# NanoScope™ Operative Arthroscopy System

2025 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions about arthroscopic procedures completed with the NanoScope system, the following information is shared for educational and strategic planning purposes only. While Arthrex believes this information to be correct, coding and reimbursement decisions by AMA, CMS, and leading payers are subject to change without notice. As a result, providers are encouraged to speak regularly with their payers.

### FDA Regulatory Clearance

The NanoScope system is intended to be used as an endoscopic video camera in a variety of endoscopic surgical procedures, including but not limited to: orthopedic, laparoscopic, urologic, sinuscopic, and plastic surgical procedures. The device is also intended to be used as an accessory for microscopic surgery (K190645).

### Value Analysis Significance

The NanoScope imaging system is the first medical-grade, 3-in-1, chip-on-tip disposable camera system. It provides the latest technology in 1 mm image sensors, LED lighting, image management, digital documentation, and OR integration with an intuitive tablet control unit. Busy surgeons immediately note the clinical efficacy of the NanoScope system, while facility administrators readily document the operational efficiencies achieved by performing common endoscopic procedures with a disposable camera system and minimally invasive instruments in a lower-cost ambulatory site-of-service.

### Coding Considerations

Codes provide a uniform language for describing services performed by health care providers. The actual selection of codes depends upon the primary surgical procedure, supported by details in the patient's medical record about medical necessity. It is the sole responsibility of the health care provider to correctly prepare claims submitted to insurance carriers.

### Physician's Professional Fee

The primary endoscopic procedure determined by the surgeon may include:

| **2025 Medicare National Average Rates and Allowables** (Not Adjusted for Geography) | | **Physician**[b,c] | | **Hospital Outpatient**[d] | | **ASC**[e] |
|---|---|---|---|---|---|---|
| | | **Medicare National Average** | | | | |
| CPT®[a] Code HCPCS Code | Code Description | Facility Setting (HOPD and ASC) | Non-Facility Setting (Office) | APC and APC Description | Medicare National Average | Medicare National Average |
| **Shoulder** | | | | | | |
| **29805** | Shoulder arthroscopy, diagnostic | $468.70 | N/A | 5113 - Level 3 Musculoskeletal (MSK) Procedures | $3244.61 | $1579.16 |
| **29819** | Removal of loose body or foreign body | $582.24 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29820** | Synovectomy, partial | $531.45 | N/A | 5114 - Level 4 MSK Procedures | $7143.73 | $3510.84 |
| **29821** | Synovectomy, complete | $590.00 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29822** | Debridement, limited | $538.89 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29823** | Debridement, extensive | $587.74 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29828** | Biceps tenodesis | $902.47 | N/A | 5114 - Level 4 MSK Procedures | $7143.73 | $3510.84 |



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| **Elbow** | | | | | | |
| **29830** | Elbow arthroscopy, diagnostic | $457.38 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29834** | Removal of loose body or foreign body | $492.96 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29835** | Synovectomy, partial | $508.81 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29836** | Synovectomy, complete | $583.21 | N/A | 5114 - Level 4 MSK Procedures | $7143.73 | $3510.84 |
| **29837** | Debridement, limited | $517.87 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29838** | Debridement, extensive | $591.29 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **Wrist** | | | | | | |
| **29840** | Wrist arthroscopy, diagnostic | $455.44 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29843** | For infection, lavage and drainage | $486.49 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29844** | Synovectomy, partial | $500.08 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29845** | Synovectomy, complete | $583.53 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29846** | Excision and/or repair of triangular fibrocartilage and/or joint debridement | $521.10 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29848** | Endoscopy, wrist, surgical, with release of transverse carpal ligament | $512.69 | N/A | 5112 - Level 2 MSK Procedures | $1600.41 | $838.29 |
| **Hand** | | | | | | |
| **29900** | Arthroscopy, metacarpophalangeal joint, diagnostic, with synovial biopsy | $505.58 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29901** | Arthroscopy, metacarpophalangeal joint, surgical, with debridement | $541.16 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **Knee** | | | | | | |
| **29870** | Knee arthroscopy, diagnostic, with or without synovial biopsy | $412.74 | $548.60 | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29873** | With lateral release | $535.98 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29874** | Removal of loose body or foreign body | $532.42 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29875** | Synovectomy, limited | $494.25 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29877** | Debridement/shaving of articular cartilage (chondroplasty) | $616.52 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29880** | With meniscectomy (medial and lateral, includes meniscal shaving) includes debridement/shaving of articular cartilage (chondroplasty, same or separate compartment(s) when performed) | $558.30 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |

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| **29881** | With meniscectomy (medial or lateral, includes meniscal shaving) includes debridement/shaving of articular cartilage (chondroplasty, same or separate compartment(s) when performed) | $538.25 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29882** | With meniscus repair (medial or lateral) | $681.86 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29883** | With meniscus repair (medial and lateral) | $829.04 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29884** | With lysis of adhesions, with or without manipulation (separate procedure) | $615.23 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **Foot and Ankle** | | | | | | |
| **29893** | Endoscopic plantar fasciotomy | $435.06 | $644.67 | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29894** | Arthroscopy, ankle (tibiotalar and fibulotalar joints) surgical, with removal of loose body or foreign body | $500.40 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29897** | Debridement, limited | $486.81 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29898** | Debridement, extensive | $552.80 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29904** | Arthroscopy, subtalar joint, surgical, with removal of loose body or foreign body | $637.23 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29905** | With synovectomy | $505.58 | N/A | 5114 - Level 4 MSK Procedures | $7143.73 | $3510.84 |
| **29906** | With debridement | $658.25 | N/A | 5113 - Level 3 MSK Procedures | $3244.61 | $1579.16 |
| **29999** | Unlisted procedure, arthroscopy | Contractor Priced | | 5111 - Level 1 MSK Procedures | $239.88 | N/A |

[a] CPT (Current Procedural Terminology) is a registered trademark of the American Medical Association. Health care providers and their professional coders must closely review this primary citation along with the patient's medical record before selecting the appropriate code.

[b] AMA CPT 2025 and CMS PFS 2024 Final Rule

[c] CMS Conversion Factor (CF) effective January 1, 2025: $32.3465

[d] CMS 2025 OPPS Final Rule @ www.cms.gov

[e] CMS 2025 ASC Final Rule @ www.cms.gov

| HCPCS Code | Code Description | Notes |
|---|---|---|
| **A4649** | **Surgical supply, miscellaneous**<br>This code reports miscellaneous surgical supplies and should only be reported if a more specific HCPCS Level II or CPT code is not available. | For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (eg, hospital, ASC). These costs are absorbed by the facility via the appropriate reimbursement mechanism (eg, MS-DRG, APC, etc).<br><br>For non-Medicare (eg, commercial) patients, depending on contractual terms and general stipulations of the payer, direct invoicing by the facility may be allowed. Contact the patient's insurance company or the facility's payer contract for further information. |
| List of Pass-Through Payment Device Category Codes (Updated September 2022) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment | | |

For more information about the primary procedure, please speak with your admitting surgeon. You may also call the Arthrex Coding Helpline at 1-844-604-6359 or email arthrexRSP@arthrex.com.

The content provided in this guide is for informational purposes only. The Arthrex Coding Helpline does not guarantee reimbursement by third-party payers.

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