The Coding Institute

Otolaryngology Coding Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency in otolaryngology practices

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2009 CCI Puts More Restrictions on Turbinate Procedure Codes

▶ ***You might face denial next time you use 30801 and a FESS code.***

If you thought the CPT 2006 redefinition of 30801 made it safe to use when also coding a FESS procedure, the Correct Coding Initiative (CCI) has bad news for you.

CCI's latest edits, effective Jan. 1, bundle turbinate "coblation" code 30801 (*Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial*) into several codes, including 31200 (*Ethmoidectomy; intranasal, anterior*) and 31287 (*Nasal/sinus endoscopy, surgical, with sphenoidotomy*). Both 30801 and 30802 (*Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; intramural*) are bundled into 31231 (*Nasal endoscopy, diagnostic, unilateral or bilateral [separate procedure]*) and 31238 (*Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage*).

Carriers, Doctors Wrangle Over 30801, 30802

The context: Private carriers have long tried to bundle 30801 and 30802 with functional endoscopic sinus surgery (FESS) codes such as 31235 (*Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy [via puncture of sphenoidal face or cannulation of ostium]*). "Carriers use software that automatically bundles these codes with FESS," warned *ENToday* in August 2006. "Your claim may be denied based on same incision or gaining access."

The CCI editors feel that doctors were using 30801 and 30802 to describe ways to gain access for the endoscope to sinus passages, or to control bleeding associated with an endoscopy, says **R. Waguespack, MD,** the chair of American Academy of Otolaryngology-Head and Neck Surgery's (AAO-HNS) CPT & Relative Value Committee.

The committee disagrees. "The typical use of these codes for turbinate reduction associated with hypertrophic rhinitis and airway obstruction was explained to NCCI decision-makers, especially with regard to 30802," Waguespack says.

When your ENT performs a sinus endoscopy, he must pass the middle turbinates on his way to the ethmoids and the maxillary sinuses — for instance, to perform the procedures described by 31254 (*Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial [anterior]*) or 31267 (*Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus*).

Take Care When Coding 30801 When Also Coding These Procedures

The Correct Coding Initiative (CCI) now bundles superficial shrinkage of the inferior turbinates (30801 — *Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial*) into these codes:

- 31200-31201 — *Ethmoidectomy ...*
- 31231* — *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)*
- 31233 — *Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)*
- 31235 — *Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)*
- 32137, 31238,* 31239, 31240, 31254, 31255, 31256, 31267, 31276, 31287, 31288, 31290, 31291, 31292, 31293, 31294 — *Nasal/sinus endoscopy, surgical ...*

* CCI now also bundles 30802 (*Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; intramural*) with 31231 and 31238. ❑

The inferior turbinates, however, do not provide access for these procedures. In the 2006 CPT Manual, the AMA redefined 30801 and 30802 (as well as 30930, 30130, and 30140) to refer only to the inferior turbinates to avoid these denials. Now, carriers have a new tool in their denial toolbox.

However, it shouldn't hurt too badly, Waguespack suggests. "Edits of 30801 with nasal/sinus surgeries should have relatively little impact on otolaryngologists, as most are reasonable or can be reported with the 59 modifier [*Distinct procedural service*]," he says. "Further, it is our understanding that 30802 would be the more typically reported service."

What Is Cautery of the Inferior Turbinates?

Three sets of turbinate pairs in the nose (superior, middle, and inferior) secrete mucous, which provides humidity and keeps the inside of the nose clean. Swollen turbinates (478.0, *Hypertrophy of nasal turbinates*) may obstruct breathing. ENTs perform several procedures, including those that 30801 and 30802 describe, to alleviate this swelling — alone or, more often, with other procedures, such as FESS and septoplasty.

30801/30802: These codes describe electrocautery or ablation of the turbinate mucosa to shrink enlarged tissues. No incision or excision is performed. The code 30801 describes a superficial, or external, cauterization on the surface of the mucosa, whereas 30802 describes the destruction of the mucosa from within.

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If your ENT performs these procedures with an unrelated service, you should append modifier 59 to 30801 or 30802 to show that the turbinate shrinkage is not bundled with the other procedure.

