Find Out When to Report Dissections Separate From Thyroidectomy

Heads up: “Functional,” “selective,” and “radical” refer to the same procedure.

Thinking you know thyroidectomy codes through and through may set you up for disaster. You really have to study the code descriptors and know the terminology associated with neck dissection to accurately code these procedures.

Tip: When coding for thyroidectomy procedures (60240-60271), keep a close eye on the code descriptors. “Many of them include all of the procedures that the otolaryngologist performed, so you won’t have to report additional codes for the auxiliary services,” says Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J.

Decide Whether to Report Dissections

Challenge yourself with the following examples.

Suppose your otolaryngologist removes both thyroid lobes with the isthmus and pyramid lobe tissue. He also identifies and excises all enlarged lymph nodes. The malignancy has not spread significantly, so the otolaryngologist excises only a few selected lymph nodes. As a result, he performs a thyroidectomy with limited neck dissection. What CPT code(s) should you report, and should you report a separate code for the dissection?

Answer 1: You should report only 60252 (Thyroidectomy, total or subtotal for malignancy; with limited neck dissection). You should not report a separate code for the dissection. This code includes reimbursement for the thyroidectomy and the limited dissection.

What if the physician states in the operative note that she performed a “central neck dissection?” What would you code in this situation?

Answer 2: A central neck dissection is similar to the example above and represents a limited neck dissection, not a radical neck nor a modified radical neck dissection. So, if it is stated that a central neck dissection is performed with a total thyroidectomy, you would report 60252 (Thyroidectomy, total or subtotal for malignancy; with limited neck dissection).

Let’s try another example. During a total thyroidectomy, an otolaryngologist dissects all the levels of lymph nodes and must sacrifice the spinal accessory nerve, jugular vein and sternocleidomastoid muscles to remove a malignant lymphatic chain. What CPT code(s) should you report, and should you report a separate code for the dissection?
Answer 3: In this case, report only the thyroidectomy with radical neck dissection with 60254 (*Thyroidectomy, total or subtotal for malignancy: with radical neck dissection*). By definition, you shouldn’t separately report the radical neck dissection (38720, *Cervical lymphadenectomy [complete]*).

CPT, however, throws you a curve ball when your physician combines thyroidectomy with modified radical neck dissection. None of the thyroidectomy codes specify this combination, which you’ll have to code out separately.

Suppose an otolaryngologist removes both thyroid lobes. But when removing a malignant lymphatic chain, she manages to preserve the spinal accessory nerve, jugular vein, and sternocleidomastoid muscles. What CPT code(s) should you report, and should you report a separate code for the dissection?

Answer 4: Because CPT doesn’t include a code for the thyroidectomy with modified radical neck dissection, you should report 60240 (*Thyroidectomy, total or complete*) with 38724 (*Cervical lymphadenectomy [modified radical neck dissection]*). In a modified radical neck dissection, the surgeon dissects all levels of the lymph nodes on one side of the neck but spares the sternocleidomastoid muscle, the spinal accessory nerve, and the jugular vein. If your payer denies the 38724 as bundled, add modifier 59 (*Distinct procedural service*) to indicate that the modified radical neck dissection is separate procedure and appeal. Point out that you cannot use the bundled CPT code (60254) because the physician did not perform a radical neck dissection. Codes 60240 and 38724 reflect what the physician performed.

Don’t forget to use modifier 50 (*Bilateral procedure*) if the physician performs the modified radical neck dissection bilaterally.

Watch Out for Other Terms

Although op report titles clue you into how to code a procedure, otolaryngologists may use several monikers for a modified radical neck dissection.

For instance, “functional neck dissection is the same as a modified radical neck dissection,” Cobuzzi says. Another name your surgeon might use is selective neck dissection. The code for these is 38724.

Surprise: Instead of “neck dissections,” CPT uses the terminology “lymphadenectomies,” which fall under three codes:

> 38700 — *Suprahyoid lymphadenectomy*
> 38720 — *Cervical lymphadenectomy (complete)*
> 38724 — *Cervical lymphadenectomy (modified radical neck dissection)*.

Suppose, an otolaryngologist removes the lymph nodes as well as the sternocleidomastoid muscle, the spinal accessory nerve, and the internal jugular vein. This is a radical neck dissection (38720). Note that you should report 38700 when the surgeon removes the nodes above the hyoid only.
Pay Attention to E/M Levels, G Modifiers, and More, OIG Warns

Check your compliance on the areas in the 2012 Work Plan before OIG does.

Every practice knows that with payer audits and recoupment requests coming in, now is the time to step up your compliance but where do you start? The HHS Office of Inspector General (OIG)’s 2012 Work Plan, released on Oct. 5 can point you in the right direction.

The OIG has some big plans next year for reviewing Part B claims, and they span the whole spectrum of issues, according to the OIG. Get to know these hot buttons with this rundown.

Review Incident-to Billing Requirements

The OIG intends to determine whether payment for incident to services showed a higher error rate than non-incident to services. “Incident-to services represent a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record,” the Work Plan notes. “They may also be vulnerable to overutilization and expose Medicare beneficiaries to care that does not meet professional standards of quality.”

Best practice: Don’t bill incident to — in the name and NPI number of the physician — unless you are sure you’ve met the requirements. To qualify for incident to, the physician must have seen the Medicare patient during a prior visit and established a clear plan of care. If the non-physician practitioner (NPP) is treating a new problem for the patient, or if the physician has not established a care plan for the patient, then you cannot report the visit incident to and must bill the service under the NPP’s own NPI number.

In addition, when meeting the requirements for a follow-up to an established plan of care, if the physician does not directly supervise the NPP, the incident-to rules do not apply. Direct supervision means a supervising physician must be immediately available in the office suite. The supervising physician, however, does not necessarily need to be the same physician who established the patient’s care plan.

