Codify BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Strategies To Master The 'Multiple Scope' Rule

Here's what you should do when there's no base procedure

If your physician performs several knee arthroscopes on the same patient on the same day, you-ll need to understand the multiple-scope rule to determine which procedures you can actually claim--and get paid for.

Important exception: Keep in mind that the multiple-scope rule applies mainly to shoulder and knee procedures in the orthopedic practice, for example, but it also affects those of the elbow, wrist and hip. On the other hand, it does not apply to ankle or metacarpophalangeal (MCP) arthroscopy, and it doesn't affect arthroscopically aided procedures (29851, 29855-29856, 29888-29889 and 29892). In addition, some surgical knee arthroscopies are excluded from the family-- specifically, 29866-29868.

Follow these expert-approved tips to clinch your coding every time.

1. Look To CPT for Scope -Families-

Before worrying about how to apply the multiple scope rule, you must know why and when it applies.

The multiple-endoscopy rule is Medicare's method to avoid paying twice (or more) for -inclusive- services by reimbursing only a portion of any scope performed at the same time as another scope of the same basic type, says **Tara L. Conklin**, a coding analyst for **CodeRyte** in Bethesda, MD.

Here's how the rule works: CPT divides groups of similar codes into so-called -families.- The first code (the base or -parent- code) describes the basic procedure. Following the base code, CPT lists any variants that -go beyond- (are more extensive than) the base code, says **Marvel J. Hammer**, owner of **MJH Consulting**, a healthcare reimbursement consulting firm in Denver.

For example, consider this partial code family:

- 29805--Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)

- 29806--Arthroscopy, shoulder, surgical; capsulorrhaphy

- 29807--- repair of SLAP lesion

- 29819--- with removal of loose body or foreign body.

In this case, 29806, 29807 and 29819 describe more extensive procedures than the family's base code, 29805, which they are listed under in CPT. In other words, 29806, 29807 and 29819 include all the work involved in 29805, plus something more.

The multiple-scope rule applies only if two or more endoscopies the physician performs are members of the same code family, Conklin says. If the physician performs 29806 and 29807 during the same operative session, for instance, the multiple-scope rule applies. But if she performs a shoulder arthroscopy 29807 and a scope from a different code family, such as knee arthroscopy (for example, 29870, Arthroscopy, knee, diagnostic, with or without synovial biopsy [separate procedure]), you need not worry about the multiple-scope rule.

CPT® 2023 American Medical Association. All rights reserved.

In addition, you should not use modifier 51 (Multiple procedures) when the multiple-scope rule applies.

2. Always Include The -Base- Procedure

Let's assume that the physician has performed a diagnostic shoulder arthroscopy (29805) plus shoulder arthroscopy for repair of SLAP lesion (29807). How does the multiple-scope rule apply?

Remember: Follow-up codes always include the work involved in the base code, and a surgical scope always includes the diagnostic scope of the same type, Conklin says. Therefore, you would report only 29807 in this case.

What about diagnostic shoulder arthroscopy followed by arthroscopic limited debridement? Once again, you should report only the more extensive procedure--in this case, 29822 (Arthroscopy, shoulder, surgical; debridement, limited).

3. No Base Procedure? Bill Both Scopes

If the physician performs two scopes in the same family, neither of which is the base procedure, you should report both codes. Therefore, if your physician performs shoulder arthroscopy with foreign-body removal (29819) followed by shoulder arthroscopy for complete synovectomy, you would submit both 29819 and 29821 (- synovectomy, complete).

Watch for CCI bundles: In some cases, the Correct Coding Initiative (CCI) will impose additional bundles on arthroscopic procedures that fall outside the multiple-scope rule. As just one example, arthroscopic shoulder debridements (29822 and 29823) bundle arthroscopic foreign-body removal (29819) and partial synovectomy (29820) in the same shoulder.

As a second example, CCI bundles many arthroscopic knee procedures, including removal of foreign body (29874), limited synovectomy (29875), debridement (29877) and lysis of adhesions (29884), into surgical knee arthroscopy with lateral release (29873).

Best bet: Before you submit a multiple-arthroscopy claim, check it against CCI edits to be sure you haven't overcoded.

4. Watch Your Reimbursement

Under the multiple-scope rule, Medicare will pay the entire fee schedule amount only for the highest-valued scope in a given code family during the same operative session. Medicare carriers will reimburse any additional scopes in the same family by subtracting the value of the base scope in that family and paying the difference.

The oil-change analogy: If this seems confusing, look at it another way. You take your car for service at the local dealer and see a sign:

- Package 1: Oil change--$15
- Package 2: Oil change and tire rotation--$25
- Package 3: Oil change and replace wiper blades--$30

You order Package 3 and ask to have the tires rotated in addition. But you would not want to pay a full $25 for Package 2 in addition to the $30 for Package 3. Why pay for the oil change twice?

Rather, you would expect to pay the $30 for Package 3 plus the difference between the cost of an oil change alone and the cost of an oil change with tire rotation, for a total of $40 ($30 for oil change and new wipers + [$25 for oil change and tire rotation - $15 for the cost of the -extra- oil change] = $40).

The situation works the same way when payors determine reimbursement for endoscopies. Because every endoscope in a given code family includes the -base- procedure, why pay for that portion of each procedure more than once?

For example: The physician performs knee arthroscopy with lateral release (29873) followed by arthroscopic medial and lateral meniscectomy (29880).

CPT® 2023 American Medical Association. All rights reserved.

Medicare and other payors that follow Medicare guidelines will reimburse the full value of the more extensive procedure (in this case, 29880 with 9.30 work relative value units, based on the 2007 National Medicare Physician Fee Schedule Relative Value File), plus the value of the second scope minus the value of the base procedure (29873 has 6.09 work RVUs, from which you must subtract the 5.11 work RVUs allotted for the family -base- code, 29870: 6.09 - 5.11 = 0.98 RVUs). Total payment for both scopes in this case would equal 10.28 RVUs (9.30 + 0.98).

Check private payors: -Although Medicare uses this rule to lessen the value of subsequent codes, it does not then lower their value by 50 percent or 25 percent as private payors do,- says **Bill Mallon,** orthopedic surgeon and medical director at **Triangle Orthopaedic Associates** in Durham, NC. Some private payors use a different system in which they reduce the second procedure by 50 percent and third and subsequent procedures to 25 percent of the accepted fee, he adds.

CPT® 2023 American Medical Association. All rights reserved.