



Getting Reimbursed for Shoulder Scopes

Even the most common procedures can challenge the most experienced coders.

Reimbursements for orthopedic surgeries under the Medicare ASC payment system are on the rise. But if you don't accurately report and code these cases, you won't receive the maximum reimbursement. This is particularly true, I've found, of common shoulder cases. Let's review a few of those procedures that, if coded improperly, could mean you're leaving money on the table.



that three of the four muscles/tendons of the rotator cuff should be torn, with further clarification from the AMA stating that CPT 23420 is an extreme tear, typically requiring rearrangement of the normal anatomy with occasional grafting of biological or nonbiological material.

Rotator cuff repair and reconstruction

CPT code series 23410 to 23420 includes acute or chronic conditions within the CPT verbiage. The operative documentation should provide whether the patient has an acute versus chronic condition. If no indication is provided in the clinical documentation, don't assume. If an uncertain coder incorrectly assumes acute, the difference is roughly \$150 in underpayment for a Medicare patient.

While the Medicare reimbursement is the same for CPT codes 23412 and 23420, base your selection on whether the surgeon *repaired* (23412) or *reconstructed* (23420) a chronic tear. AMA guidelines state

The AMA says that code determination is not necessarily based on the number of tendons. Remember, four tendons make up the rotator cuff: supraspinatus (top of humeral head), subscapularis (front of humeral head), infraspinatus (back of humeral head) and teres minor (also back of humeral head).

The American Academy of Orthopaedic Surgeons reiterates that you shouldn't use CPT 23420 simply for a *repair* of a massive tear but for a *reconstruction* of a massive tear with significant retraction that involves extensive releases and mobilization, as well as fascial or synthetic material when applicable, in order to return the tendon to its original anatomical location. In other words, we aren't simply suturing and repairing a tendon via anchors and tacks. In addition, three tendons need not be torn to support reporting CPT 23420.

Use CPT code series 23410 to 23412 to report mini open rotator cuff tear repairs, with code selection determined by acute versus chronic conditions. While CPT provides a parenthetical statement under CPT 29827 (Arthroscopy, shoulder, surgical; with rotator cuff repair) directing the CPT user to report 23412 for mini open rotator cuff repair, you still need to determine the final code selection based on the acute versus chronic condition. Recall that CPT code verbiage in 23410 to 23420 is specific to an acute versus chronic condition.

Mini open rotator cuff tear repairs typically don't involve entry into the shoulder joint while the tear can still be visualized and repaired. When a surgeon performs an arthroscopic rotator cuff repair, report

Rotator Cuff Codes

CPT Code	Procedure	MCR (approx. 2009)
23410	Repair of ruptured musculotendinous cuff open; acute	\$1,264.85
23412	Repair of ruptured musculotendinous cuff open; chronic	\$1,400.39
23420	Reconstruction of complete shoulder rotator cuff avulsion, chronic	\$1,400.39
29827	Arthroscopic surgical shoulder; repair of rotator cuff	\$1,342.79

CPT 29827 regardless of whether the condition is acute versus chronic.

The operative report should specify an acute versus chronic condition. The technique (open versus arthroscopic) will need to be apparent to include a detailed description of a repair versus reconstruction of the specific tendon(s) or cuff.

Distal claviclectomy

Excision of the distal clavicle (approximately 1cm) involving more than a simple shaving of osteophytes at the AC joint is reported separately whether performed open or closed, according to the AAOS.

The operative report must indicate the size of the

distal clavicle excision to justify the separate

reporting of this code. The facility should verify with commercial carriers and fiscal intermediaries since carrier policy may consider less than 1cm to be inclusive to the main procedure being performed.

Arthroscopic labrum repairs

Report CPT 29806 for *surgical* capsular repairs when they're performed arthroscopically. Rather than reporting CPT code 29806 for arthroscopic *thermal* capsulorrhaphy, use the unlisted code 29999 versus S2300 for *arthroscopic thermal capsulorrhaphy*, pending carrier guidelines.

Note that many commercial carriers don't recognize S codes. Here's an opportunity going forward to incorporate S codes and unlisted codes into your facility's new and revised commercial insurance contracts. In addition, your facility will want to review implants and Category III codes in order to separately define or carve out these supplies or procedures.

