Coping arthroscopic knee procedures

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Although coding arthroscopic knee procedures should be pretty straightforward, confusion persists around coding and reimbursement for chondroplasty and removal of loose or foreign bodies. This tends to result from a lack of understanding of the Current Procedural Terminology (CPT) coding rules and payer reimbursement rules.

Chondroplasty, loose/foreign body coding basics

According to CPT, code 29877 (Arthroscopy, knee, surgical; debridement/shaving of articular cartilage [chondroplasty]) should be reported to indicate the performance of an arthroscopic chondroplasty in the medial, lateral, and/or patello-femoral compartment(s). This code may only be reported one time per surgical session and may only be reported if the chondroplasty is performed in a separate compartment from the primary surgical procedure.

Modifier 59, the distinct procedural service modifier, should be appended to indicate to the payer that the chondroplasty was performed in a separate compartment. CPT code 29877 should be used with all private payors, unless the payor has issued written instructions related to the reporting of this code.

As shown in Code X (Fig.1), code 29874 (Arthroscopy, knee, surgical; for removal of loose body or foreign body [eg, osteochondritis dissecans fragmentation, chondral fragmentation]) may be reported in addition to other arthroscopic knee procedures, including arthroscopic chondroplasty and arthroscopic microfracture, if either of the following requirements are met:

• The arthroscopic loose/foreign body was greater than 5 mm
• The loose/foreign body was removed through a separate incision or portal (not through the inflow or outflow portal).

If arthroscopic removal of loose/foreign bodies was the only procedure performed, the size or separate incision guidelines do not apply.

Medicare coding

There is no issue with reporting CPT code 29877 to Medicare if the only procedure performed is a chondroplasty, regardless of the number of involved compartments (ie, CPT rules apply). Likewise, reporting CPT code 29874 to Medicare if the only procedure is the arthroscopic removal of loose/foreign body is also not problematic.

However, when either code 29877 or 29874 is reported in addition to another arthroscopic knee procedure, Medicare payment rules are different from CPT rules and can be confusing.

Medicare has created a separate HCPCS “G” code, G0289 (Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage [chondroplasty] at the time of other surgical knee arthroscopy in a different compartment of the same knee). When billing Medicare, a physician has to use HCPCS code G0289 to report arthroscopic removal of loose or foreign bodies and/or arthroscopic chondroplasty in a separate compartment of the knee.

Figure 2 shows the Medicare Correct Coding Initiative (CCI) edits for certain CPT codes under CPT code 29881 (Arthroscopy, knee, surgical; with meniscectomy [medial OR lateral, including any meniscal shaving]). Both code 29877 and 29874 have a “0” modifier, indicating these procedures are inclusive to CPT code 29881 and may not be overridden with a modifier. Although Medicare shows the “0” modifier, it also provides written instructions in the General Policy Section of the Musculoskeletal Section of the CCI edits. Because Medicare does not include HCPCS code G0289 in the list of codes that may be reported in addition to CPT code 29881, some confusion may result.

The CPT Assistant (April 2003) gave the following instructions regarding HCPCS code G0289:

“...This add-on code should be reported in addition to the knee arthroscopy code for the major procedure being performed. Code G0289 is only reported once per extra compartment, even if chondroplasty, loose body removal, and foreign body removal are all performed. The code may be reported twice (or with a unit of two) if the physician performs these procedures in two compartments, in addition to the compartment where the main procedure was performed.”

This means that CPT code 29877 should be reported to private payors when other arthroscopic knee procedures are performed and HCPCS code G0289 should be reported to Medicare when other arthroscopic procedures are performed. If the private payor denies CPT code 29877 and refers you to the CCI edits, you should appeal, using supportive documentation from CPT and the AAOS. If the private payor continues to deny the service, appeal using the Medicare information showing the bundled edits and the instructional paragraphs.

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