Does Your Nose Know When It's the Right Code?

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Global Surgical Package Definition

CPT vs. Medicare
What is included in the code for a procedure?

CPT	Medicare
Local infiltration, metacarpal/metatarsal/ digital block or topical anesthesia. Moderate (conscious) sedation may be reported as indicated in CPT.	Anesthesia of any kind given by the operating surgeon. Exception: moderate (conscious) sedation may be reported by the surgeon when appropriate.
Subsequent to the decision for surgery, one related E&M encounter on the date immediately prior to or on the date of procedure (including history and physical);	E&M in which the decision is made is separately billable. Visits to perform history and physicals are not separately reportable.
• Immediate postoperative care, including dictating operative notes, talking with the family and other physicians; • Writing orders; • Evaluating the patient in the post-anesthesia recovery area;	• Discussion with patient/family about the nature of the procedure, alternative treatment risks, benefits and other informed consent issues • Scheduling surgery • Writing preoperative admission notes and orders • Dictating the operative record • Writing postoperative orders and postoperative prescribed care

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Global Surgical Package Definition

CPT vs. Medicare
What is included in the code for a procedure?

CPT	Medicare
Postoperative pain management including catheter placement by operating surgeon	Postoperative pain management including catheter placement by operating surgeon
No mention about the number of days included in follow-up	**Major** procedure has a global period of 90 days **Minor** procedure has a global period of 0 or 10 days
Typical postoperative follow-up care	Follow-up care including **treatment of complications** unless they require a return to the operating room for the prescribed follow-up period

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Global Surgical Package Definition

From CPT Assistant, May 2009:

Q: *Are preoperative visits billable? If so, what code should be used and what is the time frame before surgery to submit this code?*

A: If the decision for surgery occurs on the day of or day before the major procedure and includes the preoperative evaluation and management (E/M) services, then this visit is separately reportable. Modifier 57, *Decision for Surgery*, is appended to the E/M code to indicate this is the decision-making service, not the history and physical (H&P) alone. If the surgeon sees a patient and makes a decision for surgery and then the patient returns for a visit where the intent of the visit is the preoperative H&P, and this service occurs in the interval between the decision-making visit and the day of surgery, regardless of when the visit occurs (1 day, 3 days, or 2 weeks), the visit is not separately billable as it is included in the surgical package.

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Endoscopic Sinus Surgery

CPT Code	Descriptor	2011 RVU-F	Global Period
31240	Nasal sinus endoscopy, surgical; with concha bullosa resection	4.83	0
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	8.23	0
31255	with ethmoidectomy, total (anterior and posterior)	12.06	0
31256	Nasal sinus endoscopy, surgical with maxillary antrostomy;	5.95	0
31267	with removal of tissue from maxillary sinus	9.56	0
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	15.22	0
31287	Nasal sinus endoscopy, surgical with sphenoidotomy;	6.99	0
31288	with removal of tissue from the sphenoid sinus	8.12	0

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Endoscopic Sinus Surgery

- May separately report 31240 for endoscopic resection of concha bullosa when appropriately documented (e.g., pre-op diagnosis, CT scan findings). Otherwise, middle turbinate surgery is included in the endoscopic sinus surgery codes.
- "Removal of tissue" = polyps, mucocele, fungus ball; not – "debris," mucous or pus.
- Do not report 31254 – 31288 with the new balloon dilation codes (31295-31297) for procedures on the same sinus.

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Endoscopic Sinus Surgery

- May report 31276 for the Draft I/IIA-B/III procedure where one can visualize the frontal sinus for exploration and proceed with removal of tissue from the frontal sinus (per AAOHNS).
  - A Draf I frontal sinusotomy would include removing the posterior wall of the Agger nasi cells, the superior attachment of the bulla lamella of the ethmoid bulla, and/or Type I and II frontal cells. This removes tissue obstructing the frontal sinus and is not part of the typical ethmoidectomy.
  - A Draf IIA frontal sinusotomy would include removal of a Type III frontal cell reaching into the frontal sinus.
  - A Draf IIB/III (endoscopic modified Lothrop) frontal sinusotomy not only reaches the ostium but enlarges it with punches, drills, etc.
  - Be sure to dictate name of specific "Draf" procedure to support use of 31276.

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Balloon Dilation in Endoscopic Sinus Surgery

New 2011!

