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Outpatient Facility Coding Alert

Scopes: Become an Expert in Coding Multiple Scopes

Have you mastered the art of applying the multiple scope rule yet?

The basics: When your orthopedic surgeon performs a knee arthroscopy along with several other procedures, you'll need to know which procedures to actually claim and how to prioritize them. Read on to master the specifics of this rule.

Get the Basics Right

What it means: With the help of the multiple-endoscopy rule, Medicare aims to save on costs, by reimbursing only a part of the arthroscopy procedure the provider performs simultaneously as another scope of the same basic type.

In other words, under the multiple-scope rule, Medicare will pay only for the highest-valued scope in a given code family during the same operative session.

You may apply the multiple-scope rule to:

- Knee and shoulder procedures.
- Procedures of the elbow, wrist and hip.

The multiple-scope rule doesn't apply to:

- Ankle or metacarpophalangeal (MCP) arthroscopy.
- Arthroscopically aided procedures such as 29855-29856 (Arthroscopically aided treatment of tibial fracture...), 29888-29889 (Arthroscopically aided posterior cruciate ligament repair).
- Some surgical knee arthroscopies. For example procedures described by codes: 29866-29868 (Arthroscopy, knee, surgical...) are specifically excluded from the family.

Here's how the rule works: CPT® segregates groups of similar looking codes into "families." The first CPT® code in the series, i.e. the base or "parent" code describes the primary procedure. Succeeding the base code, CPT® lists further codes that represent more extensive work over and above the base code. For example, here is apartial code family:

- 29806 (Arthroscopy, shoulder, surgical; capsulorrhaphy)
- 29807 (... repair of SLAP lesion)
- 29819 (... with removal of loose body or foreign body)

In this case, 29807 and 29819 signify more detailed procedures than the family's base code, 29806, under which they are listed in CPT®. In other words, 29807 and 29819 include all the work involved in 29806, plus something more, clarifies **Sarah Goodman, MBA, CHCAF, CPC-H, CCP, FCS**, president of the consulting firm SLG, Inc., in Raleigh, N.C.

Rule #1: Check whether codes are from the same CPT® family

Apply the multiple-scope rule only when the multiple arthroscopic procedures your surgeon performs belong to the same code family. For example, you may apply the rule if the surgeon performs 29806 and 29807 within a single operative session. However, in case he carries out a shoulder arthroscopy 29807 and an arthroscopy procedure from another code family, say knee arthroscopy 29870, (Arthroscopy, knee, diagnostic, with or without synovialbiopsy [separate procedure]), you may not apply the multiple-scope rule.

In addition, remember not to use modifier 51 (Multiple procedures) when you apply the multiple scope rule.

Rule #2: Surgical procedure supersedes the 'Diagnostic' Procedure

Suppose the provider performs a diagnostic shoulder scope 29805 (Arthroscopy, shoulder, diagnostic, with or without synovial biopsy [separate procedure]) as well as a shoulder arthroscopy to repair SLAP lesion (29807). Can you apply the multiple-scope rule here?

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

If the provider performed diagnostic shoulder arthroscopy along with an arthroscopic limited debridement, you would report only the more extensive procedure 29822 (Arthroscopy, shoulder, surgical; debridement, limited).

Rule #3: No base procedure? Bill both scopes.

What if the surgeon performs two scopes in the same family, yet neither of them is the base procedure? In this case, you should report both codes. Let's assume the provider performs shoulder arthroscopy with foreign-body removal (29819) and a scope for complete synovectomy, you should report both 29819 and 29821 (... synovectomy, complete).

Watch for CCI bundles: In some cases, the National 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 loose or 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.

"Refer to the NCCI Manual Chapter 4, especially Section E, #4; which reads '... With the exception of the knee joint, arthroscopic debridement should not be reported separately with a surgical arthroscopy procedure when performed on the same joint at the same patient encounter...,'" says **Joanne Schade-Boyce, MS, BSDH, CPC, ACS,** AHIMA Approved ICD-10-CM/PCS Trainer and Ambassador, with FairCode Associates, LLC, Marco Island, FL. "In some cases, the debridement codes will not evoke an edit, but that doesn't release the coder from understanding the aforementioned guideline the NCCI Manual."

Rule #4: CMS will pay for the base code, plus the difference for numerous codes.

Medicare pays for the highest-valued arthroscopy procedure in a code family from all the procedures during a single operative session. As for the additional scopes from the same scope family, Medicare carriers will pay the difference after subtracting the value of the basic scope.From that of the additional scope.

Case Scenario: The surgeon performs knee arthroscopy with lateral release-29873 (Arthroscopy, knee, surgical; with lateral release) followed by arthroscopic medial and lateral meniscectomy-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).

In this case you can expect to receive full value of the more extensive procedure (29880 with 7.39 work relative value units, based on the 2016 National Medicare Physician Fee Schedule Relative Value File), plus the value of the second scope minus the value of the base procedure (29873 has 6.24 work RVUs, from which you must subtract the 5.19 work RVUs allotted for the family "base" code, 29870: 6.24-5.19 = 1.05 RVUs). Total payment for both scopes in this case would equal 8.44 RVUs (7.39 +1.05).

Check with the private payers: Most private payers use a different system in which they reduce the second procedure by 50 percent and the third and some subsequent procedures to 25 percentof the accepted fee. Multiple subsequent procedures are often not reimbursed by private payers.

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