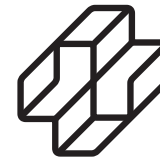


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Coding Procedures Involving the Knee

By Kathy Johnson

Q: A review of denial patterns has shown that we need to review code guidelines for chondroplasty procedures as they relate to different knee compartments. What are key considerations when assigning codes in such cases?

A: Knee compartments are actually three areas or zones where a bone makes contact with another bone. The medial and lateral compartments are formed by the rounded ends of the femur (condyles) where they make contact with the flat top of the tibia bone. The patellofemoral compartment is where the kneecap (patella) makes contact with the femur below.

The challenge comes in understanding when procedures performed in different compartments are reported separately and when they are considered bundled. The questions to answer through review of the case documentation include: Was the chondroplasty the only procedure performed? If another procedure was performed, was the chondroplasty in the same compartment

or another compartment? Is the substantive nature of the chondroplasty evident? Who is the responsible carrier or fiscal intermediary?

When assigning codes, keep in mind these key considerations: In the case of chondroplasty, report code 29877—arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)—once per knee, per case, *regardless of the number of compartments* or areas the physician performed it in. When a provider performs a chondroplasty in the *same* compartment with another arthroscopic procedure, the chondroplasty is considered bundled and should not be billed separately. When provider documentation denotes performing a chondroplasty in a *different* compartment than the repair or excision, assign 29877 and append modifier -59 to indicate the performance of this procedure in a separate compartment. This code may be reported twice (or with a unit of 2) if the provider performs these procedures in two compartments, in addition to the compartment where the main procedure was performed.

If the carrier is Medicare and the chondroplasty is performed in a *separate* compartment from another procedure, report code G0289 rather than code 29877 with modifier -59. Note modifier -59 is not appended to code G0289 because there is no National Correct Coding Initiative (NCCI) edit. Verifying the carrier in each case is important because some non-Medicare carriers also use NCCI edits, and there are often differences in carrier and fiscal intermediary reporting instructions or guidelines. To use code G0289, documentation must denote a *substantive* procedure (i.e., necessary for significant improvement in the patient's condition). The provider may document the amount of time taken for the chondroplasty in the separate compartment as well.

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