

Anatomy, Conditions, and Coding Concerns Encountered in Pediatric Otolaryngology

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Objectives

- Understand why a good relationship between surgeon and coder is important
- Understand different physician personalities and stressors; how to approach with questions
- Be able to start to visualize teamwork needed in your setting to succeed

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Why Talk?

- Each have different knowledge bases from our experience, education, and brain style
- Increase correct coding
- Increase revenue

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Barriers

- Time
- Language
- Stress
- Fear

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Time

- Coder typically in office 8 am to 5 pm. This is when the surgeon is in the operating room or in the clinic seeing patients. Trying to discuss an issue will add stress and poor attention
- Possible solution: weekly or monthly meeting time that works for both coder and surgeon

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Language

- Coder is using the medical vocabulary learned in the classroom while the surgeon is using jargon used in the operating room
- Need to talk with each other, use the CPT® guidebooks and tools, so begin to use a common language

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Stress

- Coder wants to get the codes for diagnosis and procedures correct, matched correctly, be sure edits addressed if need be, and maximize payment decreasing rejections – all this in a timely manner
- Surgeon wants to get his work done and get some sleep, worried about patient with a complication, family not seen all week, lecture not done, etc. – billing not on radar

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Fear

- Coder afraid of Surgeon:
 - boss, knowledge, attitude or anger received
- Surgeon afraid of Coder
 - knowledge, not paid again, more work

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Things to Help it Work

- Coder's MUSTS:
 - educate surgeon about documentation
 - educate surgeon about coding
 - discuss coding of complicated cases
 - be prepared, knowledgeable, ready with corrective suggestions

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Ways to Motivate Surgeon

- Depends on Surgeon
 - money
 - recognition complex care
 - audit risks
 - partners apply pressure
 - kill them with kindness

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Personalities

- Long thought that surgeons were “different” from other medical doctors
 - Turns out with the exception of psychiatry they all score the same on personality testing
- The differences you see: scars from training, life’s lessons, stress

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Coding Misconception

- Surgeon: coding for payment
- Coder: coding for data

- Coder is correct

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Comon Doctor Errors

- Not enough detail in documentation
- Not utilizing modifiers: depending on the coder to use them for us
- Not taking a coding course every few years to stay current
- Depending on the computer to do the coding

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General Approach to Mass in Child

- History
- Physical Exam
- Labs
- Radiology
- Specials

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History Guidance

- Congenital: present at birth, onset with infection, multiple family members with same
- Inflammatory: onset with infection, calor, rubor, pain, recent
- Malignant: rapid growth, no or little pain

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Physical Exam

- Color of skin overlying
- Consistency on palpation
- Location in patient
- Pain/tenderness with exam
- Torticollis

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Labs

- CBC with Diff
- Cultures
- FNAs
- TFT
- Titres

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Radiology

- Ultrasound
- CT Scan
- MRI
- Esophagram

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Ultrasound of Masses

- Tells cystic vs. solid vs. mixed
- Encapsulation
- Vascularity and relationship to vessels

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CT Scan of Masses

- Do with contrast if possible
- Tells location
- Bone Integrity
- Inflammatory changes
- Abscess vs. Cellulitis
- Can combine with image guidance

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MRI of Masses

- Soft tissue better defined
- Fluid planes (ie glioma)
- Abscess vs. cellulitis
- Vascularity (lymphangioma vs. hemangioma)
- Less radiation exposure than CT Scan

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Specials

- TB test
- Fistulagram
- Thyroid Scan

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Lymphadenitis Causes

- USUALLY Staph or Strep pyogenes (grpA)
- Areobic (Strep grp B and C)
- Anaerobic (mouth!)
- Viral (EBV, Adenovirus)
- Toxoplasmosis
- Cat Scratch
- Abcess
- Sialadenitis

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Lymphadenitis Emperic Thx

- Augmentin
- Cephalosporins
- Macrolides
- IV: Clindamycin/Cefuroxime/Unasyn

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Lymphadenitis Surgical Tx

- Incision and Drainage: worry about TB, immunocompromised pt., skin contamination
- FNA
- Excisional Biopsy
- Incisional Biopsy

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Lymphadenitis LN Pathology

- Reactive Hyperplasia 50%
- Bacterial Infection 25%
- Neoplasm 15%
- Miscellaneous 10%

