

NanoScope™ Operative Arthroscopy System

2026 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, sinusopic, 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 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 endoscopic procedure determined by the surgeon may include:

2026 Medicare National Average Payment Rates (Not Adjusted for Geography)		Physician ^{b,c}		Hospital Outpatient ^d		ASC ^e
CPT ^a Code HCPCS Code	Code Description	Work RVUs	Medicare National Average	APC and APC Description	Medicare National Average	Medicare National Average
Shoulder						
29805	Shoulder arthroscopy, diagnostic	5.88	\$451.15	5113 – Level 3 Musculoskeletal (MSK) procedures	\$3342.87	\$1644.87
29819	Removal of loose body or foreign body	7.60	\$552.86	5114 – Level 4 MSK procedures	\$3342.87	\$1644.87
29820	Synovectomy, partial	7.03	\$504.52	5113 – Level 3 MSK procedures	\$7413.38	\$3695.53
29821	Synovectomy, complete	7.69	\$560.24	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29822	Debridement, limited	6.85	\$518.62	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29823	Debridement, extensive	7.78	\$561.25	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29828	Biceps tenodesis	12.83	\$847.92	5114 – Level 4 MSK procedures	\$7413.38	\$3695.53
Elbow						
29830	Elbow arthroscopy, diagnostic	5.73	\$441.41	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29834	Removal of loose body or foreign body	6.26	\$470.95	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29835	Synovectomy, partial	6.45	\$489.75	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87



2026 Medicare National Average Payment Rates (Not Adjusted for Geography)		Physician ^{b,c}		Hospital Outpatient ^d		ASC ^e
CPT [®] Code HCPCS Code	Code Description	Work RVUs	Medicare National Average	APC and APC Description	Medicare National Average	Medicare National Average
29836	Synovectomy, complete	7.53	\$550.84	5114 – Level 4 MSK procedures	\$7413.38	\$3695.53
29837	Debridement, limited	6.83	\$509.22	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29838	Debridement, extensive	7.68	\$561.25	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
Wrist						
29840	Wrist arthroscopy, diagnostic	5.54	\$443.43	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29843	For infection, lavage and drainage	6.00	\$471.96	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29844	Synovectomy, partial	6.35	\$473.30	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29845	Synovectomy, complete	7.50	\$549.50	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29846	Excision and/or repair of triangular fibrocartilage and/or joint debridement	6.72	\$490.42	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	6.23	\$488.07	5112 – Level 2 MSK procedures	\$1642.82	\$872.87
Hand						
29900	Arthroscopy, metacarpophalangeal joint, diagnostic, with synovial biopsy	5.73	\$496.80	5114 – Level 4 MSK procedures	\$3342.87	\$1644.87
29901	Arthroscopy, metacarpophalangeal joint, surgical, with debridement	6.43	\$526.34	5114 – Level 4 MSK procedures	\$3342.87	\$1644.87
Knee						
29870	Knee arthroscopy, diagnostic, with or without synovial biopsy	5.06	\$401.80 (HOPD and ASC) \$605.89 (Office)	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29873	With lateral release	6.08	\$523.65	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29874	Removal of loose body or foreign body	7.01	\$508.55	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29875	Synovectomy, limited	6.29	\$476.66	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29877	Debridement/shaving of articular cartilage (chondroplasty)	8.09	\$589.78	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29880	With meniscectomy (medial and lateral, includes meniscal shaving) includes debridement/shaving of articular cartilage (chondroplasty, same or separate compartment[s] when performed)	7.21	\$535.74	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29881	With meniscectomy (medial or lateral, includes meniscal shaving) includes debridement/shaving of articular cartilage (chondroplasty, same or separate compartment[s] when performed)	6.85	\$518.62	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29882	With meniscus repair (medial or lateral)	9.36	\$645.17	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29883	With meniscus repair (medial and lateral)	11.48	\$790.18	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29884	With lysis of adhesions, with or without manipulation (separate procedure)	8.07	\$589.11	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
Foot and Ankle						
29893	Endoscopic plantar fasciotomy	6.16	\$419.93 (HOPD and ASC) \$669.00 (Office)	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29894	Arthroscopy, ankle (tibiotalar and fibulotalar joints) surgical, with removal of loose body or foreign body	7.17	\$477.33	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87

2026 Medicare National Average Payment Rates (Not Adjusted for Geography)		Physician ^{b,c}		Hospital Outpatient ^d		ASC ^e
CPT ^a Code HCPCS Code	Code Description	Work RVUs	Medicare National Average	APC and APC Description	Medicare National Average	Medicare National Average
29897	Debridement, limited	7.14	\$467.60	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29898	Debridement, extensive	8.28	\$526.34	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29904	Arthroscopy, subtalar joint, surgical, with removal of loose body or foreign body	8.43	\$605.22	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29905	With synovectomy	8.95	\$480.02	5114 – Level 4 MSK procedures	\$7413.38	\$3695.53
29906	With debridement	9.41	\$629.39	5113 – Level 3 MSK procedures	\$3342.87	\$1644.87
29999	Unlisted procedure, arthroscopy	0.0	\$0 (carrier-priced)	5111 – Level 1 MSK procedures	\$252.01	\$0 (carrier-priced)

^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 2026 and CMS PFS 2026 Final Rule

^c CMS Conversion Factor (CF) effective January 1, 2026: \$33.5675

^d CMS 2026 OPPS Final Rule @ www.cms.gov

^e CMS 2026 ASC Final Rule @ www.cms.gov

HCPCS Code	Code Description	Notes
A4649	Surgical supply, 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 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). 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 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.