Priority Health	BILLING POLICY No. 125
KNEE ARTHROSCOPY	
Date of origin: Aug. 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Knee arthroscopy is a minimally invasive surgical procedure used to diagnose and treat various knee problems.

MEDICAL POLICY

- Osteoarthritis of the Knee - medical policy 91571
- Computer Assisted Surgical Navigation - medical policy 91641
- Neuroablation for Pain Management - medical policy 91647
- General Coding Billing policy 022

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Reimbursement specifics

- **TurningPoint clinical criteria** – used to review musculoskeletal, spine and cardiac procedures – are available here. Alternatively, you may log into prism and use the **Authorization Criteria Lookup** under the Authorizations menu to access the criteria within TurningPoint's provider portal.

Billing details

According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT.

A separate procedure, by definition, is usually a component of a more complex service and is not identified separately.

A diagnostic arthroscopy (29870 for the knee) is always included in surgical arthroscopies and cannot be billed separately. If a diagnostic arthroscopy leads to a surgical arthroscopy at the same patient encounter, only the surgical arthroscopy may be reported.

Arthroscopic removal of a loose or foreign body may only be reported when the loose/foreign body is at least the size of the diameter of the arthroscopic cannula that is being used for the procedure or larger. When removing the loose/foreign body it must be performed through a cannula larger than the one being used for the actual procedure or a separate incision or a portal that is large enough to allow removal of the loose/foreign body.

CPT codes 29874 (Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation) and 29877 (Arthroscopy, knee, surgical; for debridement/shaving of articular cartilage (chondroplasty)) **shall** not be reported with other knee arthroscopy codes (29866-29889).

With some exceptions, HCPCS code G0289 can be reported in conjunction with other knee arthroscopy codes. For example, HCPCS code G0289 may be reported with CPT codes 29880 and 29881, but only for the removal of a loose body or foreign body from a different compartment of the same knee. HCPCS code G0289 should not be reported if the removal or debridement occurs in the same compartment as another arthroscopic procedure.
Limited synovectomy (CPT code 29875) is integral to CPT codes 29877, 29879, 29880, 29881, 29882, and 29883 and should not be reported separately.

A synovectomy performed to clean up a joint is not separately reportable. Specifically, CPT code 29875 should not be reported with any other arthroscopic procedure on the ipsilateral knee.

CPT code 29876 may be reported for a medically necessary synovectomy if it is performed in two compartments, provided that no other arthroscopic procedure is conducted in those compartments. For example, code 29876 would not be reported alongside CPT code 29880 (Knee arthroscopy, medial AND lateral meniscectomy) on the ipsilateral knee, as procedures other than the synovectomy are performed in two of the knee compartments.

CPT code 29866 or 29867 should not be reported in conjunction with codes 29870, 29871, 29875, or 29884 when performed in the same session. Additionally, codes 29874, 29877, 29879, or 29885–29887 should not be reported together when surgical procedures are conducted within the same compartment.

CPT code 29867 should not be reported with 27570 during the same surgical session or with procedures performed in the same compartment.

Abrasion Arthroplasty (29879)
A shaving or chondroplasty in the same compartment as a meniscectomy (29880 or 29881) is considered part of the global services for the latter procedure. Code 29879 (Abrasion arthroplasty) includes performing a chondroplasty. Therefore, if a provider bills 29879 and it represents a chondroplasty in the same compartment as the meniscectomy, 29879 should not be billed separately.

Coding specifics

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply:

29850 - Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)

29851 - Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)

29866 - Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])

29867 - Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)

29868 - Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral

29870 - Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)

29871 - Arthroscopy, knee, surgical; for infection, lavage and drainage

29873 - Arthroscopy, knee, surgical; with lateral release

29874 - Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)

29875 - Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)

29876 - Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)

29877 - Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)

29879 - Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture

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

29881 - Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

29882 - Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)

29883 - Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)

29884 - Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)

29885 - Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)

29886 - Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion

29887 - Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation

29888 - Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction

29899 - Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction

29891 - Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect

The diagnosis code(s) must best describe the patient's condition for which the service was performed including laterality. Diagnosis codes should be reported to the highest level of specificity.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

The medical record should clearly specify the affected side (right, left, or bilateral) of the body or organ. Specificity in documentation

- Site and Location: Specify the exact location of the procedure within a body part (e.g., medial compartment of the right knee).
- Severity and Status: Describe the severity of any conditions treated and the patient's current status and response to treatment.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Modifier RT – Indicates that the procedure was performed on the right side of the body.

Modifier LT – Indicates that the procedure was performed on the left side of the body.

Report the anatomical modifier that best identifies the anatomical site (i.e., RT, LT, etc.) from the anatomical modifier list.

Modifier 50 – Bilateral procedure; procedures/services that occur on identical, opposing structures

Read the CPT code description closely. If it contains wording such as "unilateral" or "bilateral," the service is not valid for use of the 50 modifier.

When performing a procedure bilaterally during one session and the Medicare Physician Fee Schedule BILAT SURG indicator is 1:

- Report codes with a BILAT SURG indicator of 1 on one line, appending modifier 50 and submitting one unit of service.

Modifier 50 exceptions

Ambulatory Surgical Centers (ASCs) must bill bilateral procedures separately. We'll deny professional claims from ASCs billed with Modifier 50. This edit is based on regulations from Center for Medicare & Medicaid Services and is applied across all lines of business.

How to bill bilateral procedures for ASC to ensure payment

When an ASC performs a bilateral procedure, they should bill as two procedures either as:

- A single unit on two separate lines
- Or with “2” in the units field on one line

Modifier 59 – Distinct Procedure Service

Modifier XE — Separate Encounter: A service that is distinct because it occurred during a separate encounter.

Modifier XS — Separate Structure: A service that is distinct because it was performed on a separate organ/structure.

Modifier XP — Separate Practitioner: A service that is distinct because it was performed by a different practitioner.

Modifier XU — Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap the usual components of the main service.

Modifier 22 – Increased Procedural Service

Modifier 53 – Discontinued procedure

Modifier 58 – Staged or related procedure or service by the same physician during the postoperative period.

Modifier 62 – One surgical procedure requiring two surgeons

Modifier 73 & 74 – Outpatient procedure discontinued

Modifier 77 – Repeat procedure by another physician

Modifier 76 – Repeat Procedure by the same physician

Modifier 78 – Unplanned return to the operating room

Modifiers 80, 81, 82, AS – Assistant at surgery

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient’s medical needs and condition. Authorization may be required. Click here for additional information.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

- Medical necessity criteria | Priority Health
- Policy Search - TurningPoint Provider Portal
- https://priorityhealth.stylelabs.cloud/api/public/content/TurningPoint_Provider_Guide_downloadOriginal?v=11f369ce
- https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=285
- https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual
- https://www.priorityhealth.com/provider/manual/billing/modifiers
- Modifiers 59, XE, XS, XP & XU, separate or distinct services | Priority Health
- MLN1783722 - Proper Use of Modifiers 59, XE, XS, XP & XU

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made