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Coding of Treatment Choices

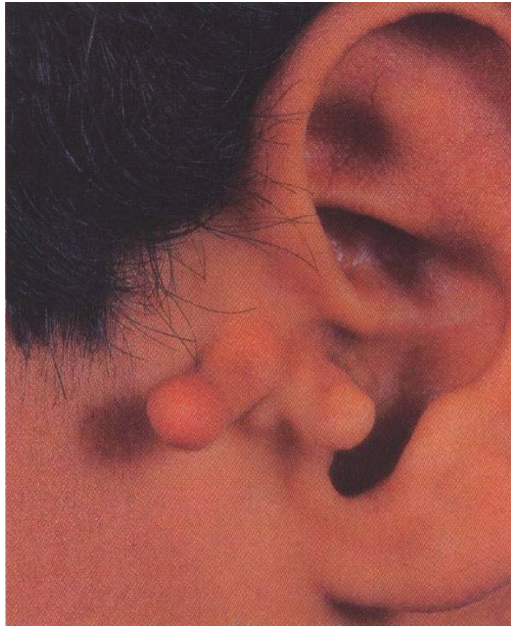
- 38300 Drainage of lymph node abscess or lymphadenitis, simple
- 38500 Bx or Excision of Lymph Node(s) open, superficial
- 38505 by needle, superficial
- 10021/10022 FNA without and with imaging guidance
- 38510 Bx/Excision LN, Deep cervical
- 38542 Dissection deep jugular node(s)

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Skin Tags

- Can occur anywhere
- ENT sees most commonly in preauricular area
 - sometimes called Hillocks or accessory lobules
- Excision is usually for benign reasons
- Cartilage may be found underlying these lesions

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Coding Excision

- 11200 removal with or without anesthesia up to 15 lesions any method
- what if there is cartilage in the base?

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Congenital Masses

- Hemangioma
- Lymphangioma
- Branchial Cleft Cyst/Sinus/Fistula
- Thyroglossal Duct Remnant
- Dermoid
- Laryngocele
- Saccular Cyst
- Esophageal Diverticulum/Duplication
- Cyst Bronchogenic
- Cyst Teratoma
- Thymic Cyst

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Hemangioma

- Most common neoplasm of childhood
- 10-12% of Caucasians
- Women 3: men 1
- Several types: cavernous, capillary, lobular
- Color/bluish helpful
- Compressable and mildly firm
- 90% involute by age 2 yrs
- Dx: physical exam, CT Scan, MRI
- Thx: observation, steroids, interferon, sclerosis, surgical intervention with laser or knife

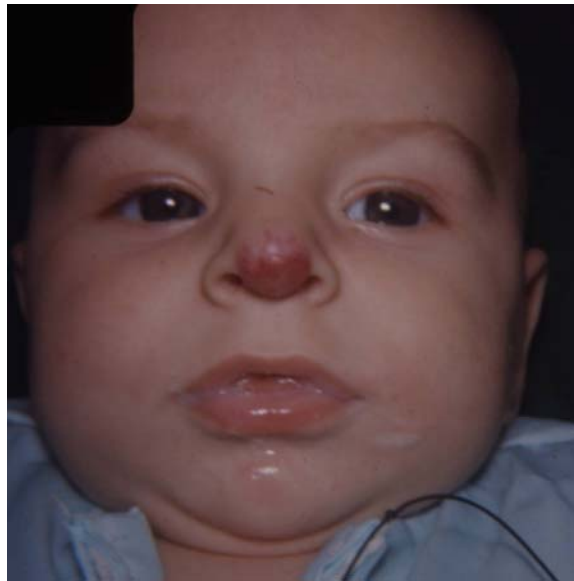
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Hemangioma

- Less commonly involve the airway
- Usually subglottic
- Size of airway lesion does not correlate with external lesions
- Symptoms appear within the first 8 weeks



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Coding Options

- Observation: All E&M Codes
- Biopsy: 11100 single including closures +11101 is more than one
- Laser: No good code!! 17000 likely one lesion and it could be huge and you may not be destroying but shrinking
- Sclerosis: 11900 Injection intralesional up to 7 lesions or 96405 intralesional chemo. or 38999 unlisted heme/lymph

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Coding Options con't

- Excise: benign lesion 11400's with size deciding if a graft or flap is needed or 17999 unlisted procedure skin/mucous membrane or subcutaneous tissue

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Lymphangioma

- Painless compressible mass
- Usually present by age 2 yrs.
- Growth continues
- Infection risks
- Associated with poor T cell function
- Sclerosis (macrocytic better results)
- Surgical Excision

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Coding for Lymphangioma Tx

- Sclerosis: again visit the 96405 or 38999 debate – not 11900 because deeper than the skin
- Excise: 38550 axial or cervical without deep neuromuscular dissection
- Excise: 38555 with neuromuscular dissection

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What about other components?

