Part B Insider (Multispecialty) Coding Alert

ORTHOPEDIC: Make Sure You're Up To Speed On How To Report 29873

Bad news: Expect less payment than what you're used to

As of July 5, 2005, Medicare implemented special coding rules for multiple-endoscopic- procedures when you bill the procedure with another endoscopy in the same family. Here's a reminder about the change and why you may be surprised by your payment.

Remember: The "arthroscopic base code" column in the Fee Schedule determines if your arthroscopies fall under one of the base codes. "If they do, then you have to follow the multiple-endoscopy rule," advises **Angela Daniels, RN,** office manager for **Thomas Daniels, MD**, in Seattle.

Old way: In the past, if you reported 29873 (Arthroscopy, knee, surgical; with lateral release) with another arthroscopic knee procedure, such as 29880 (...with meniscectomy [medical AND lateral, including any meniscal shaving]), Medicare payors applied the "multiple procedure rule" to the lower-valued procedure. Medicare paid the first procedure at the full RVU allowable rate, but discounted the procedure by 50 percent.

New way: Now, if you report 29873 with any other code in the 29870-29887 group, you will encounter Medicare's multiple-endoscopic procedure rule, not the multiple procedure rule. Using the old payment rules, you would have collected the full $797 for 29883, and about $248 for 29873 (50 percent of the $496 allotted for 29873). Under the new rules, you'll lose more than $140 if you report 29873 with other codes in the 29870 base family.

Rule of thumb: "For multiple endoscopic procedures, use the full value of the highest valued endoscopy plus the difference between the highest and the base endoscopy," instructs the Medicare Carriers Manual. Explanation: The knee family's base code (29870) carries 10.81 RVUs, so if you **bill 29873** with 29883 (Arthroscopy, knee, surgical...), your Medicare carrier will reimburse you using the full RVU allocation for 29883 (22.04 RVUs or about $797.00).

The numbers: The payor will then pay you just 2.91 RVUs for 29873. The insurer calculates this figure by subtracting 29870's 10.81 RVUs from 29873's 13.72 RVUs. Medicare carriers then multiply the RVUs by 36.177, which is the conversion factor listed in the 2006 Fee Schedule, to come up with the procedure's value: about $105.