

To help answer common coding and reimbursement questions about arthroscopic procedures completed with Corkscrew FT anchors, 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

Corkscrew FT anchors are intended to be used for suture fixation of soft tissue to bone in the shoulder. Procedures include, but are not limited to: rotator cuff repairs, Bankart repair, SLAP lesion repair, biceps tenodesis, acromioclavicular separation repair, deltoid repair, capsular shift, or capsulolabral reconstruction (K193157, K173788, K143745, K082810, K061863, K043337).

Value Analysis Significance

The family of Corkscrew suture anchors was designed for maximum bone and knotted or knotless soft-tissue fixation. These implants are available in a variety of materials, including titanium, PLLA, PEEK, and biocomposite. The anchors are available double- or triple-loaded with FiberWire® suture or SutureTape to provide the best possible combination for superior repair strength.

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 endoscopic/arthroscopic procedure 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
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
Shoulder						
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	\$810.93	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	\$7143.73	\$3510.84
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	\$842.63	N/A	5114 - Level 4 MSK Procedures	\$7143.73	\$3510.84
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	\$964.25	N/A	5114 - Level 4 MSK Procedures	\$7143.73	\$3510.84
23430	Tenodesis of long tendon of biceps	\$737.18	N/A	5114 - Level 4 MSK Procedures	\$7143.73	\$4603.45
29806	Arthroscopy, shoulder, surgical, capsulorrhaphy	\$1042.20	N/A	5114 - Level 4 MSK Procedures	\$7143.73	\$3510.84
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion	\$1017.94	N/A	5114 - Level 4 MSK Procedures	\$7143.73	\$3510.84
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	\$1050.29	N/A	5114 - Level 4 MSK Procedures	\$7143.73	\$3510.84

Corkscrew® FT Anchors

2025 Coding and Reimbursement Guidelines

^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 2025 and CMS PFS 2025 Final Rule

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

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

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

HCCPS 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 HCCPS 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 HCCPS 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 AskMarketAccess@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.