Here's how: According to CMS instruction, you should append modifier 59 to "the secondary, additional, or lesser procedure(s) or service(s)" — in this case, 30801 — to indicate that you performed two separate procedures.

The CCI edit table has a "modifier indicator" column. If the codes you're trying to report together have an indicator of "1" next to them, you may be able to append modifier 59 to bypass the edit, says **Maggie M. Mac, CMM, CPC, CMSCS, CCP, ICCE**, consulting manager for Pershing, Yoakley and Associates in Clearwater, Fla. If the code has a "0" indicator, you cannot bypass the edit under any circumstances. The CCI edits change quarterly, so be sure to keep abreast of all updates.

An example of proper modifier 59 use would be when the turbinate is shrunk on one side of the nose and the other procedure is performed on the other side. Modifier 59 is appropriate as these two procedures are performed on separate sites. ❑

Keep Your Coding Cool During Cold and Flu Season

▶ *If your office tests for flu, here's how to maximize your reimbursement.*

You probably don't have many patients coming to your office just because they have a cold or the flu. But many of them have problems — such as sinus and ear infections — that started with a cold or flu, so you should be on top of the relevant codes, especially this time of year.

Flu Has a 4th Digit, May Require Additional Code

The flu and the common cold are both respiratory illnesses, but different viruses cause them, the Centers for Disease Control and Prevention (CDC) says. Because these two types of illnesses have similar symptoms, your ENT may have a hard time differentiating between them based on symptoms alone. In general, the flu (487.x *Influenza*) is worse than a cold (460 *Acute nasopharyngitis*), and symptoms such as fever, body aches, extreme tiredness, and dry cough are more common and intense when a patient has the flu, the CDC says.

Correction

In *Otolaryngology Coding Alert,* Vol. 10, No. 12, the story "Bypass Septoplasty Global By Sidestepping Modifier Mishaps" referred to an earlier article in Vol. 11, No. 9. It should have referred to Vol. 10, No 9. ❑

More info: Additional digits help you describe flu that has progressed to other medical problems:

- 487.0 — *Influenza with pneumonia*
  You'll use an additional diagnosis code to describe the type of pneumonia.

- 487.1 — *Influenza with other respiratory manifestations*
  This code describes a patient who has laryngitis, pharyngitis, or another respiratory infection.

- 487.8 — *Influenza with other manifestations*
  You'll use this when a patient has encephalopathy due to flu, or gastrointestinal problems related to the flu (but not for stomach flu, for which you'd use the appropriate code from the 008.x [*Intestinal infections due to other organisms*] range).

Colds are usually milder than the flu. People with colds are more likely to have a runny or stuffy nose. Colds generally do not result in serious health problems, such as pneumonia, bacterial infections, or hospitalizations. But a cold can progress to a sinus infection.

Example: A patient presents with acute sinusitis and an upper respiratory infection that have resulted from a lingering cold. You'll code 461.9 (*Acute sinusitis, unspecified*) for the first-listed diagnosis, 460 for the second, and 465.9 (*Acute upper respiratory infection NOS*) for the third.

Don't Blow Your Flu-Test Coding

In-office testing: Because colds and flu share so many symptoms, it can be difficult (or even impossible) to tell the difference between them based on symptoms alone. Tests that usually must be done within the first few days of illness can be carried out to tell whether a person has the flu.

Should your ENT test a patient for influenza, coding is not always as easy as reporting 87804 (*Infectious agent*

(Continued on next page)

antigen detection by immunoassay with direct optical observation; influenza). Your code choice will depend on the type of test the physician conducts and what method and product she uses. Not all influenza tests that qualify for 87804 deserve multiple-unit coding — and the same product doesn't always deserve multiple coding.

Use a modifier: Code 87804 describes the rapid flu test approved by the FDA requiring Clinical Laboratory Improvement Act (CLIA)-waived status, says **Kevin Perryman,** administrator at the office of Teri Perryman, MD, in Kerrville, Texas. In some cases, carriers may require you to follow Medicare guidelines and append modifier QW (*CLIA-waived test*) to 87804, Perryman says. To keep coding uniform, Perryman uses modifier QW regardless of payer and hasn't had any denials due to its use.