- Facial or Chest wall or Nasal?
- Do you add each of these separately for example: parotid dissection 42420 and a neck dissection or the lymphangioma code and parotid dissection

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Teratoma

- Frequently diagnosis is prenatal (EXIT procedures)
- Benign
- Three tissue types represented
- Compression causes problem

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Coding the Resection

- Neck Dissection Codes
 - 38700 Suprahyoid lymphadenectomy
 - 38720 Cervical lymphadenectomy (complete)
 - 38724 Cervical lymphadenectomy (modified)

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Return at End if Time

- Where do we go with intrauterine consults?

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Branchial Cleft Anomalies

- Think about arches and associated artery, nerve, and muscles
- 1st Arch has type I and II classification (Dr. Walter Work)
- 2nd is most common
- 4th is questionable existence
- If bilateral anomalies question Brachio-oto-renal Syndrome

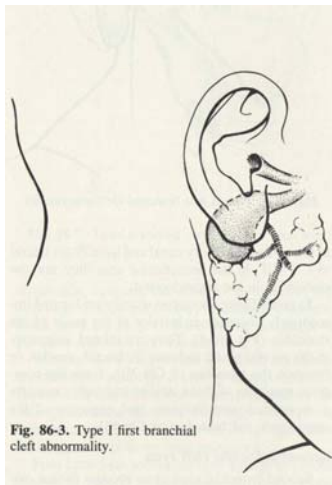
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BCA Con't

- Look over drawings...note travel lines. The keys to note are BCA I has type I short and to canal and type II thru parotid (work), BCA II between carotids and over both nerves, BCA III behind both carotids and between the nerves.

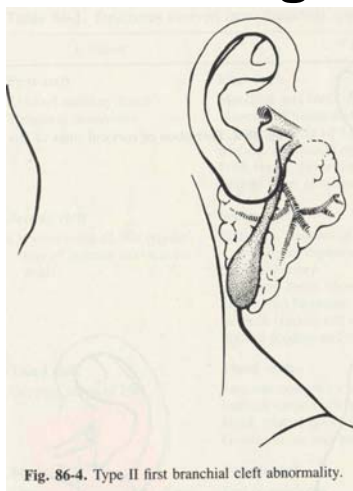
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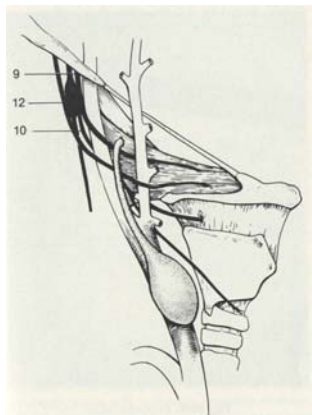


Fig. 86-6. Second branchial cleft cyst and sinus tract.

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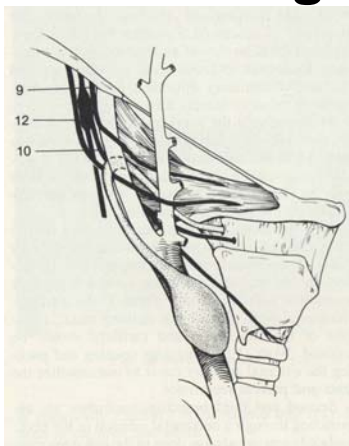
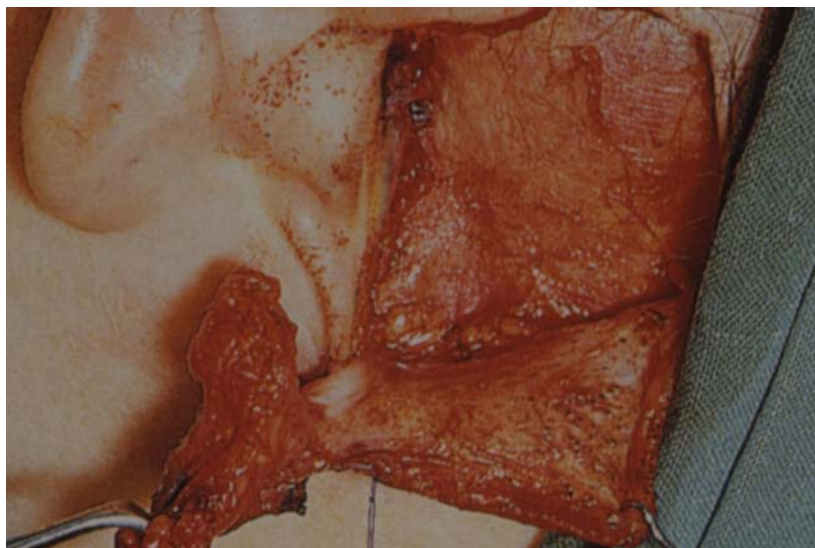


