

Help text from CPT, background information on each area of CPT, and references to other sections containing pertinent coding information

All CPT codes with long descriptions, including deleted codes for current year

MAG Mutual Healthcare Solutions' 2005 Physicians Fee & Coding Guide

ENDOSCOPY/ARTHROSCOPY

(Surgical endoscopy/arthroscopy ~~also~~ includes a diagnostic endoscopy/arthroscopy) (When arthroscopy is performed in conjunction with arthroscopy, add modifier -51)

29800 Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)

29804 Arthroscopy, temporomandibular joint, surgical (For open procedure, use 21010)

29805 Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure) (For open procedure, see 23065-23066, 23100-23101)

29806 Arthroscopy, shoulder, surgical, capsulorraphy (For open procedure, see 23450-23460) (To report thermal capsulorraphy, use 29999)

29807 repair of slip lesions (29815 has been deleted. To report, use 29805)

29819 Arthroscopy, shoulder, surgical, with removal of loose body or foreign body (For open procedure, see 23040-23044, 23107)

29820 synovectomy, partial (For open proc, see 23105)

29821 synovectomy, complete (For open procedure, see specific open arthroscopy procedure performed)

29822 debridement, limited (For open procedure, see specific open arthroscopy procedure performed)

The rule in the left indicator is not appropriate in most procedures related to the temporomandibular joint, including 29800, 29804, are considered by many managed care organizations to be "potentially OVERUTILIZED procedures."

Policies developed for Medicare's National Covered Coding Initiative include the following statement: "In accordance with the appropriate procedure policy, when an arthroscopic procedure is followed by an open procedure at the same session, only the most comprehensive service performed is billed, generally, this would be the open procedure. If an arthroscopic service is performed at one site and an open procedure is performed at another, the arthroscopic procedure is billed with a modifier indicating that these services were performed at different anatomic sites (e.g., RT or -LT modifier, -50 modifier, etc.)."

Be sure to identify procedures performed arthroscopically vs. open incision or percutaneous surgeries. The codes are usually different.

| RV04 | NAA | \$ FEE RANGE | REL VAL | |
|-------|--------|--------------|----------|-------|
| 14.80 | \$ 513 | \$ 952 | \$ 1,137 | 104.4 |
| 17.39 | 611 | 1,832 | 2,177 | 200.5 |
| 12.50 | 442 | 807 | 1,040 | 97.1 |
| 27.75 | 975 | 2,814 | 256.0 | |
| 27.04 | 950 | 2,229 | 2,711 | 247.0 |
| 15.60 | 548 | 2,096 | 2,491 | 229.3 |
| 14.40 | 508 | 2,127 | 2,523 | 232.4 |
| 15.73 | 553 | 2,413 | 2,865 | 263.9 |
| 15.28 | 537 | 2,150 | 2,545 | 234.7 |

20000 - 29902 Miscellaneous

Fees, Billing Tips and Relative Values ©2003 MAG Mutual Healthcare Solutions, Inc. CPT™ Codes and Descriptions Only, Copyright 2003 American Medical Association (CPT™ 2004)

311

Coding and billing tips for thousands of CPT codes

Medicare's National Average Allowance and total RBRVS values for all CPT codes

MMHSI's Fee Range and MMHSI's Relative Values compiled from all specialties