

# OTOLARYNGOLOGY CODING ALERT

The practical adviser for ethically optimizing coding reimbursement and efficiency in otolaryngology practices

SAMPLE ISSUE

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## Stop on Higher-Paying Scope Code Minus Laryngeal Exam Indication

► **Anatomy paints picture of 92511, 31231 or 31575 territory**

You can net almost \$100 more in diagnostic scope pay if you can spot the words that should keep you with 31231 or 92511 instead of 31575.

With ENTs billing Part B carriers for 537,507 scopes with 31575 in 2006, you can't afford to miss capturing higher-paying codes when the physician performed and documented the medically necessary service. An otolaryngologist can actually make more money per hour on in-office procedures than in surgery, says **Bob Glazer**, CEO of ENT and Allergy Associates in Tarrytown, N.Y., based on a study he conducted. The office setting is much less bureaucratic and thus allows for a more efficient patient flow than a hospital.

The numbers should be on your side if you grasp these scope fundamentals.

### Dispel 92511 'Loser' Myth

"ENT coders often don't want to code 92511 because they think it pays the least of the flexible scope codes," says **Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J. The code's total value, however, is in between the lower-paying 31575 and the higher-paying 31231.

Using the 2008 Medicare Physician Fee Schedule and first-half conversion factor of 38.0870, the codes' relative value units and payments in ascending order include:

Code	Description	Work RVUs	In-office total RVUs	In-office total rate
31575	Laryngoscopy, flexible fiberoptic; diagnostic	1.10	2.99	\$113.88
92511	Nasopharyngoscopy with endoscope (separate procedure)	0.84	4.09	\$155.78
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	1.10	4.68	\$178.25

**Surprise:** Although 92511 pays \$41.90 more than 31575, and 31231 pays \$64.37 more than the laryngoscopy code, the Correct Coding Initiative considers 31575 the comprehensive code. CMS forgot to change the bundles when it revalued the codes, Cobuzzi says. Code 31575 includes 92511 and 31231.

## Check for 31575 Medical Necessity

Trace how far a flexible scope goes to see if you're in 31231, 92511 or 31575 territory. Use 31231 for a scope of the nasal cavity. Code 92511 reflects viewing up until the nasopharynx. Code 31575 is for a medically necessary scope that examines all the way down to the larynx.

**Example:** An ENT used topical lidocaine for anesthesia and performed flexible fiberoptic laryngoscopy via the right nostril. The procedure note indicates, "The nasopharynx, vallecula, epiglottis, sinuses and vocal cords were all visualized."

Because the scope goes all the way into the larynx, 31575 might be correct based on anatomy. You should use 31575 instead of 92511 only if the note shows that examining this far was medically necessary. "There has to be a chief complaint and a history of a laryngeal problem," Cobuzzi says.

"If, however, the ENT examines only the nasopharynx, such as for eustachian tube dysfunction or a mass in the nasopharynx, you would code 92511," Cobuzzi says. For information on billing a separate E/M, see "Crack Down on Flexible Laryngoscopy Coding Mishaps With These FAQs" in the March 2007 *Otolaryngology Coding Alert*.

## Spot 'Rigid' or 'Flexible'

To choose between 31525 (*Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn*) and 31575 (*Laryngoscopy, flexible fiberoptic; diagnostic*), look

at the type of scope and location. "Code 31525 is for rigid laryngoscope, and 31575 is for flexible laryngoscope," says **Denae M. Merrill, CPC-E/M**, owner of Merrill Medical Management in Saginaw, Mich.

**Clinical lowdown:** Physicians may use a rigid scope, which is a straight metal instrument that goes through the mouth into the throat, for surgical procedures, such as removing foreign objects, collecting tissue (biopsy), removing polyps, or performing laser surgery, Merrill says. A rigid scope also aids in diagnosing cancer of the voice box (larynx). Physicians perform the procedure in the operating room under sedation.

In contrast, a flexible scope allows better diagnostic views, is tolerated better by patients and can be performed in the office. "It is a pencil-thin, flexible fiber optic scope that goes in through the nose and then down the throat," Merrill says.