Simply because a labrum is torn and repaired, it doesn't automatically warrant reporting 29807 if the

Distal Claviclectomy Codes

CPT Code	Procedure
23120	Claviclectomy; partial
29824	Arthroscopy, shoulder, surgical; distal claviclectomy



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torn labrum isn't a SLAP (superior labrum from anterior to posterior) tear. CPT 29807 is specific for a SLAP repair; don't use it for labral tears that aren't

Arthroscopic Labrum Repairs Codes

CPT Code	Procedure
29806	Arthroscopic surgical shoulder; capsulorrhaphy
29807	Arthroscopic surgical shoulder; repair of SLAP Lesion

whether there is a true SLAP tear and also the "type" of SLAP.

Report both 29807 and 29806 per AAOS if the surgeon performs SLAP Type II or Type IV in addition to capsulorrhaphy for a different indication. To simplify, there should be two separate and distinct indications to report the capsular repair and the SLAP tear repair. Verify with commercial carriers as to reporting guidelines for CPT 29807 and 29806 during the same session.

SLAP tears. The surgeon will determine

Medicare edits bundle CPT code 29807 into CPT 29806 at this time, but allows for a modifier if the surgeon performs SLAP separately and distinctly from the capsulorrhaphy. Use caution when considering the application of a modifier. Remember the terms "separate" and "distinct." Simply because you can use a modifier doesn't imply automatic application of a modifier with every scenario.

A coder shouldn't confuse the surgeon's repair of the labrum by attaching it to the capsule as a separately identifiable capsulorrhaphy. The separate reporting of the capsulorrhaphy is indicated when there is a capsular defect unrelated to the labrum tear that in itself also warrants a repair.

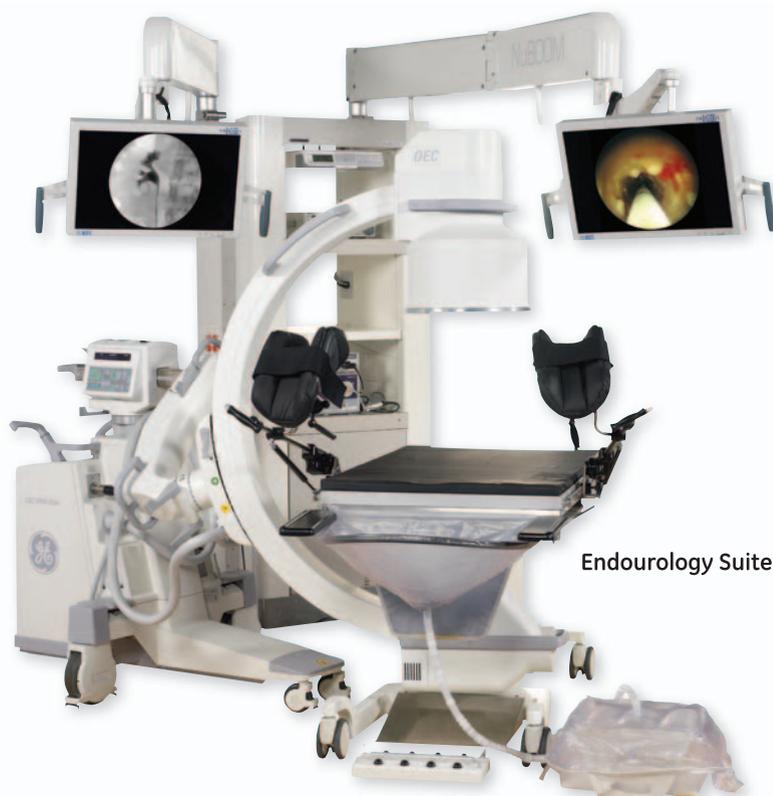
Arthroscopic SLAP debridement is reported from the arthroscopic shoulder debridement codes pending other debridements performed during the operative session. These debridement codes may be considered inclusive into other surgical procedures performed during the same operative session.