Fig. 86-7. Third branchial cleft cyst and sinus tract.

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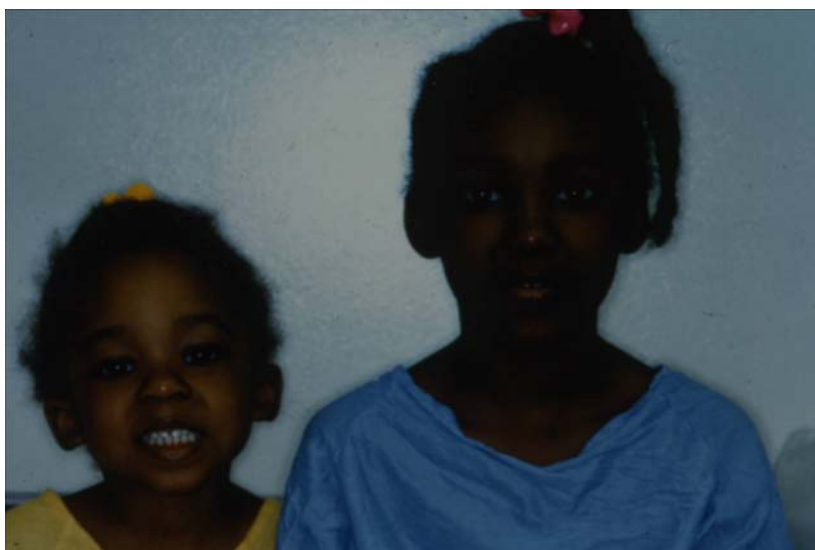
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Branchial Cleft Coding

- 42810 Exc. Branchial Cleft Cyst or Vestige (confined to skin and subcutaneous tissue)
- 42815 Exc. Branchial Cleft Cyst or Vestige (extending beneath subcutaneous tissue and/or into pharynx)
- What about the ones that necessitate a parotidectomy?
 - 42415 added on or instead of?

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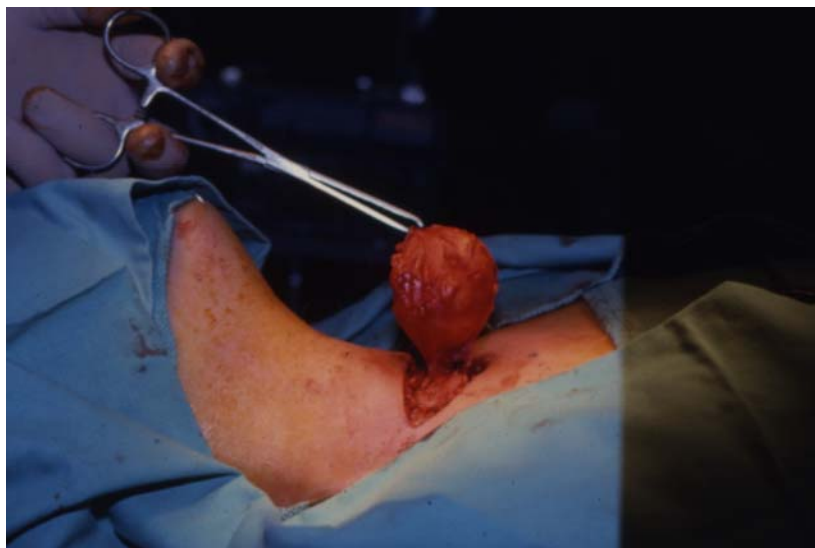
Thyroglossal Duct Cyst

- 0-5 years old (rare cases of later)
- Enlarges after a viral illness
- Controversy if need to verify normal thyroid
- Sistrunk procedure (1920 decrease recurrence from 40% to 10%)
- Recurrence rate increases after infection

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Thyroglossal Duct Cyst Excision Codes

- 60280 Exc. TGDC or Sinus
- 60281 Exc. Recurrent TGDC
- What to do with a recurrence that requires an anterior neck? 38542? (neck dissection) Bilateral? or is this a 38999 (unlisted heme/lymph) or a 21556 (excision tumor soft tissue neck, deep superficial, intramuscular)?