**Example:** An otolaryngologist documents a "direct laryngoscopy used to view the vocal cords by using a fiberoptic scope without taking a biopsy." In this case, you should code the procedure with 31575. Link the diagnostic code to the chief complaint, such as halitosis (784.99, *Choking, sneezing, halitosis, mouth breathing*).

## Replace 31575 for Abnormal Findings

When your otolaryngologist finds a problem during a diagnostic scope, you should convert from the diagnostic scope code to a surgical flexible scope code. The surgical scope code includes the diagnostic scope, according to CPT guidelines and multiple endoscopy payment rules.

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Suppose during the above fiberoptic scope scenario the ENT found and biopsied a polyp on the vocal cords (478.4, *Polyp of vocal cord or larynx*). You should assign 31576 (... *with biopsy*), rather than 31575 for a diagnostic laryngeal scope.

Other procedures the ENT might perform with a flexible laryngoscope include removal of the following:

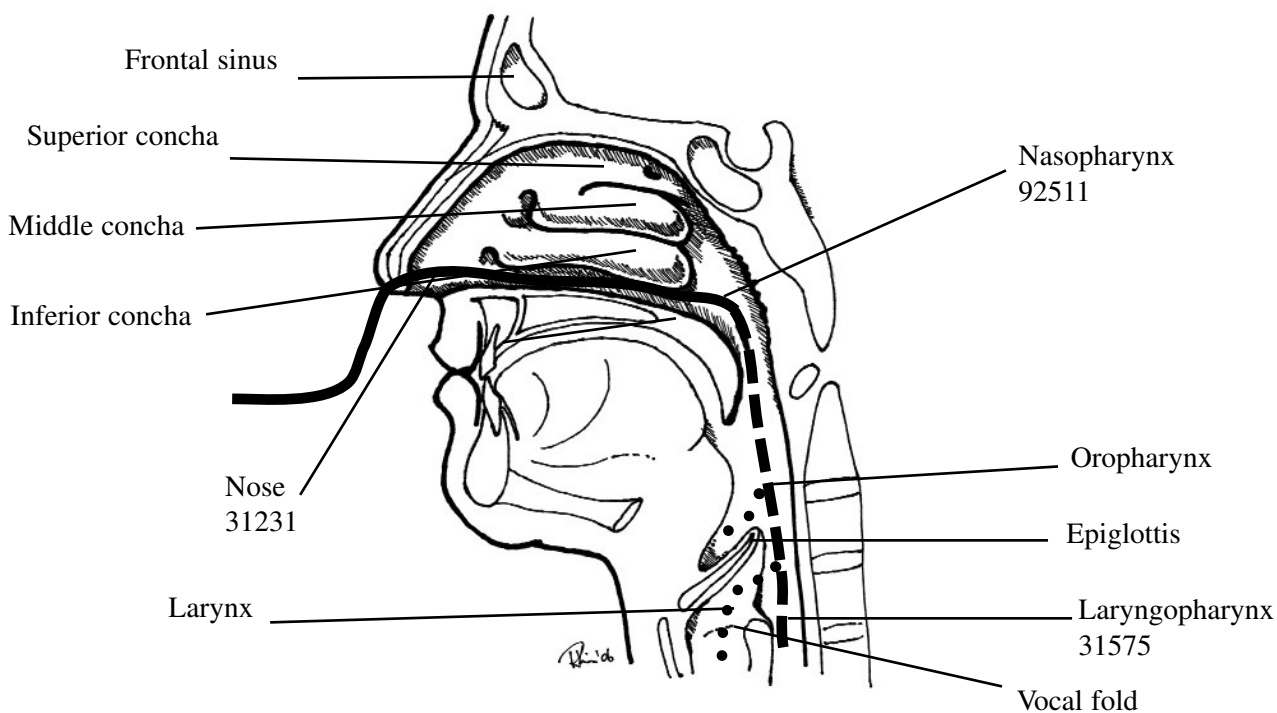
- foreign body (31577) with 933.1 (*Foreign body*)
- lesion (31578) linked to 478.29 (*Pharyngeal polyp*).

Similarly, if during a nasal scope for obstruction, the ENT found and removed a polyp, you would report 31237 (*Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement [separate procedure]*) instead of the diagnostic nasal scope (31231). □

## Clinch Extra \$100 in Diagnostic Pay With Scope Essentials

### ► Anatomy and CC steer 31231 to 31575 selection

You'll avoid undercoding or overcoding your ENT's diagnostic scopes from the nasal cavity to the laryngopharynx if you hit the codes' trifecta of extent, reason and type.