CPT Code	Descriptor	2011 RVU	Global Period	May Report as Bilateral Procedure
● 31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g., balloon dilation), transnasal or via canine fossa	5.16 F 59.83 NF	0	Yes
● 31296	with dilation of frontal sinus ostium (e.g., balloon dilation)	6.16. F 112.02 NF	0	Yes
● 31297	with dilation of sphenoid sinus ostium (e.g., balloon dilation)	5.05 F 110.97 NF	0	Yes

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Balloon Dilation in Endoscopic Sinus Surgery

- New codes include fluoroscopy – do not separately report 76000.
- Do not report 31295 in conjunction with 31233, 31256, 31267 when performed on the same sinus.
- Do not report 31296 in conjunction with 31276 when performed on the same sinus.
- Do not report 31297 in conjunction with 31235, 31287, 31288 when performed on the same sinus.
- Non-facility RVUs are very high due to the practice expense incurred associated with purchasing the equipment.
- NOTE: Some payors consider this "experimental" or "investigational" and will not pay. This service may possibly be billed to the patient.

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Endoscopic Sinus Surgery/ Balloon Dilation Scenario

Surgeon Dictated

- Bilateral endoscopic maxillary antrostomies using forceps and microdebrider for removal of bone and mucosa
- Balloon catheter maxillery sinus ostia dilation technology under fluoroscopy.

Choose the correct code combination: _____

A	B	C	D
31256 31256-50 31295-51 31295-50	31299	31256 31256-50	31295 31295-50

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Stereotactic Computer Assisted Navigation (SCAN) in ESS

Out with the Old!!

+61795 (6.55 RVUs) was deleted in 2011.

In With the New!!

+61782 Stereotactic computer assisted volumetric (navigational) procedure, cranial, extradural (List separately in addition to code for primary procedure) (7.13 RVUs-F)

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SCAN Documentation Requirements per American Rhinologic Society

- Include in the "Indications for Surgery" paragraph the ***medical necessity*** of need for stereotactic guidance.
- Document pre-op surgical planning including downloading and verifying images.
- Document registration of data.
- Document instrument calibration.
- Document Target Registration Error (TRE).
- Document anatomic localization and confirmation during surgery.
- Include "endoscopic" approach and intra-operative computer findings.

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Endoscopic Sinus Surgery with InstraTrack Navigation Scenario

Surgeon Dictated:

- Revision bilateral endoscopic maxillary antrostomies with removal of polyps from within the maxillary sinus,
- Revision bilateral endoscopic total ethmoidectomies,
- Use of the InstaTrak stereotactic navigation system.

Choose the correct code combination: _____

A	B	C	D
31255	31254	31255	31255
31254-59	31254-50	31255-50	31267-51
31267-51	31267-51	31267-51	31267-50
31267-50	31267-50	31267-50	31254-51
+61795	+61782	+61782	+61795

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Endoscopic Sinus Debridement (31237)

Debridement defined…

- Debridement: The removal of foreign material, and devitalized, or infected tissue from or adjacent to a traumatic or infected lesion until surrounding healthy tissue is seen.
- Use CPT 31237 to report post-operative endoscopic debridements performed outside the global surgery period following FESS.
- Following intranasal procedures performed endoscopically, particularly those involving the paranasal sinuses, inspection and debridement of the operative sites are, in most instances, considered the standard of care. Accumulation of clots and crusts are felt to contribute to postoperative synechia (scar) formation and delay return of function to the native ciliated mucosa.

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Endoscopic Sinus Debridement (31237)

Debridement defined…

- Presence of such material along with retained blood and secretions likely contributes to post-operative residual or recurrent infection. Debridement is usually performed at least once in the post-operative period.
- Although the exact number of post-operative débridements depends on the surgeon's judgment, most patients require four or fewer. If performed outside of the global surgical period, report 31237 without a modifier each time a debridement is performed.
- Do not use CPT 31237 for non-endoscopic nasal sinus debridements.

Remember: Do not report an E&M code with 31237 unless there is also a significant, separately identifiable service provided (e.g., a different diagnosis such as acute otitis media).

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Endoscopic Sinus Debridement

ICD-9-CM Code(s):

1. 473.2 Chronic Ethmoid Sinusitis
2. 473.0 Chronic Maxillary Sinusitis

CPT Code/ Modifier(s)	Description	ICD-9-CM Code	RVU-NFs Reported	Expected RVUs-NF Paid
OR				

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Modifier 50: Bilateral Procedure

Do:	Don't:
• Use to identify that a code was performed bilaterally. • Use format payor requires.. • Watch reimbursement closely! • Do expect 100% reimbursement on first procedure and 50% reimbursement on second procedure. (Except for add-on and exempt codes—where reimbursement for bilateral procedure would be expected at 100% of allowable.)	• Allow the carriers to "forget" to reimburse appropriately for bilateral procedures. • Use when the CPT procedure code states "unilateral or bilateral" (e.g., 69210).