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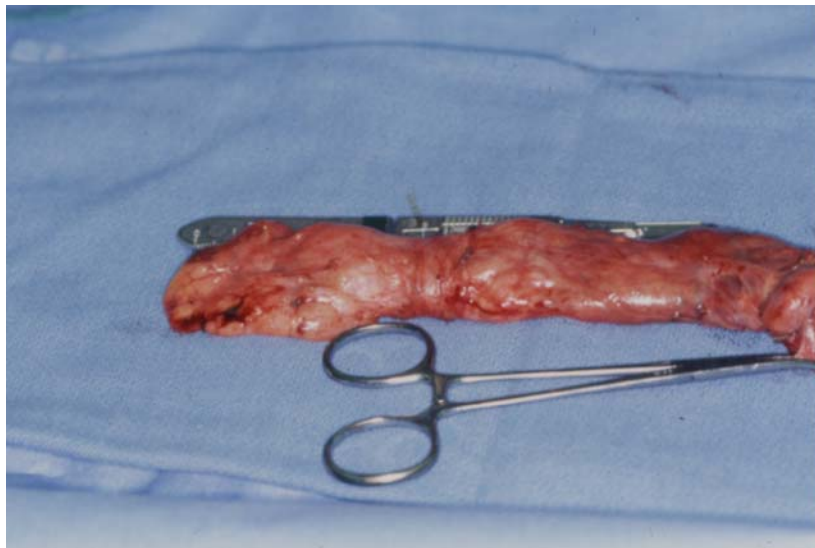
Thymic Cyst

- Occur from angle of mandible to midline of neck
- 3rd pharyngeal pouch is source of thymus

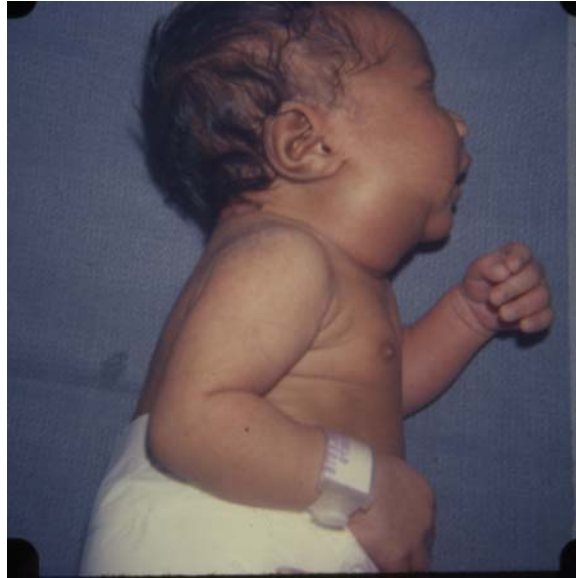
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Coding Thymic Cyst Excision

- 60520 Thymectomy partial or total transcervical approach

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Ranula

- Mucocele of FOM
- Can be minor gland, submandibular gland, or submandibular duct related
- Surgical excision usual
- New tx: sclerosis

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Rannula Coding

- 42408 Excision of sublingual salivary cyst
- 42409 Marsupulization of salivary cyst
- 42699 for sclerosis or the chemo code?
- ADD ON gland resections too!!!