Code	Extent	Key words	Indications
31231	nose	Flexible, fiberoptic, nose	nasal obstruction
92511	nasopharynx	Flexible, fiberoptic, nasopharynx	
31575	laryngopharynx	Flexible, fiberoptic, nasopharyngeal	larynx airway obstruction (chronic, 496; NEC, 519.8); aspiration, chronic (507.0, <i>Pneumonitis due to inhalation of food or vomitus</i> ); cough, chronic (786.2); dysphagia (787.2x); dyspnea (786.09); foreign body (933.1, <i>larynx</i> ); head and neck mass, no primary (784.2); hemoptysis (786.3); history of tobacco use (V15.82); hoarseness, chronic (784.49); laryngeal trauma (959.09); neoplasm, suspected; obstructive sleep apnea (OSA) severe snoring (327.23); otalgia (388.70); stridor (786.1); throat pain (784.1)

# End Fruitless HPI Rule Search With Inside Scoop

## ► CMS does make this element your ENT's territory

Your ENT isn't wasting his time confirming a patient's history of present illness (HPI). Turns out it's his duty.

You're not alone if you've read and re-read the E/M documentation guidelines looking for the definitive answer to who can perform the HPI. Many practices allow a nurse to take the past, family and/or social history (PFSH) and review of systems (ROS), or allow a patient to complete a form detailing this information. The physician then obtains the HPI.

If your practice wants to verify whether this is a proper use of everyone's time, you might be hard-pressed to find the guideline in writing. Here's where to turn and the requirements staff need to stick to.

## Get Clear Insight on 2 History Elements

You may permit a staff member or even allow the patient to record the PFSH and ROS elements. This guidance stems from the AMA- and CMS-approved E/M guidelines. "The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient," according to the 1995 and 1997 documentation guidelines for E/M services.

**Don't miss:** The physician must document that he reviewed the PFSH and ROS history elements. The notation must supplement or confirm the information that others recorded, the guidelines stipulate.

For instance, if an ENT reviews a patient-completed PFSH and ROS form, he could indicate his review "with a brief line, such as 'I reviewed the history form filled out by the patient on Sept. 4, 2007,'" says **Margaret M. Maley BSN, MS**. He should also sign and date the form and retain it in the patient's medical record.

## Stop Hunting Here for HPI Guidance

Because the E/M guidelines create concrete PFSH and ROS recording criteria, many people look to the same place for HPI reporting information. "The guidelines have never defined if the staff was allowed to document the history of present illness," says **Teresa Thompson, CPC, CMSCS, CCC**, a consultant in Carlsborg, Wash.

## Adhere to National Payment Policy

Some Medicare carriers closed the door on any confusion in this area. A CMS carrier clarified that only the physician or nonphysician practitioner (NPP) who is conducting the E/M visit can perform the HPI and chief complaint (CC), according to Noridian's E/M clarification that appeared in *Medicare B News Issue 238*, July 10, 2007: "This is physician work and shall not be relegated to ancillary staff."

**Get this:** You should always adhere to this guidance. "Although only some carriers published the policy, it is Medicare's national policy," says **Mary Pat Johnson, COMT, CPC, COE**, senior consultant for Corcoran Consulting Group.

**Why:** Medicare bases its rationale on the fee schedule, Johnson says. The E/M service code values include physician work for performing the HPI.

**Catch this:** The absence of any HPI performer statement indicates ancillary staff does not have permission to collect the HPI. CMS specifically states that ancillary staff can collect ROS and PFSH. If CMS had extended HPI permission to staff, the guidelines would have included this allowance.

## Limit Staff, Recorder Role Accordingly

The policy, however, allows for some staff involvement in the HPI. Ancillary staff, such as a nurse, can gather preliminary information by questioning the patient regarding the CC, but the physician must confirm this information, Noridian's policy says.

## Solve a Complex Op Report?

### BE A SUPER CODER

*Otolaryngology Coding Alert* wants chart notes and operative reports that give you hiccups. Send in as many solved or unsolved documentation demystifiers from now until Nov. 1.