Apply Code for Each Result, Not Each Device

When your office uses an A&B influenza test, you should code multiple units of 87804 when appropriate. "You should report 87804 per strain tested or per result," says **William Dettwyler, MT-AMT,** president of Codus Medicus, a laboratory coding consulting firm in Salem, Ore. Here's how you should apply the "1 Result = 1 Code" rule to three tests:

Product 1: For an in-office test that does not identify the influenza strain, report one unit of 87804. "Quidel QuickVue Influenza Test picks up only the presence of influenza with a single positive/negative result," Dettwyler says. Because the test gives you one result, you should report one unit of 87804. If you use a product that differentiates between influenza A & B, you should report 87804 twice. When you get two results from a test, you should code for two units, Dettwyler says.

Products 2 and 3: Two products that use a single test device (such as a swab) to test for different strains resulting in two results include the Quidel Quickvue Influenza A+B Test and the Binax NOW A&B Test.

Because you code per result, not per device, don't automatically code two units of 87804 every time you use a Quidel Quickvue Influenza A+B Test or Binax NOW A&B Test kit. "Clinicians do not always require both tests even if the kit can identify two types of influenza," Dettwyler says.

You code it: Your office runs the Quidel Quickvue Influenza A+B Test and tests for both strains. Test results indicate:

- positive for influenza A
- negative for influenza B.

Solution: "You should code two units of 87804: one code for each result," Dettwyler says.

Learn more about flu season at www.cdc.gov/flu/weekly/fluactivity.htm. ❑

Make Good ROS Documents Routine to Avoid Charges of Overcoding E/Ms

▶ Don't undercode the level-4 and -5 services your ENT performs.

You already know that insurers scrutinize your practice's evaluation and management levels to see whether you're coding more high-level E/Ms than the average ENT. Don't undercode out of fear of the auditor — instead, get in the habit of good documentation to back up your practice's good patient service.

Evaluation and management of otolaryngology patients can be complicated business. A thorough review of systems is an everyday thing for an ENT, so make sure good documentation of ROS is routine, too.

Level-four and -five E/Ms are not that uncommon for an ENT's practice, so mastery of your doctor's review of systems is critical to backing up codes like 99204 (*Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity …*) or 99214 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key*

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components: a detailed history; a detailed examination; medical decision making of moderate complexity....), which you probably see more often.

Comprehensive History Requires Complete ROS

When your physician performs an E/M service, he conducts a review of systems as part of the patient's history. For coding purposes, the history requires all three elements — history of present illness (HPI), review of systems (ROS), and past family and social history (PFSH) — be met, so failing to fully conduct and document any of these areas will pull down the history level.

Therefore, the ROS helps determine patient history level, which has a great effect on the level of E/M level. If you do not know the ROS level, you will be unable to decide which level of E/M code you should use on the claim.

To claim a level-four or -five E/M, documentation must indicate a comprehensive history. That requires an extended HPI (document four of seven HPI); a complete PFSH; and a complete ROS.

The basics: The main purpose of the ROS is to be sure your ENT has missed no important symptoms, especially in areas not already covered in the HPI.

The ROS is an interview in which the physician or nurse asks the patient about a specific system and records the patient's answers. Some physicians also get ROS information from patients through a questionnaire.

CMS defines 14 systems for documentation:

- Constitutional symptoms (such as fever)
- Eyes (blurred vision)
- Ears, nose, mouth, throat (trouble swallowing)
- Cardiovascular (hypertension)
- Respiratory (shortness of breath)
- Gastrointestinal (nausea)
- Genitourinary (urine incontinence)
- Musculoskeletal (joint pain)
- Integumentary (discolored skin)
- Neurological (numbness)
- Psychiatric (depression)
- Endocrine (taking synthetic hormones)
- Hematologic/lymphatic (anemia)
- Allergic/immunologic (asthma/immunodeficiency).

Tip: The physician can hand off the ROS work. "Your ancillary staff can document your review of systems and personal, family, social history," says **Kim Garner-Huey, CPC, CCS-P, CHCC**, an independent coding and reimbursement consultant in Auburn, Ala.

There are three levels of ROS: problem-pertinent, extended, and complete. If the nature of the presenting problem supports coding a level-four or -five E/M, the ROS must be at the highest level: complete.

