TenJet™

HydroCision™

2025 US Coding Reimbursement Guide

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Disclaimer

The codes and payment rates provided in this guide represent procedures that may be performed by physicians using TenJet per its intended use as a resection device. Please contact the patient's insurer for direct guidance on coding and payment, as polices and contracts vary.

This is general reimbursement information to provide general guidance only and is not legal advice nor is it advice about how to code, complete, or submit any particular claim for payment. Information provided is not intended to increase or maximize reimbursement by any payer. This information has been gathered from third party sources and was accurate at the time of publication and subject to change without notice. When considering CPT coding for any procedure it is important to assess the procedural steps, rather than the tool used to treat the patient. It is the provider's responsibility to exercise independent clinical judgement to determine appropriate codes, charges, and modifiers, that accurately reflect the patient's conditions and services provided.

Third-party payer policies and coding requirements vary and are updated and change over time. Providers should check and verify current policies and requirements with the payer for any particular patient.

The information provided here is for informational purposes only and represents no statement, promise, or guarantee by HydroCision concerning levels of reimbursement, payment or charges. HydroCision disclaims all responsibility related to provider coding and billing.

Indications for Use

The HydroCision TenJet Device is indicated for orthopedic surgical procedures where the cutting, debridement and removal of soft and hard tissue is required in a variety of open, arthroscopic, and minimally invasive surgical procedures, including the treatment of tendinopathy through partial or full thickness tenotomy.

Procedure Technique

The protocol when using the TenJet device to perform an ultrasound image-guided procedure involves using ultrasound to identify and confirm areas of pathologic tendon/fascia tissue prior to the procedure. The entire area is prepped to create a sterile surgical field. Using ultrasound image guidance, a local anesthetic is administered to create a skin wheel

and down to the pathologic tissue. Local anesthetic may also be used to perform hydro-dissection and separate the tendon from adjacent soft tissue if the tendon is tethered due to scarring. Depending on physician and patient preference, general anesthesia could be used during the procedure.

Once adequate anesthesia is confirmed, an incision is made and the scalpel is directed to the diseased tendon tissue through the tendon sheath. The scalpel is removed and the TenJet device is advanced through the incision under ultrasound guidance. The system is activated, and under continuous ultrasound guidance, the physician uses the device to resect and remove intra-tendinous diseased tissue and/or calcifications along the length and width of the tendon until satisfactory changes are observed on ultrasound imaging. If necessary, the physician may use the device to remove scar tissue surrounding the tendon. At the end of the procedure, the device is removed and the incision is closed.

When using the TenJet device during open or arthroscopic procedures, the physician will observe standard established protocols for preparing the sterile field and accessing the diseased tissue. After guiding the needle tip of the TenJet device to the diseased tissue under direct or arthroscopic visualization, the physician will activate the system to resect and remove diseased tissue until satisfactory changes are visually observed. Standard wound closure techniques will be followed.

Procedures using the TenJet device are generally performed in a procedure room at a hospital outpatient facility or ambulatory surgery center.

General Reimbursement Overview

Coding Overview

Codes allow healthcare providers to communicate with insurance companies to facilitate the reimbursement process and explain why the patient needed treatment, what services were provided, and where services were rendered. Coding guidelines, rules around allowed charges, allowed codes and coding combinations may differ by insurer and are updated regularly to reflect the addition and deletion of applicable codes.

Individual payers may also have guidelines and specific contracted terms with the facility or a physician practice about the use of unlisted codes. Generally, for unlisted CPT codes payers may require physicians to provide estimated charges based on estimated RVUs (Relative Value Units) for physician payment. In these situations, physicians may choose to reference CPT codes that reflect similar work and effort. Use of modifiers, like modifier 52 reduced services, may also require physicians to estimate RVUs in similar manners to unlisted codes.

Coding System	Description/Purpose
International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes	Numeric and alpha-numeric codes used to report diagnosis
Current Procedural Terminology (CPT®)[1] Codes (Level I HCPCS Codes)	Numeric coding system used to report medical services and procedures provided by healthcare professionals.

Payment System Overview

Provider Type	Relevant Payment System
Hospital Outpatient Department	Hospital outpatient departments (HOPDs) are reimbursed under the Hospital Outpatient Prospective Payment System (HOPPS). Procedures are assigned to Ambulatory Payment Classification (APC) groups and each APC has an established payment rate.
Ambulatory Surgical Center (ASC)	Ambulatory surgical centers (ASCs) are reimbursed under the ASC Payment System.
Physicians (facility and non-facility)	Physicians are reimbursed under the Medicare Physician Fee Schedule (MPFS). Payments vary based on where the physician's services (i.e. the procedure) was performed (e.g. office or facility).