Look for these in issues throughout the year. The

most helpful detangler will receive a Super Coder T-shirt to show everyone how great you are.

**E/M note got you stumped?**

\* Submit entries to [supercoder@mac.com](mailto:supercoder@mac.com) or fax to (954) 333-3629. Include your name, title, employer, employer's location and preferred contact information. Black out all patient name and HIPAA-protected information.

**Scribe allowed:** The nurse may record the HPI as the ENT dictates and performs it. In this case, the physician must review the information as documented, recorded or scribed and write a notation that he reviewed it for accuracy, did perform it, adding to it if necessary and signing his name, according to Noridian's Part B News.

### Document ENT's Involvement 3 Ways

Carriers have requested information that supports the physician's HPI performance, including asking patients and/or staff to verify the doctor's role. To support services on post-payment review, the physician must document his involvement in obtaining the HPI, Thompson says.

Depending on your documentation system, follow these Thompson-recommended best practices:

**Written:** The difference in handwriting as well as notes from the physician expanding on the information obtained from the patient can support the physician's role.

**Paper templates with boxes:** The physician must obtain the information from the patient, which he indicates by checking a box.

**Electronic medical records (EMR):** Your ENT could indicate in the note that he participated in obtaining the information. Your practice might want to implement a clinic protocol indicating that the physician is responsible for obtaining the HPI information and that ancillary staff may or may not document the information obtained, depending on the physician.

Want to get the exact documents? Go online for Noridian's resources:

- [www.noridianmedicare.com/cgi-bin/coranto/viewnews.cgi?id=EEZAZlkyFyxzeFsPmT&tmpl=part\\_b\\_viewnews&style=part\\_ab\\_viewnews](http://www.noridianmedicare.com/cgi-bin/coranto/viewnews.cgi?id=EEZAZlkyFyxzeFsPmT&tmpl=part_b_viewnews&style=part_ab_viewnews)
- [www.noridianmedicare.com/shared/partb/bulletins/2007/238\\_jul/Evaluation\\_and\\_Management\\_Clarification\\_.htm](http://www.noridianmedicare.com/shared/partb/bulletins/2007/238_jul/Evaluation_and_Management_Clarification_.htm). □

## You Be the Coder

### Is 69424-69610 Bundle Appealable?

**Question:** An otolaryngologist places a paper patch (69610) on a patient's right ear and removes a tube from the patient's left ear. Medicare denied the claim. Was I correct to code it with modifier 59?

New Jersey Subscriber

**Answer:** Turn to page 55. □

## Reinstate 'Old' J Codes to Get Claims Paid

### ► You're going to code rescue med supply based on drug — again

If you flagged J7611-J7614 as invalid for CMS, you can green light the codes with a "valid as of April 1, 2008" notation.

The spring-quarter updates to HCPCS 2008 delete albuterol/levalbuterol codes J7602 (*Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per 1 mg [albuterol] or per 0.5 mg [levalbuterol]*) and J7603 (... *unit dose* ...). Effective April 1, HCPCS reinstates:

- J7611 — *Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 1 mg*
- J7612 — *Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 0.5 mg*
- J7613 — *Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 1 mg*
- J7614 — *Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 0.5 mg.*

**The swap:** In March, "We were using J7603 for albuterol," says **Diane Nelson, RTR, CPC**, medical coder for Vanguard Medical Services in Frederick, Md. In April, "We changed back to J7613." The CMS fee schedule Web site recognizes J7611-J7614 and not J7602-J7603.

### Switch Back to Drug-Specific Codes

You may recall that last July, CMS replaced J7611-J7614 with Q4093 (*Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per 1 mg [albuterol] or per 0.5 mg [levalbuterol]*) and Q4094 (... *unit dose* ...)

"Both Q4093 and Q4094 were deleted effective Jan. 1, 2008," says **Jay Neal**, a coding consultant in Atlanta. "HCPCS introduced new albuterol-levalbuterol combination codes J7602-J7603 to take the place of those deleted Q codes for 2008."

(Continued on next page)

Medicare decided it was better to use the four codes that separated albuterol from levalbuterol, rather than the combined drug codes J7602-J7603.

