VisionScope® Imaging

Coding & Reimbursement Directional Guidance

Guidance Reminder

The information in this document was compiled using public sources and is intended for the sole purpose of guidance. Each patient case should be considered unique and proper steps should be taken to satisfy individual payer request/requirements. This document, or VisionScope Technologies, makes no guarantees about reimbursement. As with all claims, individual hospitals and physicians are responsible for making appropriate clinical judgments pertaining to code selection (based upon patient procedure and care path). Laws, regulations and coding information are subject to change without notice.

defining VSI

VSI = Diagnostic Arthroscopy

A VSI procedure is classified as a diagnostic arthroscopy. Diagnostic arthroscopies can be performed in the office setting (POS), the Ambulatory Surgical Center (ASC) or as a Hospital Outpatient Procedure (HOPD).

Medicare and many private healthcare plans assign CPT codes (Current Procedural Terminology). Keep in mind, the attachment of a CPT code to any procedure does not guarantee reimbursement. It simply means that it may qualify. So, we suggest you keep detailed documentation in your patient records and strive to meet the reimbursement criteria for any given procedure to ensure payment.

PATIENT RECORD

Don't forget that images captured during a VSI procedure can be downloaded to a flash drive – in a PDF-formatted report – or original media formats (jpg) for archiving in the patient's chart.

Step-wise Approach

It is suggested that all patients be pre-authorized prior to a VSI exam being performed to avoid any claim confusion, delay or denial. As you become more familiar with the requirements of each carrier, you will determine the best practice for your facility and patients. Our training curriculum recommends a conservative, step-wise approach.

1. Identify patient as a VSI candidate during the clinical exam
2. Schedule VSI exam (allow 1-2 weeks)
3. Pre-Authorize Reimbursement with Insurance Carriers
4. Perform VSI exam on qualified patient
5. Submit claim for reimbursement

cptCODES

Joint	CPT Code	Description
Knee	29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
Shoulder	29805	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
Humerus/Elbow	29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
Wrist	29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
Ankle	29897 29999	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical debridement, limited Unlisted Procedure, Arthroscopy
Foot/Toes	29906 29904	Arthroscopy, subtalar joint, surgical; with debridement Arthroscopy, subtalar joint; removal of loose body
Hip	29860	Arthroscopy, hip, diagnostic, with or without synovial biopsy (separate procedure)

cptCODES

Joint	CPT®	Description	*MPFS		**ASC	**HOPPS	
			Facility	Non-Facility		SI	Payment
Knee	29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy(separate procedure)	$ 424.18	$ 592.12	$1,256.16	JI	$2,623.34
Shoulder	29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy(separate procedure)	$ 424.18	$ 592.12	$1,256.16	JI	$2,623.34
Humerus/ Elbow	29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy(separate procedure)	$ 471.39	$ 471.39	$1,256.16	JI	$2,623.34
Wrist	29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy(separate procedure)	$ 466.35	$ 466.35	$1,256.16	JI	$2,623.34
Hip	29860	Arthroscopy, hip, diagnostic, with or without synovial biopsy(separate procedure)	$ 686.18	$ 686.18	$2,742.94	JI	$5,699.59

*MPFS indudes National values based upon 2019 Revisions to Payment Policies under the Physicians Fee Schedule; Addendum B

**HOPPS and ASC National Values are based upon Final Rule with Comment and Final CY2019 Payment Rates. Addendum B and ASC Addenda

icdCODES

Knee

Physician Office Setting (POS)		Ambulatory Surgical Center (ASC) Hospital Outpatient Department (HOPD)	
Code	Description	ICD-10-PCS-	Description
S83.2	Series, Meniscal Tears (current)	0SJC4ZZ	Inspection of Right Knee Joint, Percutaneous Endoscopic Approach
S83.3	Tear, Articular Cartilage Knee (current)	0SJD4ZZ	Inspection of Left Knee Joint, Percutaneous Endoscopic Approach
M23.4	Loose Body in Knee		
M23.30	Other Meniscus Derangements		
M23.6	Series, Spontaneous Disruptions of Knee		

Shoulder

Physician Office Setting (POS)		Ambulatory Surgical Center (ASC) Hospital Outpatient Department (HOPD)	
Code	Description	ICD-10-PCS-	Description
M75.00	Adhesive capsulitis of unspecified shoulder		
M75.01	Adhesive capsulitis of right shoulder		
M75.02	Adhesive capsulitis of left shoulder		
M75.100	Unspecified rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic		
M75.110	Incomplete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic		
M75.120	Complete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic		
S43.01	Anterior dislocation avulsion of joint or ligament		
S43.431	Superior glenoid labrum lesion of right shoulder		
S43.432	Superior glenoid labrum lesion of left shoulder		
M24.019	Loose body in unspecified shoulder		
M24.119	Articular cartilage disorder, unspecified shoulder		

codeMODIFIER

Patient needs a surgical procedure?

