Endoscopic Carpal Tunnel Release with the NanoScopic™ Release System

2025 Coding and Reimbursement Guidelines

To help answer common coding and reimbursement questions regarding arthroscopic procedures completed with the products in this guide, the following information is shared for educational and strategic planning purposes only. It is the sole responsibility of the treating health care professional to diagnose and treat the patient, and to confirm coverage, coding, and claim submission guidance with the patient's health insurance plan to ensure claims are accurate, complete, and supported by documentation in the patient's medical record. Any determination regarding if and how to seek reimbursement should be made only by the appropriate members of the staff, in consultation with the physician, and in consideration of the procedure performed or therapy provided to a specific patient. Arthrex does not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy and legislation are subject to continual change.

FDA Regulatory Clearance

The NanoScope system is intended to be used as an endoscopic video camera in a variety of endoscopic diagnostic and surgical procedures, including but not limited to: orthopedic, spine, laparoscopic, urologic, sinuscopic, and plastic surgical procedures. The device is also intended to be used as an accessory for microscopic surgery soft tissue release system is indicated for patients diagnosed with carpal tunnel syndrome, plantar fasciitis, and equinus contracture.

The Centerline endoscopic soft tissue release system is indicated for patients diagnosed with carpal tunnel syndrome, plantar fasciitis, and equinus contracture.

Value Analysis Significance

A simplified, all-in-one sterile system, the NanoScopic Release system streamlines endoscopic carpal tunnel release (ECTR)" or similar as noted here: Arthrex - NanoScopic™ Release System. The system connects to the NanoScope monitor, eliminating the need for a large tower. As a result, it may be used in an operating room, medical office, or procedural room. Anesthesia options include general anesthesia, regional block, or local anesthesia.

Coding Considerations

Codes provide a uniform language for describing services performed by health care providers. The actual selection of codes depends on 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 procedure(s) determined by the surgeon may include:

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		**Physician**[b,c] **Medicare National Average**		**Hospital Outpatient**[d]		**ASC**[e]
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
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	$512.69	$512.69	5112 – Level II MSK Procedures	$1600.41	$838.29

[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] Source: AMA CPT 2025 and CMS PFS 2025 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

arthrex.com

Endoscopic Carpal Tunnel Release with the NanoScopic™ Release System

2025 Coding and Reimbursement Guidelines

Facility Coding		
HCPCS Code	**Code Description**	**Notes**
C1889	**Implantable / insertable device for device-intensive procedure, not otherwise\classified** Use this code for an implantable or insertable device that a provider places during a procedure, and the device is not covered by any other HCPCS category C–code.	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).
A4649	**Surgical supplies; miscellaneous** 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 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 refer to the facility's payer contract for more 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 AskMarketAccess@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.

The information provided in this handout was obtained from many sources and is subject to change without notice as a result of changes in reimbursement laws, regulations, rules, and policies. All content on this website is informational only, general in nature, and does not cover all situations or all payers' rules and policies. This content is not intended to instruct medical providers on how to use or bill for health care procedures, including new technologies outside of Medicare national guidelines. A determination of medical necessity is a prerequisite that we assume will have been made prior to assigning codes or requesting payments. Medical providers should consult with appropriate payers, including Medicare fiscal intermediaries and carriers, for specific information on proper coding, billing, and payment levels for health care procedures. It is the sole responsibility of the medical provider to determine the appropriate coding.

This information represents no promise or guarantee concerning coverage, coding, billing, and payment levels. Arthrex specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this handout or through the Arthrex Coding Helpline. This guide does not constitute legal, coding, coverage, reimbursement, business, clinical, or other advice and no warranty regarding completeness or accuracy is implied.

arthrex.com