Codify by AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Knee: Kick Your Knee Surgery Payment Into Gear With These Expert Tips

Hint: Precertification does not address coverage issues.

Knee surgery remains one of the top procedures for orthopedic surgeons, but coders can find it difficult to navigate the codes for new procedures and for combination surgeries. If you could use a quick knee coding primer, we've got just the information you need.

You Can Report ACL Repair With Meniscectomy

Patients who suffer complex sports injuries often present with a combination of problems. Your surgeon might repair not just the medial or lateral meniscus but also ligament injuries. The good news is that you can usually report both procedures.

For example: Suppose your surgeon repairs a torn anterior cruciate ligament (ACL) and a torn medial meniscus on a Medicare patient. He also performs chondroplasty on the lateral femoral condyle.

Problem solved: You can report all three surgeries, as follows:

- 29888 (Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction) for the ACL repair.
- 29882-51 (Arthroscopy, knee, surgical; with meniscus repair [medial OR lateral]; Multiple procedures) for the medial meniscus repair.
- 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) for the lateral chondroplasty.

Note: Depending on your payer, if this procedure was for a non-Medicare patient, you could report 29877-59 (Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty); Distinct procedural service) instead of G0289.

Because the Correct Coding Initiative (CCI) does not bundle these codes together, you do not need to append modifier 59 (Distinct procedural service) to any of them.

Buckle Down on ACI Specifics

Here is a quick lesson on ACI coding (27412, Autologous chondrocyte implantation, knee).

Patients are usually referred for autologous chondrocyte transplantation if they remain symptomatic after already having surgery for an articular cartilage problem. Once the patient/surgeon decides this is the best option, an arthroscopic biopsy will be performed (29870, Arthroscopy, knee, diagnostic, with or without synovial biopsy [separate procedure]).

Note: Some payers prefer HCPCS code S2112 (Arthroscopy, knee, surgical for harvesting of cartilage [chondrocyte cells]) when the surgeon harvests the cells. Ask your insurer which code you should report.

The surgeon performs the arthroscopy with a biopsy to harvest normal cartilage from a low-load-bearing area within the

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knee. The chondrocytes are sent to a lab to be isolated from the cartilage matrix then cultured for three to four weeks. Once the viable cells are returned in suspension, they are now ready for surgical implantation. The surgeon then performs a knee arthrotomy with any necessary debridement, and harvests a periosteal flap, usually along the medial aspect of the tibial ridge, using a template drawn from the defect. The surgeon sutures the graft into place and injects a gel-like medium containing the cultured chondrocytes into the area. Then the surgeon may perform a water test to ensure no fluid is escaping. The wound will then be lavaged and closed in layers.

How many codes? You should report only 27412 when the physician is implanting chondrocytes. Don't be tempted to report 20926 (Tissue grafts, other [e.g., paratenon, fat, dermis]). You shouldn't report that, because the graft was harvested during a previous procedure.

Payers Differ on 29866 Reimbursement

You also have 29866 (Arthroscopy, knee, surgical; osteochondral autograft[s] [e.g., mosaicplasty] [includes harvesting of the autograft]) and 29867 (Arthroscopy, knee, surgical; osteochondral allograft [e.g., mosaicplasty]), as options.

What the procedure involves: This surgery is similar to the ACI discussed above, but it requires only one surgical visit to complete the procedure. During the osteochondral autograft, the surgeon takes one or several cylindrical osteocartilaginous grafts from peripheral and non-weight-bearing areas of the knee (donor site) and transfers them to the prepared damaged area (recipient site), usually under arthroscopic visualization.

Surgeons may use different techniques to perform the procedure, and each technique bears a different manufacturer's name. Surgeons most commonly refer to osteocartilaginous transfers using one these instrumentation brands: OATS (Arthrex), COR Systems (DePuy), and Mosaicplasty (Smith and Nephew). Reimbursement can be sketchy for 29866 and 29867 claims. Although CMS assigned 31.18 relative value units (RVUs) to 29866, you are not guaranteed payment for this service by your Medicare carriers.

Watch out: Because some payers still deem this procedure investigational, you need to confirm whether or not the payer covers the service prior to scheduling the surgery. Precertification only establishes medical necessity; it does not address coverage policy issues.

When faced with a denial for billing 29866 to repair a small focal chondral defect of articulating cartilage, you can appeal and receive payment by submitting records, op notes, scope pictures, etc. It helps to have a very thorough surgeon who details everything. Read the policy, verify that you have documentation to support the medical necessity, and submit for appeal if you did not get preauthorization for the procedure prior.

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