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Endoscopic Sinus Debridement During Post Op of Septoplasty or Other Unrelated 90 Day Global Period Surgery

ICD-9-CM Code(s):

1. 473.2 Chronic Ethmoid Sinusitis
2. 473.0 Chronic Maxillary Sinusitis

CPT Code/ Modifier(s)	Description	ICD-9-CM Code	RVU-NFs Reported	Expected RVUs-NF Paid
OR				

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Modifier 79: Unrelated Procedure, Same Physician During Post-Op Period

DO:

- Use when the patient has a procedure in the post-op period that is unrelated to the original procedure.
- **Use different (unrelated) diagnosis and make it the primary diagnosis**
- Not use for treatment of complications

Remember:

- Protects procedure from being bundled into the global surgical package.
- Only necessary if the unrelated surgery is **within** the global period.

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Common Codes for Snoring/Sleep Apnea

CPT Code	Description	2011 RVU - F	Global Period
21685	Hyoid myotomy and suspension	29.65	90
30140	Submucous resection	12.77	90
41512	Tongue base suspension, permanent suture technique	18.39	90
41530	Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session	94.85 NF 12.03 F	90
42145	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)	21.03	90
42826	Tonsillectomy with Adenoidectomy	7.55	90
21199	Osteotomy, mandible, segmental; with genioglossus advancement	30.13	90

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Snoring/Sleep Apnea Procedures

- Don't forget to use separate diagnoses for these procedures such as turbinate hypertrophy, tonsillar hypertrophy, deviated septum, etc.
- **Note:** Many payors do not reimburse for 41512 or 41530. Obtain written prior authorization.
- NF RVUs for 41530 are high because the physician assumes the practice expense for performing the procedure (e.g., radiofrequency probe).

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Snoring/Sleep Apnea Scenario

- Septoplasty,
- Bilateral submucosal inferior turbinate reduction using radiofrequency,
- Coblation of the tongue base,
- Tonsillectomy,
- Uvulopalatopharyngoplasty

Choose the correct code combination: _____

A	B	C
42145 30520-51 41530-51 42826-51 30140-52, 51 30140-52, 50	42145 30520-59 41530-59 42826-59 30802-59	42145 30520-51 41530-51 42826-59 30802-51

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Neck Dissections

- 38720 = complete or radical neck dissection
- 38724 = modified radical, functional, or selective neck dissection
- 38700 = suprahyoid (level I nodes only)
- It is appropriate to report a neck dissection code (e.g., 38724) with a direct laryngoscopy (e.g., 31525) if both are performed.
- Be sure to document lymph node removal.
  Alert: There is no CPT code for only a "neck dissection"!
- Do not use a primary procedure code if it includes a radical neck dissection and you've done a modified radical neck dissection.

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Laryngectomy/ND Scenario

Otolaryngologist performs total laryngectomy with bilateral modified radical neck dissections and tracheostomy.

31360= Total Laryngectomy without RND
31365= Total Laryngectomy with RND
31600= Tracheostomy, planned

Choose the correct code combination: _____

A	B	C	D
31365 31365-50 31600-51	31365 38724-59 31600-51	31360 31360-50 31600-51	31360 38724-59 38724-50,59

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Cerumen Removal

Code	Description	2011 RVU-F	2011 RVU-NF
69210	Removal impacted cerumen (separate procedure), 1 or both ears	0.96	1.47

Adapted from CPT Assistant, July 2005 page 14

Three scenarios:

1. The patient presents to the office for the removal of "ear wax" by the nurse via irrigation or lavage.

   Report an E&M code – not 69210

2. The patient presents to the office for the removal of "ear wax" by the primary care physician via irrigation or lavage.

   Report an E&M code – not 69210

3. The patient presents to the office for "ear wax" removal as the presenting complaint.

   Report 69210 if the patient had a cerumen impaction and the removal required physician work using at least an otoscope (or other magnification such as a microscope) and instrumentation (such as wax curettes, forceps, suction) rather than simple lavage.

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Cerumen Removal

A major element in determining whether code 69210 should be reported is understanding the definition of *impacted cerumen.* By definition of the AAO-HNS,

"If any one or more of the following are present, cerumen should be considered 'impacted' clinically:

- Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
- Qualitative considerations: Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.
- Inflammatory considerations: Associated with foul odor, infection, or dermatitis.
- Quantitative considerations: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills."