The operative report should specify the type of

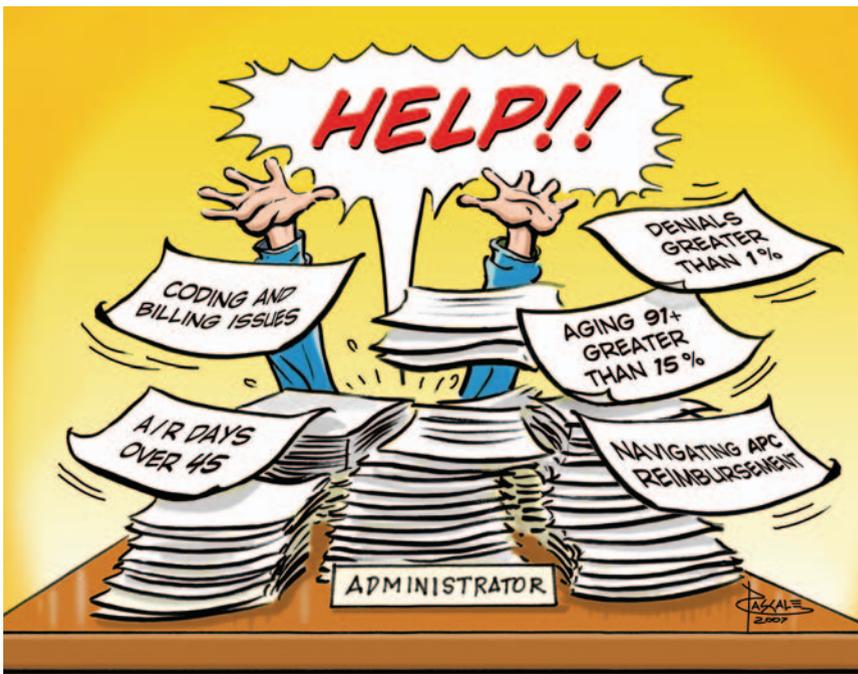
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SLAP (I, II, III, IV, etc.), document the diagnosis for either or both the SLAP and capsulorrhaphy, and describe the procedure(s) in detail.

Shoulder debridement

CPT 29822 covers *limited* debridement of soft or hard tissue. Use it for *limited* labral debridement, cuff debridement or the removal of osteophytes and degenerative cartilage.

Only use CPT 29823 for *extensive* debridement of soft or hard tissue. It includes, for example, an abrasion chondroplasty of the humeral head or glenoid and associated osteophytes, or multiple soft tissue structures that are debrided, such as the labrum, subscapularis and supraspinatus.

Operative documentation should describe all areas, sites, tendons and lesions debrided or excised. A sentence stating, "I performed an extensive debridement" does *not* justify reporting

Shouldering the Coding Load

Coding common shoulder procedures can challenge even the most experienced coder.

- The facility should determine both the fiscal intermediary and carrier reimbursement guidelines and establish a consistent protocol for your coder to follow.
- Your coder must be familiar with the varying coding guidelines, including Medicare edits, American Medical Association guidelines and the American Academy of Orthopaedic Surgeons specialty guidelines.
- Your coder must know the ins and outs of varying carrier contracts. Some commercial contracts reimburse similarly to Medicare, some contracts don't follow Medicare reimbursement — allowing for more aggressive

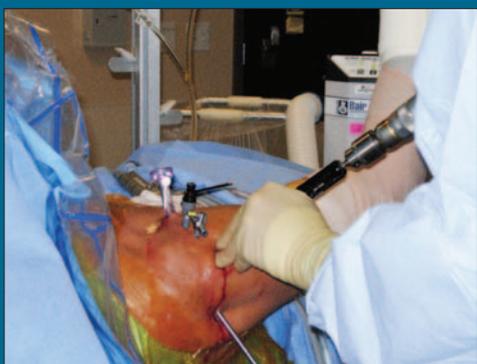
Arthroscopic Debridement Codes

CPT Code	Procedure	MCR (approx. 2009)
29822	Arthroscopy, shoulder limited debridement	\$842.28
29823	Arthroscopy, shoulder extensive debridement	\$1,241.87

CPT code 29823.

What was debrided? How much was debrided? Did the surgeon debride from two or three joint areas/regions? If so, could this debridement stand alone, or was it part of another procedure?

Let's look at an example: The surgeon may debride the rotator cuff in preparation for repairing the rotator cuff via the arthroscope. If this were the only debridement he performed, you'd consider this inclusive to the arthroscopic rotator cuff repair, since he performed the debridement in preparation for the repair. However, if the surgeon thoroughly describes the debride-



coding and reporting — and still others follow the beat of a different drummer.

None of this matters if the documentation in the operative report is lacking in detail. Whether it's underpayments or denials, both the facility and the physician will miss reimbursement opportunities.

— **Cristina Bentin, CCS-P, CPC-H, CMA**

ment of multiple areas/sites, such as the labrum debridement, abrasion arthroplasty, biceps tendon debridement and

partial synovectomy, which are not typically included in a rotator cuff, then you can feel comfortable reporting CPT 29823. **OSM**

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biceps tendon debridement and



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