If after performing a VSI procedure, it is determined that a surgical procedure is required as part of the treatment path, it is important that both procedures (the VSI and the surgery) are coded and documented.

MODIFIER -58

Modifier -58: Allows for a subsequent procedure.

Definition: Staged or related procedure/service by the same physician during the post-operative period.

Assignment: Attach the modifier to the subsequent surgical procedure NOT the VSI procedure.

90-day global period

A VSI procedure (diagnostic arthroscopy) and all other diagnostic arthroscopic procedures have a 90-day global period. This means that subsequent procedures performed by the **same physician** on the **same joint** may be rejected if the payer is not informed in advance. If the claims are accurately coded and documented, both the VSI diagnostic procedure and the subsequent procedure may be eligible for full reimbursement. **Pre-authorization, in this case, is advised.**

preAUTHORIZE

Overview

Some private insurance carriers require pre-authorization prior to a physician performing a diagnostic exam. VSI – a diagnostic arthroscopy – is considered a diagnostic exam.

The pre-authorization process may vary by carrier. Some may require nothing more than a phone call to verify benefits and obtain an approval number to include in the claim submission documentation. Others may require a more comprehensive substantiation for the necessity of the exam.

To prepare a pre-authorization submission that includes additional information, you may choose to submit a letter that includes technical information about the procedure as well as information about the technology to be used (in this case VisionScope Imaging). You will seek to establish medical necessity for the procedure, for each individual patient.

What should be included in the pre-authorization submission:

- Patient Clinical Notes (include documentation of conservative care)
- Technology description – and utilization in patient case
- Necessity substantiation for the specific procedure, for the specific patient

What might be requested by the insuring party

- Technical Information (FDA clearance letter, peer-reviewed published literature, clinical trial information, other technical resources)

preAUTHORIZE

Pre-Authorization Letter Template

Create a VSI pre-authorization letter template that is fast and easy to personalize. Below is suggested language that you can customize for your practice and individual patient needs.

This document is intended to provide **directional guidance only**. It should be customized by your practice to reflect specific language, needs and considerations. We suggest it be reviewed/approved by the appropriate committee/legal teams of your practice prior to use. Your letter should be printed on practice letterhead.

VisionScope holds no responsibility whatsoever for the use of this document or language. Payer pre-authorization letters – their content, use and accuracy – are the sole responsibility of your medical practice.

Practice Letterhead

Date

Name of Insurance Carrier
Attn:
Fax Number:

PATIENT INFORMATION

Patient Name	Primary CPT Code
Insurance Identification Number	Primary ICD-10 (Dx) Code

Dear [Name]

On behalf of my patient, [PATIENT NAME], I submit this letter as a pre-authorization request as well as a request for coverage by [INSURANCE COMPANY] for the medically necessary health care services referenced above.

[PATIENT NAME] presented to me with [DESCRIBE SPECIFIC SYMPTOMS]. These symptoms are exacerbated by [DESCRIBE ACTVITIES THAT WORSEN THE SYMPTOMS]. [IF APPROPRIATE, DESCRIBE RELEVANT, ADDITIONAL LIMITATIONS IDENTIFIED].

The VisionScope® system enables the physicians in our practice to perform diagnostic arthroscopic imaging procedures in an office exam room, rather than ordering equivocal or inaccurate MRI imaging studies or scheduling a surgical diagnostic arthroscopy.

By combining VisionScope Imaging (VSI) with our standard clinical examination, a definitive diagnosis and optimal treatment plan can be determined during a single visit, eliminating supplemental testing/studies and multiple medical appointments.

In conclusion, please allow for coverage of the VisionScope procedure as it will be beneficial to this patient. If you have any questions or concerns, you can contact me at my office XXX-XXX-XXXX.

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