Confirm 10+ Systems for Complete ROS

For a level-four or -five visit, the ROS requirement is steep: The physician must document that he checked at least 10 systems.

Consider this example: A new patient reports to the ENT with a chronic sore throat and a persistent cough. She also has trouble swallowing (ear, nose, mouth, throat.)

The notes indicate that the patient has lost weight (constitutional), and has negative responses for eye discharge (eyes), dysuria (genitourinary), headache (neurological), and rash (integumentary). The physician also notes that the patient reports anxiety (psychiatric), some pain in her right shoulder (musculoskeletal), and has urinary frequency (genitourinary). Her blood pressure is a little elevated (cardiovascular).

During this encounter, the physician checked a total of 10 systems (noted in parentheses.) Remember, you may count a single system once only; though the example mentions ear, nose, mouth, and throat, and genitourinary systems more than once, they only count once each.

On the claim, if there was medical necessity and the documentation meets all other factors (the balance of the history, exam, and medical decision-making), this level of ROS would support 99204 or even 99205 (*... a comprehensive history; a comprehensive examination; and medical decision making of high complexity ...*) for the E/M.

Templates for success: One easy way to ensure providers document the E/M visit components is to create

(Continued on next page)

You Be the Coder

What Code is Right for This Artery Ligation?

Question: *I am looking for a CPT code for "endoscopic sphenopalatine artery ligation." I can find codes for ethmoidal and maxillary but not for sphenopalatine. Would I use the unlisted code 30999?*

Michigan Subscriber

Answer: Turn to page 15. ❑

Success Story:

Thyroidectomy Lesson: Don't Give Up When Bundles Conflict

▶ ***In 2009, this successful 60512 appeal would bring in $229.***

Appealing a 60512 denial can be tricky business, but don't give up.

Barbara Cobuzzi, MBA, CENTC, CPC-H, CPC-P, CPC-I, CHCC, president of CRN Healthcare Solutions, Tinton Falls, N.J., shares a war story in which she untangled conflicting bundles.

"One of my memorable appeals with my Medicare carrier was a case where the doctor performed a thyroidectomy, parathyroidectomy, and parathyroid autotransplantation.

"I only billed the thyroidectomy — 60240 (*Thyroidectomy, total or complete*) — and the parathyroid autotransplantation — 60512 (*Parathyroid autotransplantation [List separately in addition to code for primary procedure]*) — because the parathyroidectomy was bundled with the thyroidectomy.

"My Medicare carrier denied 60512. I appealed, but they said they had an edit in the system that denied pay for 60512 unless 60500 (*Parathyroidectomy or exploration of parathyroid[s]*), 60502 (*...re-exploration*) or 60505 (*... with mediastinal exploration, sternal split or transthoracic approach*) are also billed. So, I had to go to Fair Hearing (the predecessor to the qualified independent contractor [QIC] hearing) and make the point that, although 60500 was performed and shown in the operative note, it could not be coded or billed because it is bundled with the thyroidectomy. I won the appeal at the Fair Hearing."

Code 60512 pays about $229 (6.35 transitional non-facility total relative value units [RVUs]), using the 2009 Medicare Physician Fee Schedule and conversion factor of 36.066.

Brag on yourself a little: If you have a coding success story you'd like to share, please write editor Jim McBee at jmcbee@eliresearch.com. ❑

templates they can follow. Have your provider reference an ROS in the dictation, and initial and date the form.

What to include: "I think that a good template should really prompt the physician to put in the information specific to his practice," says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-OBGYN, CPC-CARDIO,** manager of compliance education for the University of Washington Physicians and Children's University Medical Group Compliance Program. It should remind him to put in "a complete review of systems (or remind him to refer to 'that patient questionnaire' that they have every patient fill out). It should remind the physician to ask about social history and family history and should lead him away from words like 'non-contributory' or 'unremarkable,' which are not good indicators of the service provided."

Standard operating procedure: "An excellent template should also remind the doctor to document exam elements that are routinely performed but not always documented," Bucknam says. And "it should remind him to list the patient's co-morbid conditions."

