Arthroscopy Coding for Major Joint
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An accurate understanding of coding rules increases likelihood of receiving appropriate payment. Correctly reporting and billing for arthroscopy services is often confusing.

Arthroscopic shoulder procedures

The traditional coding rule about the shoulder is to consider the joint as one compartment. Due to continuous efforts by orthopaedic societies, a two-compartment (intra- and extra-articular) viewpoint is gaining acceptance. As a result, a few coding rules have changed. Intra-articular structures include the labrum, the long head of the biceps, a Bankart lesion, and the humeral and glenoid articular surfaces. Extra-articular structures include the rotator cuff (RC), the distal clavicle, and the subacromial space.

In 2017, the Centers for Medicare & Medicaid Services (CMS) made a significant change to the extensive debridement code (29823). There are now three situations in which this code can be billed if the extensive debridement portion of the procedure is performed in a separate area of the shoulder joint. This is similar to coding for the knee, which also has distinct anatomic compartments. The applicable codes are:

- 29824 – arthroscopic distal clavicle resection
- 29827 – arthroscopic RC repair
- 29828 – biceps tenodesis

Remember, that the limited debridement code (29822) is included with the other, more extensive arthroscopic procedure codes. These changes only pertain to the extensive debridement code.

The rules for coding loose body removal in the shoulder (29819) are slightly different. To use that code, the loose body must be larger than 5 mm. When that occurs, coding 29827 (arthroscopic rotator cuff repair) with 29819-59 is permissible.

Additionally, arthroscopic repair of a superior labral anterior posterior (SLAP) lesion (29807) may also be billed with the loose body code (29819-59). Synovectomy codes in both the shoulder and the knee are governed by the same guidance. Code 29820 (synovectomy, partial) is inclusive to more extensive procedures. Code 29821 (synovectomy, complete) should only be used when the underlying diagnosis is pathologic synovium such as is found in

rheumatoid arthritis or pigmented villonodular synovitis. Cleaning up the "whole" joint due to reactive synovitis is inclusive of the more extensive codes.
The operative report should clearly define what was specifically done during the surgery and provide the medical necessity for the procedure. When an arthroscopic subacromial decompression is performed at the same time that extensive débridement is performed, such as shaving the undersurface of the distal clavicle and débriding chondral surfaces, the primary code is 29823 (extensive débridement) and the secondary code is the acromioplasty (29826). Acromioplasty is an add-on code and can never be the primary code. As an add-on code, it does not require either modifier 51 or 59.

Coding for SLAP lesions can be confusing without a clear understanding of the anatomy of the lesion. SLAP tears involve the origin of the long head of the biceps and the labrum, and come in the following four types:

- Type I—labral fraying with firmly attached labrum and biceps origin
- Type II—labrum and biceps origin are detached from the labrum
- Type III—bucket-handle labral tear with firmly attached labrum and biceps origin
- Type IV—bucket-handle tear of superior labrum with extension into the biceps tendon with biceps displacement

Types I and III are similar, with firmly attached labrum and biceps origin. In Types II and IV, the labrum attachment has been disrupted. Code Types II and IV using 29807 to indicate repair of the lesions. Detail the anchor or suture repair in the operative note. Code Types I and III using 29822. Code 29823 should only be used if more extensive debridement is performed during the operation.

Finally, capsulorrhaphy. Code 29806 covers both anterior and posterior capsulorrhaphy. If a repair is done both anteriorly and posteriorly, it would be coded as 29806-22. The modifier 22 signifies more work than usual. Coding for mild debridement within the shoulder joint performed at the same time as the capsulorrhaphy is inappropriate, because the master code includes limited debridement. Only code for debridement if the debridement is extensive (29823).

Arthroscopic hip procedures

Advanced arthroscopy procedures are relatively new in the hip, and the "Seven Golden Rules for Reducing Hip Arthroscopy Denials," in the December 2016 issue of AAOS Now addressed many issues, including the following topics.

Coding rules for the removal of loose bodies are similar in both the hip and the shoulder. Code 29861 is used if the loose body is > 5 mm. If the procedure is performed with another procedure, append modifier 59 to ensure payment. The rules for 29863, hip synovectomy, have not changed. Use this code only when a pathologic diagnosis for the synovium exists.

The codes covering hip arthroscopy continue to expand. However, several procedures still do not have codes. These include lesser trochantericplasty, and repair of the gluteus minimus and the gluteus medius (when the tear existed prior to surgery and is not due to access). These procedures should be submitted with the unlisted code, 29999. The unlisted code should not be used for bursal excisions of either the psoas or trochanteric bursa.

Most arthroscopic hip surgery is performed to treat cam and pincer lesions. Use code 29914 (femoroplasty) to address a cam lesion, and 29915 (acetabuloplasty) to address the pincer lesion. Report code 29916 for arthroscopic labral repair. However, if you report 29916, you should not report 29915 because the acetabuloplasty is included in the global service description. If history is any indicator, arthroscopy technologies and procedures will continue to develop faster than the American Medical Association's Current Procedural Terminology can develop and publish codes for them.

If you maintain an accurate understanding of current coding rules and requirements to submit appropriate codes and modifiers, your practice will receive appropriate payment.