Ambulatory Surgery Center (ASC) Coding and Medicare Average Payment Rates

CPT® Code	Description	Subject to Multiple Procedure Discounting	Payment Indicator	CY 2025 Payment Rate
Shoulder				
23000	Removal of subdeltoid calcareous deposits, open	Y	A2	$1,201.90
23405	Tenotomy, shoulder area, single tendon	Y	A2	$3,510.84
23406	multiple tendons through same incision	Y	A2	$3,510.84
23929[2]	Unlisted procedure, shoulder	NA	NA	NA
Elbow				
24332	Tenolysis, triceps	Y	G2	$1,579.16
24357	Tenotomy, elbow, lateral or medial (eg. epicondylitis, tennis elbow, golfer's elbow) percutaneous	Y	G2	$1,579.16
24358	debridement, soft tissue and/or bone, open	Y	G2	$1,579.16
24359	debridement, soft tissue and/or bone, open with tendon epair or reattachment	Y	G2	$1,579.16
24999[2]	Unlisted procedure, humerus or elbow	NA	NA	NA
Hip				
27000	Tenotomy, adductor of hip, percutaneous (separate procedure)	Y	A2	$838.29
27001	Tenotomy, adductor of hip, open (separate procedure)	Y	A2	$1,579.16
27006	Tenotomy, adductors and/or extensor(s) of hip, open (separate procedure)	Y	G2	$1,579.16
27062	Excision; trochanteric bursa or calcification	Y	A2	$1,579.16
27306	Tenotomy, percutaneous, adductor or hamstring, single tendon (separate procedure)	Y	A2	$1,579.16
27307	multiple tendons	Y	A2	$1,579.16
27299[2]	Unlisted procedure, pelvis or hip joint	NA	NA	NA
Leg, Foot & Ankle				
27605	Tenotomy, percutaneous, Achilles tendon (separate procedure, local anesthesia)	Y	A2	$838.29
27606	general anesthesia	Y	A2	$1,579.16
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	Y	A2	$1,579.16
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision[s])	Y	A2	$1,579.16
28008	Fasciotomy, foot and/or toe	Y	A2	$1,579.16
28060	Fasciectomy, plantar fascia, partial (separate procedure)	Y	A2	$1,579.16
28062	radical (separate procedure)	Y	A2	$1,579.16
28220	Tenolysis, flexor, foot; single tendon	Y	P3	$267.18
28222	Tenolysis, flexor, foot; multiple tendons	Y	A2	$1,579.16
28225	Tenolysis, extensor, foot; single tendon	Y	A2	$1,579.16
28226	Tenolysis, extensor, foot; multiple tendons	Y	A2	$1,579.16
27899[2]	Unlisted procedure, leg or ankle	NA	NA	NA
28899[2]	Unlisted procedure, foot or toes	NA	NA	NA
Injection and Imaging				
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	Y	P3	$29.11
20551	Injection(s); single tendon origin/insertion	Y	P3	$29.11
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	Y	P3	$33.64

[2] Not payable in the ASC setting by Medicare. May be eligible for payment under non-Medicare health plans.