ROS Templates, Yes; Cloning, No

Payers and auditors who smell cloned documentation may hit your practice with fines and refund requests. Patient-completed ROS templates may be OK, but ask physicians to make their documentation specific to each patient. Also, be sure your ENT documents that the ROS was reviewed with the patient by noting any pertinent information.

For established patients, a statement of "ROS unchanged" or "same as last visit" is not acceptable. But a statement that says "reviewed history of (date) and remarkable changes are (list changes)" is acceptable; that statement links a prior history to the current visit. However, in an audit, make sure you include the prior history in the chart papers you send to the auditor.

Negativity: Some local carriers may not accept the notation of "all other systems are negative." CMS is reviewing the acceptability of this statement but has yet to release further information. ❑

READER QUESTIONS

Don't Report Tonsillectomy, Adenoidectomy Separately

Question: *My otolaryngologist performs a tonsillectomy and secondary adenoidectomy. May I separately code each surgery?*

Minnesota Subscriber

Answer: No. Regardless of whether the patient previously had adenoids removed, you should instead use one of the tonsillectomy and adenoidectomy codes:

- 42820 — *Tonsillectomy and adenoidectomy; younger than age 12*
- 42821 — *Tonsillectomy and adenoidectomy; age 12 or over*

The T&A codes don't distinguish between primary or secondary adenoidectomy. So if the otolaryngologist performs both tonsillectomy and adenoidectomy for the first or second time, you should report only 42820 or 42821. Insurers will think you're trying to get around the bundling fraudulently if you report the procedures separately — such as 42825 (*Tonsillectomy, primary or secondary; younger than age 12*) and 42835 (*Adenoidectomy, secondary; younger than age 12*).

You only report the secondary adenoidectomy if that is all the ENT does.

Use 478.19 to Describe Runny Nose Dx

Question: *What diagnosis code should I use for rhinorrhea? The only mention I find is 349.81, but that doesn't sound right.*

Nevada Subscriber

Answer: You should report rhinorrhea — otherwise known as a runny nose — with 478.19 (*Other diseases of nasal cavity and sinuses*). This unspecified code describes "other diseases of nasal cavity and sinuses" including "rhinolith," according to the code's inclusion entry in the 2007 ICD-9-CM Manual.

Tool: Your instinct is correct regarding 349.81 ((Cerebrospinal fluid rhinorrhea)). CSF rhinorrhea results

(Continued on next page)

You Be the Coder

Question on page 13

What Code Is Right for This Artery Ligation?

Answer: You'll code 30920 (*Ligation arteries; internal maxillary artery, transantral*) for the ligation of the sphenopalpatine artery. The sphenopalatine artery is a terminal branch of the maxillary artery — it carries blood to the nose. A physician will sometimes clip off this artery in a patient who has a severe, posterior nosebleed that doesn't respond to more conservative treatment, such as packing and cautery.

You'll code 784.7 (*Epistaxis*) to describe the nosebleed, and a payer is liable to want to see other techniques your ENT used to stop the bleeding and the patient's response to those treatments. If the patient has a defect in her ability to clot blood, you'll code that diagnosis, too. For instance, if the patent has coagulopathy from liver disease, you'd code 286.7 (*Acquired coagulation factor deficiency*) to bolster the case for the procedure. ❑

from a defect or injury to the skull that allows fluid to leak into the nasal passages — a much more serious condition than a runny nose.

❑

Call on Respiratory Dx for Wheezing

Question: *Concerning the coding of acute bronchospasm (519.11), when is it appropriate to simply report 786.07 for wheezing?*

Wisconsin Subscriber

Answer: The best code for wheezing or what physicians call wheezing-associated respiratory illness (WARI) is 519.11 (*Acute bronchospasm*). Although 786.07 (*Wheezing*) states "wheezing," the code refers to narrowing of respiratory passages. Code 519.11 is more specific for bronchospasm.

Physicians use the diagnosis of WARI for patients who don't meet the criteria for a diagnosis of asthma. An example of WARI is a child with an upper respiratory infection (URI) who has his first episode of associated wheezing and requires treatment of bronchospasm. This would typically not warrant labeling a child with "asthma," using ICD-9 code 493.02 (*Extrinsic asthma; with [acute] exacerbation*).

— *Answers to* You Be the Coder *and* Reader Questions *provided/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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