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Dermoid

- Occur in midline anywhere in the body
- Benign growths
- Continuous growth
- Tends to attach to skin

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Dermoid Coding

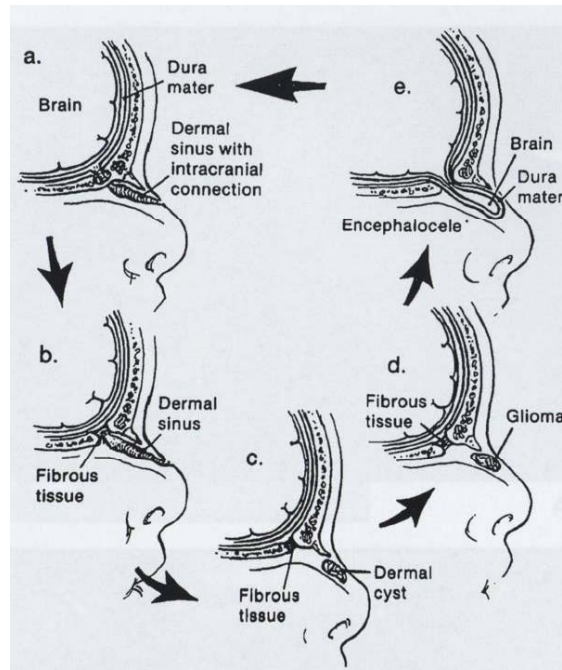
- 30124/5 NO!!! this is nasal dermoid
- 21555 Excision tumor soft tissue of neck or thorax subcutaneous
- 21556 Excision tumor soft tissue of neck deep or subfascial; intramuscular

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The THREE

- Need to be able to distinguish from each other
- Encephalocele
- Glioma
- Dermoid
- BE CAREFUL...no biopsy, until sure, no brain

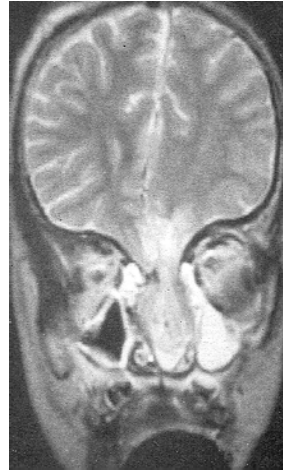
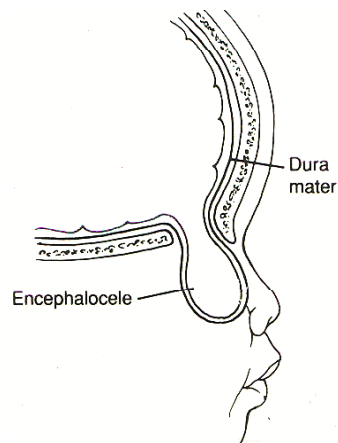
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Encephalocele

- Meninges and brain in hernia sac in nose
- Anterior neuropore failed to close
- Positive Furstenberg test
- Can have meningitis
- Have neurosurgery there too
- Often need CT and MRI

Encephalocele



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Sinusitis: Encephalocele

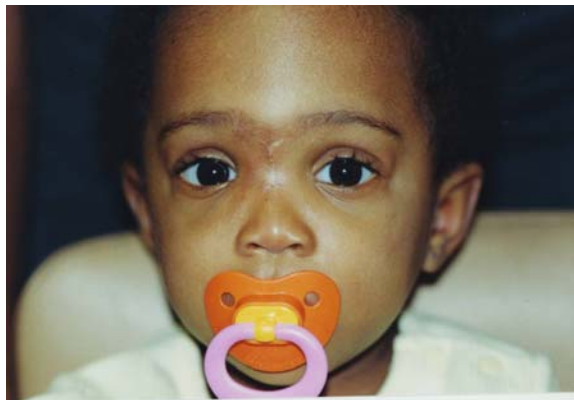


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Glioma

- Heterotopic glial tissue in nose
- 15% with dural stalk
- Negative Furstenberg test
- CT +/- MRI
- Consider Neurosurgery on standby

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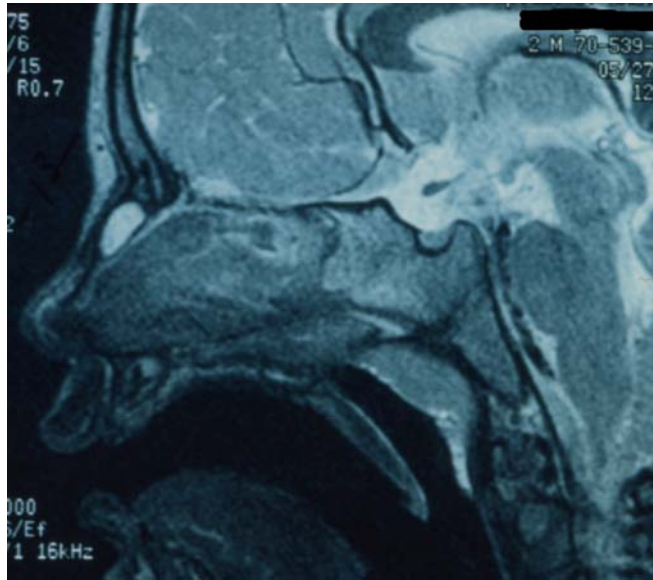
Dermoid

