

Achilles Soft-Tissue Implants

2025 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the Achilles soft-tissue implants, 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

Arthrex has developed multiple systems for both insertional and ruptured Achilles pathologies. These systems were designed to incorporate minimally invasive techniques and use innovative, cutting-edge technology for fixation with a variety of suture options. The development improves stability such that immediate postoperative weight-bearing and range of motion are possible.

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:

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
Leg (Tibia and Fibula) and Ankle Joint						
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	\$652.11	N/A	5114 - Level 4 Musculoskeletal (MSK) Procedures	\$7143.73	\$3510.84
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	\$657.28	N/A	5114 - Level 4 MSK Procedures	\$7143.73	\$4628.28
27654	Repair, secondary, Achilles tendon, with or without graft	\$709.36	N/A	5114 - Level 4 MSK Procedures	\$7143.73	\$4440.78

^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 OPPS Final Rule @ www.cms.gov

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



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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 voids 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).
C1762	Connective tissue, human These tissues include a natural, cellular collagen or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue.	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.
L8699	Prosthetic implant, not otherwise specified This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	
A4649	Surgical supply, 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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