## Focus on 2 J7611-J7614 Factors

You can get the correct noncompounded solution supply code if you zoom in on two items:

- **form** — concentrated (J7611, J7612) or unit dose (J7613, J7614).
- **drug** — albuterol (J7611, J7613) or levalbuterol (J7612, J7614). □

## READER QUESTIONS

### Oral Lesions: Check Method, Site

**Question:** *An otolaryngologist plans on treating precancerous multiple mucosal lip lesions with a laser. Should I use 40810 x 2 for Medicaid?*

Utah Subscriber

**Answer:** No, laser lesion destruction in the mouth's vestibule falls under 40820 (*Destruction of lesion or scar of vestibule of mouth by physical methods [e.g., laser, thermal, cryo, chemical]*). If the physician had instead excised a mucosal or submucosal lip- or cheek-tissue lesion without repair, you would use the code you mention, 40810 (*Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair*).

**Warning:** Code only completely distinct additional lesions your surgeon destroyed. If the lesions share borders or are adjacent, do not code separate destructions.

Wait to file the claim until you have the pathology report. The diagnoses may help you to substantiate coding an additional 40820. For instance, if the lip lesions come back as cancerous, and documentation shows they are on the upper and lower lip, you would report on separate lines:

- 40820 linked to 140.3 (*Malignant neoplasm of lip; upper lip, inner aspect*)
- 40820-59 linked to 140.4 (... *lower lip, inner aspect*).

When you have the same diagnosis, for instance, two separate-location upper lip mucosal lesions (140.3), you may be able to report the destruction with 40820 x 2. To

avoid the carrier considering the second 40820 duplicate, you may need to append modifier 59 (*Distinct procedural service*) to the second 40820.

## Auditing: Count Otalgia HPI

**Question:** *I'm auditing a note that states:*

*"CC: A patient seen in the office complains of left ear pain.*

*HPI: Patient complains of dull ache in left ear over the past 24 hours."*

*Does the note support a brief or extended history of illness (HPI)?*

Maryland Subscriber

**Answer:** The note includes four HPI elements, which the AMA and CMS consider extended HPI (at least four HPI elements or the status of at least three chronic or inactive conditions for extended HPI). You have location (left ear), quality (dull), symptom (ache), and duration (over past 24 hours).

The other HPI elements include severity, scale, timing, context and modifying factors. See if you can spot the additional HPI elements in this note:

"Patient complains of dull ache in left ear over the past 24 hours. Patient states he went swimming two days ago. Symptoms somewhat relieved by warm compress and ibuprofen." In addition to the same location, quality and duration elements listed in your note, the second note also indicates:

- context (went swimming)
- modifying factors (relieved by warm compress and ibuprofen).

## Is Cochlear Device Implantation Bilateral?

**Question:** *An otolaryngologist implants a cochlear device with mastoidectomy on both ears. Should I use modifier 50 or 59?*

Texas Subscriber

**Answer:** The 2008 Medicare Physician Fee Schedule allows you to report a cochlear device with mastoidectomy bilaterally. Column Z "Bilat Surg" of the fee schedule lists a "1" for 69930 (*Cochlear device implantation, with or without mastoidectomy*). For payers that recognize modifier 50 (*Bilateral procedure*), you should report on one line:

- 69930-50.

Medicare's bilateral-surgery rules pay the first surgery at 100 percent and the second-side surgery at 50 percent. Expect 69930-50 to pay about \$1,880 using the Medicare fee schedule.

**Loss averted:** Check your explanation of benefits (EOB) for payment on 69930-50 to make sure the insurer paid you for the bilateral procedure. If you don't have the payer's fee schedule, use the benchmark of \$1,880 or compare the rate to unilateral 69930 charges to ensure you didn't receive payment for one side only.

Some insurers require you to report bilateral surgeries with units or with modifier 59 (*Distinct procedural service*) and body-side modifiers (LT, *Left side* and RT, *Right side*). In these cases, you would instead assign 69930 x 2 on one line or use the following on two lines:

- 69930-LT
- 69930-59-RT.

**Catch this:** Medicare changed 69930's status from unilateral to bilateral, effective Oct. 1, 2004. The fee schedule change from "0" (*150 percent payment adjustment for bilateral procedures does not apply*) to "1" (*150 percent payment adjustment for bilateral procedures applies*) applies to otolaryngology codes 69440-69979 (except 69676, which already contained "1," and 69710 for which the concept does not apply, indicated by the "9" modifier). This means you can also report mastoidectomy (69501-69511, 69601-69605) and tympanoplasty (69631-69646) bilaterally.