- Ecto and mesoderm: hair follicles, sebaceous glands
- Comes from division of dura and ectoderm
- Assoc. with nasal pit (+/- hair), can be intra or extranasal
- CT +/- MRI
- Consider Neurosurgery on standby

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A



B



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Fibromatosis Coli

- Infants within 6 weeks
- Within the body of the SCM
- Torticollis noted
- US can confirm
- PT may be needed
- Can cut SCM, but last resort

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Fibromatosis Coli Codes

- 21720 Division of SCM open operation (biopsy done too?)
- 64613 Botox injection

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Neurilemmoma

- Aka: benign schwannoma
- Women > men
- Lateral neck (other is middle ear and sinonasal)
- Solitary painless neck mass

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Chondroma

- Men > women
- Cricoid most common, then thyroid, arytenoid, and epiglottis
- Globus sensation, dysphagia, hoarseness
- Smooth round fixed mass
- CT, can see calcifications

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Paraganglioma

- Aka: carotid body tumor, chemodectoma
- Painless neck mass
- Slow growing
- Sx: neck mass, hoarseness, CN deficits
- Familial
- Multicentric

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Neurofibroma

- Benign peripheral nerve sheath neoplasm
- Not von Recklinghausen's disease (that is multiple)
- Sx's based on site of mass

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Hamartoma

- Benign tumor-like proliferation or overgrowth of tissue indigenous to a specific anatomic location

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Malignant Lymphoma

- Hodgkin's and non-Hodgkin's
- MALT (mucosa associated lymphoid tissue)
share: tendency to remain local, evolve slowly, Bcell
- Non-Hodgkin's: 2-12yrs, 50% of extranodal lymphomas in H&N, M>W, staged I-IV, includes Burkitt's
- Hodgkin's rare in <5yr, F:M=1:2, 90%intranodal, rare Waldeyer's ring

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Rhabdomyosarcoma

- Most common soft tissue malignancy of childhood (40% by age 5 yrs, 70% by age 12 yrs)
- Malignant tumor of skeletal muscle cells
- 19% of all sarcomas
- Most common sarcoma of kids, and most common in H & N
- Peds: 50% of all rhabo's in H&N
- Orbit>NP> ear> sinonasal

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Histiocytosis

- Langerhan's cells
- Eosinophilic Granuloma: monostotic, 50% diagnosis by age 5 yrs, good prog.
- Hand-Christian-Schuller Dis: multifocal lesions, chronic course, morbidity
- Letterer-Siwe Dis: disseminated histio. Usually dx. by 3yr, multiple organs, rapidly progressive to mortality, men > women

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Neuroblastoma

- Malignant tumor cells from neurofibromas
- 5% of sarcomas
- Surgery, chemo and XRT to treat
- 40% 5 year survival

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Fibrosarcoma

- Malignant tumor of fibroblasts
- 10-15% occur in H&N
- Nasal cavity > paranasal sinuses > larynx > neck
- Unencapsulated polypoid or sessile, white/tan firm tumor
- Can erode bone

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Tumors

- Biopsy of site
- Await pathology to help with appropriate choice of code

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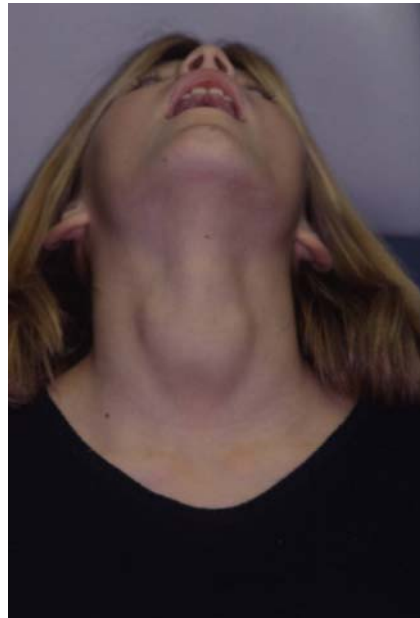
Thyroid Malignancies

