AANA Position Statement on In-Office Arthroscopy

Diagnostic arthroscopy has been established as the gold standard for accurate identification of pathologies involving shoulder and knee joints. Several members have submitted questions to the Arthroscopy Association of North America (AANA) requesting guidance on proper coding of diagnostic arthroscopic procedures performed in the office setting using small-bore arthroscopic technologies. In response, the AANA Advocacy Committee and Board of Directors performed a thorough examination of the literature, reviewed advisory opinions from the *AMA CPT Advisor*, examined prior precedent from the Federal Registry and RUC and received input from industry stakeholders. Based on this comprehensive review, we believe it is appropriate to report Current Procedural Terminology (CPT®) codes 29805 (*Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)*) and 29870 (*Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)*), when a comprehensive diagnostic procedure is performed in an office setting using small-bore arthroscopic equipment.

Safety and efficacy of in-office arthroscopy

In a multi-center clinical trial examining the efficacy of in-office arthroscopy compared to surgical arthroscopy, Gill et al. examined 110 patients and found office-based technology to be statistically equivalent to surgical arthroscopy when examining for non-ligament pathology (Gill). No complications were reported by patients in their study. Also, several studies have examined the sensitivity and specificity of office-based arthroscopy versus MRI for meniscal pathology, with superior results reported in the arthroscopy group and a lower risk for false negative or false positive treatment complications (Gill, Dines, McMillan).

Additional research has examined the cost effectiveness of in-office arthroscopy versus MRI. In an analysis of cost comparisons between MRI and office-based arthroscopy, Voight et al. calculated direct expenditure and the cost of delayed treatment, of meniscal pathology, using a retrospective care model (Voight). Findings of this study demonstrated significant cost savings and support the use of in-office arthroscopy as a more accurate diagnostic modality (Voight).

Technological rationale for in-office setting

With the advent of needle-based arthroscopic technologies, in-office diagnostic arthroscopy has become a viable option for certain patients. Common sizes for a traditional-ridged arthroscope range from 3.5mm to 2.7mm. The smaller, 2.2mm size of some office-based instrumentation, allows the camera to be inserted through a skin incision made by a small-bore needle. The smaller size of the camera allows the procedure to be performed in an office setting, using local anesthetic. Several technical articles note procedures for setup and portal placement and describe a comprehensive examination of intra-articular joint anatomy (Chabra, Chapman, Deirmengian, West).

Coding rationale for in-office setting

In 2009, the American Academy of Orthopaedic Surgeons (AAOS) recommended that the non-facility fee for the needle arthroscopy in a non-facility setting be valued like a rigid scope done in the OR/facility setting. Prior to 2008, the American Medical Association RVS Update Committee (AMA RUC) recommended that 29870 (*Arthroscopy, knee, diagnostic)* not be valued in the non-facility setting, because they believed it unsafe to perform outside the OR/facility. In the 2008 PFS final rule, the AMA

RUC deferred proposing non-facility inputs for these types of procedures, stating that the physicians performing arthroscopic services in the non-facility setting should be given the opportunity to have a formal review with multi-specialty input. In the Federal Register, Volume 74, No. 226, published November 25, 2009, it is stated as such: *"We have received many inquiries about why CPT® Code 28970 was not valued in the non-facility setting. For CY 2010, in response to a request from Centers for Medicare & Medicaid Services (CMS), the AMA RUC has recommended [Practice Expense] inputs for CPT® 29870."* The response from CMS at that time was, "*We accept the AMA RUC's recommended PE inputs for this procedure and are valuing this code in the non-facility setting."* With this documented statement, the Relative Value Units (RVU)s increased to a 5.19 Work RVU, a (Fully Implemented) Non-Facility PE RVU of 9.05, with 14.96 Total RVUs in the non-facility setting.

These determinations set precedent for greater valuation of the 29870 code in the non-facility setting and AANA supports continuation of standard compensation for office-based diagnostic procedures.

Lay description updates of CPT® Codes 29870 and 29805

In 2018, Optum360º – a national coding resource for the healthcare industry – updated the lay descriptors for codes 29870 (*Arthroscopy, knee, diagnostic, with or without synovial biopsy)* and 29805 (*Arthroscopy, shoulder, diagnostic, with or without synovial biopsy)* to reflect the ability to perform these procedures in the office setting.

The updated lay description for the knee (29870) is as follows:

> "The physician performs a diagnostic arthroscopy of the knee. Portal incisions of 1 cm in length are made on either side of the patellar tendon for arthroscopic access into the knee joint. With the use of the arthroscope and a probe, each compartment of the knee is examined for pathology. This includes examination of the patellar-articular surface, medial and lateral meniscus, cruciate ligaments and joint surfaces. Additional portal incisions may be made to better access some compartments. If there is suspicion of a primary disease of the synovium, a biopsy is performed. A temporary drain may be applied. Incisions are closed with sutures and Steri-strips."

The updated lay description for the shoulder (29805) is as follows:

> "A local or general anesthetic is commonly administered for shoulder arthroscopic procedures. Small percutaneous poke hole incisions are made above the joint and fluid is introduced into the joint space to provide a better view. A band may be placed to restrict blood flow for shoulder arthroscopy. A small incision, or percutaneous access, is made on one side of the joint and the arthroscope is inserted. The inside of the joint may be viewed through the eyepiece or the image can be reproduced on a screen. A cannula may be introduced to take a synovial biopsy. Once the biopsy is completed, the physician irrigates the joint until it is clear of blood and loose particles. A long-acting local anesthetic may be injected into the joint to help with postoperative pain. The joint is irrigated and sutures, a Band-Aid® or Steri-Strip™ may be used to close the incisions. The area is covered with a dressing and a sling or shoulder immobilizer may be applied."

Rationale for submission of code 29805 and 29870 and addition of modifier -52 when performing a limited procedure

In a clinical scenario where an abbreviated or limited arthroscopy is performed (for example visualization of one or two of the three compartments), modifier -52 should be appended. This practice is recommended regardless of the location setting of the procedure. We recommend the surgeon utilize the clinical descriptors as a guideline when considering the completeness of the individual procedure. Based on prior recommendations from the RUC, CMS have established a precedent recommending alternative location codes -24 (ambulatory surgery center), -22 (outpatient hospital) and -11 (in-office) when submitting claims for reimbursement of diagnostic arthroscopy, with the latter allotting for an additional PE payment as appropriate. Mandatory recommendation for modifier -52 (when a procedure is not limited in scope) would be in direct conflict with the prior determination for increased RUV value of the procedure when performed in the office setting. Further, a mandated modifier would penalize patients, and the surgeons who can offer their patients a more accurate and cost-saving technique of office-based arthroscopy. Appending the -52 modifier should be at the discretion of the surgeon and dependent on the nature of the procedure performed.

In summary, based on considerations mentioned above and review of medical literature and case reports, AANA believes that surgeons have demonstrated the ability to perform in-office diagnostic arthroscopy in a manner consistent with the official AMA CPT® Code descriptions and RVU valuation assigned to this office-based procedure.

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