201132), QuickFix cannulated screws (K143614).

Value Analysis Significance

Arthrex has developed multiple implants for 1st TMT fusion (screws, plates, staples, etc) that can be used in isolation or in conjunction with one another to create a stable fusion, while minimizing the shortening of the 1st ray. These systems were designed for both open and minimally invasive techniques. Procedure-specific instrumentation serves to correct the deformity and ensure proper alignment of the associated anatomy.

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 procedure(s) determined by the surgeon may include:

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician ^{b,c}		Hospital Outpatient ^d		ASC ^e
		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
28297	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	\$589.68	\$976.22	5115 – Level 5 Musculoskeletal (MSK) Procedures	\$12,866.82	\$9819.90

^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 Source: AMA CPT 2025 and CMS PFS 2025 Final Rule

^c CMS Conversion Factor (CF) effective January 1, 2025: \$32.3465

^d CMS 2025 OPPS Final Rule @ www.cms.gov

^e CMS 2025 ASC Final Rule @ www.cms.gov



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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).	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, not 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.

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.