Hospital Outpatient Department Coding and Medicare Average Payment Rates

CPT® Code	Description	APC	APC Descriptor	Payment Status Indicator	CY 2025 Medicare National Average Payment
Shoulder					
23000	Removal of subdeltoid calcareous deposits, open	5073	Level 3 Excision/Biopsy/Incision and Drainage	J1	$2,862.05
23405	Tenotomy, shoulder area; single tendon	5114	Level 4 Musculoskeletal Procedures	J1	$7,143.73
23406	multiple tendons through same incision	5114	Level 4 Musculoskeletal Procedures	J1	$7,143.73
23929	Unlisted procedure, shoulder	5111	Level 1 Musculoskeletal Procedures	T	$239.88
Elbow					
24332	Tenolysis, triceps	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
24357	Tenotomy, elbow, lateral or medial (eg. epicondylitis, tennis elbow, golfer's elbow) percutaneous	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
24358	debridement, soft tissue and/or bone, open	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
24359	debridement, soft tissue and/or bone, open with tendon repair or reattachment	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
24999	Unlisted procedure, humerus or elbow	5111	Level 1 Musculoskeletal Procedures	T	$239.88
Hip					
27000	Tenotomy, adductor of hip, percutaneous (separate procedure)	5112	Level 2 Musculoskeletal Procedures	J1	$1,600.41
27001	Tenotomy, adductor of hip, open (separate procedure)	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
27006	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
27062	Excision; trochanteric bursa or calcification	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
27306	Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure)	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
27307	multiple tendons	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
27299	Unlisted procedure, pelvis or hip joint	5111	Level 1 Musculoskeletal Procedures	T	$239.88
Leg, Foot & Ankle					
27605	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia	5112	Level 2 Musculoskeletal Procedures	J1	$1,600.41
27606	general anesthesia	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision[s])	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
28008	Fasciotomy, foot and/or toe	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
28060	Fasciectomy, plantar fascia; partial (separate procedure)	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
28062	radical (separate procedure)	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
28220	Tenolysis, flexor, foot; single tendon	5112	Level 2 Musculoskeletal Procedures	J1	$1,600.41
28222	Tenolysis, flexor, foot; multiple tendons	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
28225	Tenolysis, extensor, foot; single tendon	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
28226	Tenolysis, extensor, foot; multiple tendons	5113	Level 3 Musculoskeletal Procedures	J1	$3,244.61
27899	Unlisted procedure, leg or ankle	5111	Level 1 Musculoskeletal Procedures	T	$239.88
28899	Unlisted procedure, foot or toes	5111	Level 1 Musculoskeletal Procedures	T	$239.88
Injection and Imaging					
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	5441	Level 1 Nerve Injections	T	$295.19
20551	Injection(s); single tendon origin/insertion	5441	Level 1 Nerve Injections	T	$295.19
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	5441	Level 1 Nerve Injections	T	$295.19

76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	5523	Level 3 Imaging without Contrast	S	$241.72
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	NA	NA	N	NA
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	NA	NA	N	NA
76881	Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation	5522	Level 2 Imaging without Contrast	S	$106.34

Physician Coding and Medicare Average Payment Rates:

CPT® Code	Short Description	Global Period	Work RVUs	CY 2025 Total RVUs and Payment Rate (Non-Facility)		CY 2025 Total RVUs and Payment Rate (Facility)	
Shoulder							
23000	Removal of subdeltoid calcareous deposits, open	090	4.48	16.72	$540.83	11.03	$356.78
23405*	Tenotomy, shoulder area; single tendon	090	8.54	18.81	$608.44	18.81	$608.44
23406*	multiple tendons through same incision	090	11.01	22.51	$728.12	22.51	$728.12
23929	Unlisted procedure, shoulder	YYY	NA	Carrier Priced	NA	Carrier Priced	NA
Elbow							
24332	Tenolysis, triceps	090	7.91	19.03	$616.57	19.03	$615.55
24357*	Tenotomy, elbow, lateral or medial (eg. epicondylitis, tennis elbow, golfer's elbow) percutaneous	090	5.44	12.74	$412.09	12.74	$412.09
24358*	debridement, soft tissue and/or bone, open	090	6.66	16.42	$531.13	16.42	$531.13
24359*	debridement, soft tissue and/or bone, open with tendon repair or reattachment	090	8.98	20.41	$660.19	20.41	$660.19
24999	Unlisted procedure, humerus or elbow	YYY	NA	Carrier Priced	NA	Carrier Priced	NA
Hip							
27000*	Tenotomy, adductor of hip, percutaneous (separate procedure)	090	5.74	11.92	$385.57	11.92	$385.57
27001*	Tenotomy, adductor of hip, open (separate procedure)	090	7.14	16.57	$535.98	16.57	$535.98
27006*	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)	090	10.11	21.84	$706.45	21.84	$706.45
27062	Excision; trochanteric bursa or calcification	090	5.75	13.98	$452.20	13.98	$452.20
27306*	Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure)	090	4.74	10.58	$342.23	10.58	$342.23
27307*	multiple tendons	090	6.06	12.62	$408.21	12.62	$408.21
27299	Unlisted procedure, pelvis or hip joint	YYY	NA	Carrier Priced	NA	Carrier Priced	NA
Leg, Foot & Ankle							
27605	Tenotomy, percutaneous, Achilles tendon (separate procedure: local anesthesia	010	2.92	9.79	$316.67	5.57	$180.17
27606	general anesthesia	010	4.18	8.26	$267.18	8.26	$267.18
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	090	5.88	13.00	$420.50	13.00	$420.50