- Think of MENs first
- Papillary is most common
- Usual F > M ratio

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Thyroid Codes

- 60300 Aspirate or Inject Cyst
- 60200 Excise Cyst
- 60210-60271 Thyroidectomy

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Squamous Cell Carcinoma

- Rare in children
- Grow fast and mets fast
- Tongue most common
- Follow adult tx protocols
- Coding follows site specific guidelines

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Parotid and Submandibular Tumors

- Rare except hemangioma or vascular malformations
- Follow protocols for adults

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Salivary Coding

- 42450 Sublingual Excision
- 42440 Submaxillary Gland Excision
- 42415-42426 Parotid Gland Excision

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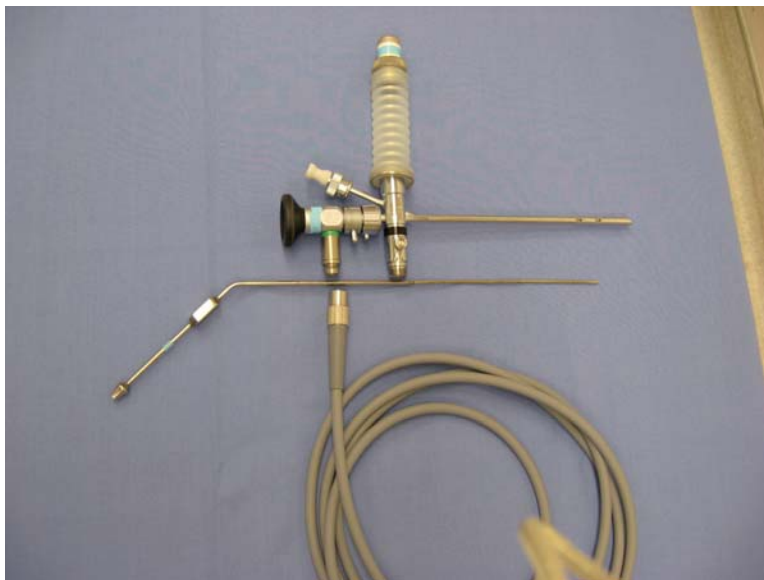
Multiteam Procedures

- Aerodigestive Team (all same tax id#)
 - Pulmonary: flexible bronchoscopy with BAL
 - Gastroenterology: EGD with Bx/ Colonoscopy
 - Otolaryngology: direct laryngoscopy, bronchoscopy and other interventions

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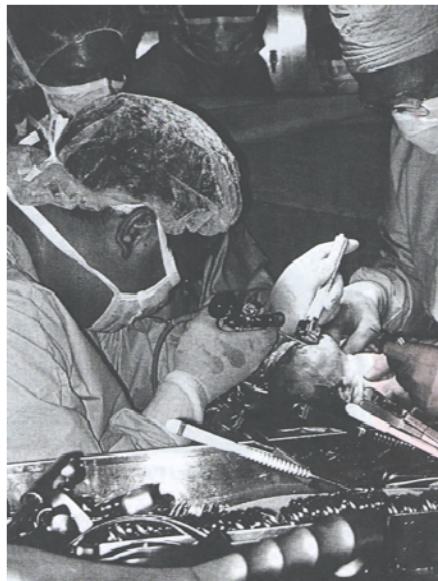
- Do not need two bronchs!
- Flexible and Rigid provide different information
- Done with different instruments
- Talk with your doctors about clearly documenting WHY both were of use or benefit for the patient

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Intrauterine Consults

- Usually requested because of concern of airway obstruction at birth and need for EXIT procedure
- No E/M of infant... cannot examine because *in utero*
- Hours of time looking at films, phone discussions, and meeting parents, and sometimes family answering questions... nothing can bill!!!

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Future

- Correct and COMPLETE diagnosis coding will help with showing more complex care
- Staff education to help capture diagnosis and ancillaries
- 100% offices with Superbills
- ICD-10, no one likes change :)

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Visualize Teamwork

- How does your office work?
- Staff help with catching coding doctor missed?
- Monthly, Quarterly meeting with staff educating them on coding?
- Superbills?
- E/M forms?
- Try something....can always try something else!!!

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It Takes a Team!



Peyton Manning
Children's Hospital
at St. Vincent

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