Part B Insider (Multispecialty) Coding Alert

Reader Question: Chondroplasties Are Inclusive to Meniscectomies

Question: What percentage of the meniscus must the surgeon remove before we should bill the meniscectomy code instead of the chondroplasty code? Also, our orthopedic surgeon performed a medial meniscectomy with lateral and patellar chondroplasties on a Medicare patient. Which codes should we report?

Answer: Let's address your first question. The orthopedic surgeon does not need to document any particular percentage of meniscus removal to report the meniscectomy codes. The meniscectomy is a completely different procedure from chondroplasty.

Op note hint: If the surgeon documents that he cleaned out a meniscal tear with an arthroscopic shaver, he performed a meniscectomy (29880-29881). If he documents that he cleaned out articular cartilage with the shaver, he instead probably performed chondroplasty. Even though the meniscus is considered "cartilage," it is not the same type of cartilage as articular cartilage that is present at the end of bones. Anytime the physician removes meniscal tissue, you should consider it a meniscectomy.

As for your second question, chondroplasty is now inclusive to meniscectomy, due to a change in the CPT® descriptors of 29880 (Arthroscopy, knee, surgical; with meniscectomy [medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty], same or separate compartment(s), when performed) and 29981 (...with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed). In this scenario, you should only report 29981.

Why: The surgeon performed meniscectomy in the medial compartment and performed the chondroplasty in the lateral and patellofemoral compartments.