27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision[s])	090	7.05	15.61	$504.93	15.61	$504.93
28008	Fasciotomy foot and/or toe	090	4.59	12.8	$414.04	9.00	$291.12
28060	Fasciectomy, plantar fascia; partial (separate procedure)	090	5.40	15.47	$500.40	10.99	$355.49
28062	radical (separate procedure)	090	6.69	17.51	$566.39	12.45	$402.71
28220	Tenolysis, flexor, foot; single tendon	090	4.67	13.40	$433.44	9.31	$301.15
28222	Tenolysis, flexor, foot; multiple tendons	090	5.76	16.07	$519.81	11.28	$364.87
28225	Tenolysis, extensor, foot; single tendon	090	3.78	12.37	$400.13	8.13	$262.98
28226	Tenolysis, extensor, foot; multiple tendons	090	4.67	18.55	$600.03	12.34	$399.16
27899	Unlisted procedure, leg or ankle	YYY	NA	Carrier Priced	NA	Carrier Priced	NA
28899	Unlisted procedure, foot or toes	YYY	NA	Carrier Priced	NA	Carrier Priced	NA
Injection and Imaging							
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	000	0.75	1.75	$56.61	1.17	$37.85
20551	Injection(s); single tendon origin/insertion	000	0.75	1.73	$55.96	1.15	$37.20
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	000	0.79	1.96	$63.40	1.36	$43.99
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	XXX	0.30	1.29	$41.73	1.29	$41.73
76000- TC			0.00	0.84	$27.17	0.84	$27.17
76000- 26			0.30	0.45	$14.56	0.45	$14.56
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	XXX	0.54	3.41	$110.30	3.41	$110.30
77002- TC			0.00	2.62	$84.75	2.62	$84.75
77002- 26			0.54	0.79	$25.55	0.79	$25.55
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	XXX	0.67	1.77	$57.25	1.77	$57.25
76942- TC			0.00	0.87	$28.14	0.87	$28.14
76942- 26			0.67	0.90	$29.11	0.90	$29.11
76881	Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation	XXX	0.90	1.60	$51.75	1.60	$51.75
76881 - TC			0.00	0.32	$10.35	0.32	$10.35
76881 - 26			0.90	1.28	$41.40	1.28	$41.40

* CPT codes with an asterisk are listed on the Medicare Physician Fee Schedule as being rarely or never used in the non-facility setting. Other payer policies may vary.

Definitions

Subject to multiple procedure discounting

Multiple surgical procedures performed in the same operative session subject to the multiple procedure reduction. The highest paying surgical procedure on the claim is paid at 100%. Other surgical procedures subject to the multiple procedure discount are paid at 50%. Modifier 51 and Modifier 59 are the appropriate modifiers to use for reporting multiple procedures in the same operative session.

Modifier TC
Technical component

Modifier 22
Increased Procedural Services

Modifier 26
Professional component

Modifier 50
Bilateral Procedures

Modifier 52
Reduced Procedural Services
Modifiers like 52 and 22 should be appended to specific CPT codes and not generic, unlisted codes and can be helpful in authorization and approval situations when appropriately used.

Payment Indicator
In the ASC payment system, each code is assigned a payment indicator to identify payment rules.

Payment Indicator; A2
Surgical procedure on ASC List in CY 2007; payment based on OPPS relative payment weight

Payment Indicator; P3
Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on MPFS non-facility PE RVUs.

Payment Indicator; G2
Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight

Payment Status Indicator: J1
Hospital Part B Services Paid through a Comprehensive APC

Payment Status Indicator: T
Significant Procedure, Multiple Reduction Applies

Payment Status Indicator: N
Items and Services Packaged into APC Rates

Sources:
American Medical Association. CPT Professional 2024.
2025 CMS PFS Final Rule, CMS 1807--F, Addendum B, RVUA25A (January 10, 2024) (available on CMS website).
2025 CMS OPPS/ASC Final Rule, CMS 1809-FC, Addendum B (December 27, 2024) (available on CMS website).
2025CMS OPPS/ASC Final Rule, CMS 1809-FC, Addendum AA (December 27, 2024) (available on CMS website).

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