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Cerumen Removal

Cerumen Removal

According to CMS, payment for the removal of cerumen will be made only when **all** of the following criteria are met:

1. The service is the sole reason for the patient encounter;
2. Service is personally performed by a physician or non-physician, (i.e., nurse practitioner, physician assistants, clinical nurse specialist);
3. Service is provided to a patient who is symptomatic; and
4. The documentation illustrates significant time and effort spent in performing the service.

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Cerumen Removal

What about using G0268 (Removal of impacted cerumen on the same day as audiologic function testing)?

According to CMS, payment for the removal of cerumen will be made only when **all** of the following criteria are met:

Q: So, is it still necessary for the physician to use G0268 or can s/he bill 69210?

A: It should not be necessary on Medicare claims since audiologists now file a separate claim that the physician. However, other payers who do not separately credential audiologists may continue to require use of G0268 to distinguish provider services.

Check with your local Medicare carrier, and other payers, to determine their payment policies.

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Cerumen Removal

Scenario	CPT Code
1. Established patient makes appointment for earwax removal. You see the patient every 3-4 months because he wears hearing aids. The cerumen is impacted and you use a microscope, curette and suction for removal	

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Cerumen Removal

Scenario	CPT Code
2. Patient is here for a recheck. He has had problems in his right ear with wax buildup and comes in for regular cleaning. I last saw him six months ago. On exam under the operating microscope the right ear has wax and skin preventing ability to visualize the TM. This was removed using a small alligator forceps. Drum appears to be intact but there was significant tympanosclerosis. The left side showed mild cerumen impaction in the lateral drum. This was moved. Diagnosis: Cerumen impaction Plan: Follow up in one year	

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Cerumen Removal

Scenario	CPT Code
3. The physician removes impacted cerumen prior to the audiologist doing a comprehensive audiogram.	Physician: Audiologist:

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Cerumen Removal

Scenario	CPT Code
4. Established patient comes in for a regular 6-month impacted cerumen removal visit. You remove the bilateral cerumen impactions as usual. Then the patient complains of yellow drainage from his nose and pressure over his sinuses. You evaluate these symptoms and prescribe antibiotics for his acute sinusitis.	

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Operating Microscope vs Binocular Microscopy

Code	Description	2011 RVU-F	2011 RVU-NF
+ 69990	Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)	6.48	N/A

Tips for Use of 69990

- 69990 is an "add-on" code, which means it must be reported with a primary procedure and is not subject to a multiple procedure discount formula
- May separately report when procedure warrants, and there is documented, microdissection / microsurgical techniques.
- Do not append a modifier 51 (multiple procedure) when reporting 69990 with a primary procedure, as 69990 is an "add-on" code
- Do not report 69990 for visualization with loupes
- Do not report 69990 in addition to procedures where use of the operating microscope is an inclusive component

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Operating Microscope vs Binocular Microscopy

Code	Description	2011 RVU-F	2011 RVU-NF
92504	Binocular microscopy (separate diagnostic procedure)	0.29	0.89

Tips for Binocular Microscopy (92504):

- Document medical necessity of need for microscope exam versus otoscope exam when 92504 is reported separately
- 92504 is a separate diagnostic procedure code, thus is not reported during the same session as other auditory system codes (cerumen removal, myringotomy, tubes) and all otology codes (69xxx)
- May report 92504 for insertion of ear wicks using binocular microscopy if no other surgical auditory system codes are reported

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Intratympanic/Transtympanic Injections

Revised in 2011

Parameter	2010	2011
69801 Code Descriptor	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal (69801 includes all required infusions performed on initial and subsequent days of treatment)	Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal (Do not report 69801 more than once per day) (Do not report 69801 in conjunction with 69420, 69421, 69433, 69436 when performed on the same ear)
RVUs	19.64 F NA NF	5.94 F 8.92 NF
Global Period	90 days	0 days

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Canalith Repositioning Procedure

Updated in 2011

95992 Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day

- 2010: 1.05 RVUs-F, 1.16 RVUs-NF. Also in 2010, Medicare assigned this code a payment indicator of "I" for "not valid." In 2009, the payment status was "B" (bundled) – it has not been separately paid since the code was implemented in 2009.
- 2011: Medicare now considers this to be an "active" CPT code and it should be paid to physicians. 1.12 RVUs-F, 1.25 RVUs-NF.

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Tympanostomy Tube Placement

Type of Anesthesia

- 69433: Local or topical
- 69436: General

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Tympanostomy Tube Removal

- Use 69424 - Ventilating tube removal requiring general anesthesia
- Code has a 0-day postoperative global period
- May be reported with modifier 50 if performed bilaterally
- Tube removed without general anesthesia may be reported with an E&M code, 92504 (binocular microscopy), or other appropriate code. It is not a "foreign body removal" (69200-69205).

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Thank You!

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