### Call on 24 for New Px at Post-Op Visit

**Question:** *An ENT sees a patient in follow-up for a tympanoplasty (69436, Tympanostomy [requiring insertion of ventilating tube], general anesthesia), within the insurer's 10-day global period for the minor procedure. The physician performs the follow-up, and the mother complains the child is sneezing and has had a clear runny nose. The note indicates,*

*"Chief complaint: Patient presents for tube check and complains of clear rhinitis.*

*Exam: Ears clear, no fluid. Nasal membranes swollen and red.*

*Assessment/Plan: This patient has chronic OM that has resolved. She is given a free sample of Astelin for the rhinitis. Follow up here as needed."*

*Should I charge an E/M service for the new problem?*

Washington Subscriber

**Answer:** Yes, the global package includes only postoperative care related to the original surgery. For an E/M service that is unrelated to the surgery, you should report the appropriate level of care appended with modifier 24 (*Unrelated evaluation and management service by the same physician during a postoperative period*).

Link 99212-24 (*Office visit for the evaluation and management of an established patient ...*) to the new problem diagnosis — rhinitis (477.9). Do not include any E/M elements related to the postoperative care in the office visit level coded.

If the physician had seen the patient for only a tube check, you would have instead used 99024 (*Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason[s] related to the original procedure*) with the reason-for-surgery diagnosis, such as otitis media (381.00-382.9).



(Continued on next page)

## You Be the Coder

### Is 69424-69610 Bundle Appealable?

**Answer:** You should code the scenario with only 69610 (*Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch*), not 69610-RT (*Right side*), 69424-59-LT (*Ventilating tube removal requiring general anesthesia; distinct procedural service; left side*).

Medicare always considers 69424 a component of 69610 and never allows a modifier to override the bundle. The Correct Coding Initiative (version 14.1) has a level 0 edit on 69610 and 69424.

Including a tube removal in a same-side tympanic membrane repair makes sense. But not allowing a modifier for a tube removal when it is the only procedure performed on that ear does not seem appropriate.

The code pair previously had a modifier indicator of "1," meaning you could have reported the scenario as you indicated and appealed for the separate-side payment. Now if the ENT places a patch on one ear and removes a tube from the other ear, he will not receive any payment for the removal. Abusing modifier 59 by using it to unbundle same-side patches and tube removals could have led to this automatic separate-side inclusion. □

## Check Carrier's CRP Performer Rule

**Question:** *Can I bill 92700 when an audiologist performs the Epley maneuver?*

Missouri Subscriber

**Answer:** The answer depends on the carrier or payer. Pinnacle Business Solutions Inc., the Part B carrier for Missouri and Rhode Island, allows audiologists to perform the Epley maneuver. "An audiologist as well as a physical therapist can perform the Epley maneuver and code it as 92700," according to the carrier's FAQs.

Nationally, however, CMS will not pay for audiologists performing therapeutic or treatment procedures, such as the Epley maneuver or canalith repositioning procedure (CRP). Audiologists should directly bill carriers for **only diagnostic** audiological services.

If you bill 92700 (*Unlisted otorhinolaryngological service or procedure*) incident-to the physician, the claim is blind as to who provided the treatment. So if the encounter and documentation meet incident-to guidelines, you could bill 92700 under the ENT's NPI, which will look as though the physician had performed the service.

Private payers may not carry Medicare's stipulation on treatment versus diagnostic codes. But if a carrier that did not specifically allow audiologists to perform the Epley maneuver audited a practice's files and found that the charts showed an audiologist performed the treatments, the carrier could request paybacks on those services because they are statutorily excluded from coverage.

**Good news:** Next year, you will probably have a specific code for BPPV (386.11, *Benign paroxysmal positional vertigo*) treatment methods. The American Academy of Otolaryngology-Head and Neck Surgery with four other academies submitted CRP (959xx) for consideration in CPT 2009.

— *Answers to You Be the Coder and Reader Questions reviewed by Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC, president of CRN Healthcare Solutions in Tinton Falls, N.J.* □

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