Watch out: The NPI used must be the NPI of the physician present in the office suite and supervising the NPP. Submission of the incident to services under the physician’s NPI who created the plan of care, but is not directly supervising the care (not present in the suite), even though there is another physician present in the office, is still a violation of the incident to regulations.

Pay Attention to Assignment Rules

When a physician accepts assignment with Medicare, he agrees to accept the Medicare-allowed amount from the carrier as the full charge for the service provided. In 2012, the OIG plans to review “to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare.”

Best practice: Confirm with your billing department or contractor that you aren’t inappropriately billing any excess patient balances to the beneficiary.

Review Your E/M Coding Practices

The OIG indicates in its Work Plan that it intends to review E/M claims to identify trends between 2000 and 2009, and to determine which providers “exhibited questionable billing for E/M services in 2009.”

(Continued on next page)
In addition, the OIG will review the number of E/M services that physicians provided during global surgery periods, and will review claims for which physicians appended a modifier so they could separately collect for E/M visits during the global period.

**Rule of thumb:** Don’t bill separately for E/M-related services relating to the original surgery during the global period. The global surgical package includes routine postoperative care during the global period. You should only append modifier 24 *(Unrelated evaluation and management service by the same physician during a postoperative period)* to an appropriate E/M code when an E/M service occurs during a postoperative global period for reasons unrelated to the original surgical procedure.

For a Medicare patient, you cannot use modifier 24 for services related to complications in the global period, because Medicare does not pay for complications in the global unless they require a return to the operating room. (This is different than defined in AMA CPT).

**Stay Up to Date on Hospital Observation Service Coding Rules**

The OIG has determined that improper use of observation services “may subject beneficiaries to high cost sharing,” and intends to review claims for outpatient observation visits to assess the appropriateness of the services.

Stay on top of CMS’s often-changing observation coding rules. For instance, CMS recently clarified how to use subsequent observation care codes 99224-99226 in *MLN Matters* article MM7405, in which the agency noted that these codes should only be used by the “treating physician.” CPT rules allow any physician seeing the patient in an observation setting (not a consultation) to then utilize the subsequent observation codes.

**Differentiate ‘G’ Modifiers Correctly**

The OIG intends to review Medicare payments for claims that included the “G” modifiers (GA, GZ, GX, GY) to indicate that a Medicare denial was expected. Often, these modifiers are used in tandem with an advance beneficiary notice (ABN). In the past, the OIG has found that Medicare inappropriately paid millions for services or supplies that should have been denied.

**Key:** Know the differences between the “G” modifiers with the chart below.

**Learn more:** To read the OIG’s complete Work Plan, visit [http://go.usa.gov/93X](http://go.usa.gov/93X).

<table>
<thead>
<tr>
<th>Modifier</th>
<th>ABN Signed?</th>
<th>What does the modifier mean?</th>
</tr>
</thead>
</table>
| GA       | Yes         | **Definition:** Waiver of liability statement issued as required by payer policy, individual case  
**Meaning:** Medicare covers the service only under certain circumstances, and you expect Medicare to deny the service as not reasonable and necessary in this case. When you use this modifier, you expect your practice to hold the patient financially responsible for the service if Medicare denies the claim, because you have a signed ABN. |
| GX       | Yes         | **Definition:** Notice of liability issued, voluntary under payer policy  
**Meaning:** Medicare never covers the service (statutorily excluded), but you got the patient to sign an ABN anyway. You will get an automatic denial from Medicare, and then you can submit a claim to a secondary payer. The patient is fully responsible for the charges |
| GY       | No          | **Definition:** Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit  
**Meaning:** Medicare never covers the service (statutorily excluded), and the patient is always responsible for the service. You didn’t have to get an ABN, and you’re adding the modifier to get a denial from Medicare so secondary insurance might pay. |
| GZ       | No          | **Definition:** Item or service expected to be denied as not reasonable and necessary  
**Meaning:** The service is not medically necessary under Medicare rules based on the frequency or other coverage criteria such as payable diagnosis. The practice did not obtain an ABN, so the practice is responsible for the charges and can’t bill the patient or secondary insurance. |
ICD-10

Uncomplicate Your Mumps Diagnosis by Shifting to B26.9 in 2013

Cheer for this 1-to-1 correlation.

Mumps is a virus common in children that can lead to fever, headache, muscle aches, tiredness, and loss of appetite. Swelling of the salivary glands follows these symptoms. No treatment is available for mumps, but the measles-mumps-rubella (MMR) vaccine can prevent it. Right now, you’ll report this condition with 072.9 (Mumps without complication).

After October 1, 2013, you will report B26.9 (Mumps without complication) instead. Notice how the code descriptors are the same.

Documentation: When a patient presents to the office with mumps, the otolaryngologist should immediately assess the damage and find an appropriate treatment. The physician bases her diagnosis on symptoms, personal medical history, and physical exam. A patient with this condition usually does not require any test.

Coder tips: Mumps is one cause of glomerulonephritis. In general, the condition lasts about 10-12 days and has no specific treatment.

For administration of the MMR vaccine to a child aged 18 years and younger, you would bill 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component) and two units of 90461 (... each additional vaccine/toxoid component [List separately in addition to code for primary procedure]) for the vaccine’s three components (measles, mumps and rubella).

Reader Questions

Avoid 99211 With 96372 at All Costs

Question:
If a patient pays for her medicine and goes to our nurse to give the injection, we can bill 96372 (Therapeutic, prophylactic or diagnostic injection ...). But CPT says we should bill 99211 (Office or other outpatient visit ...) if this visit takes place without physician supervision. We used to bill an E/M code but stopped when we were told at a coding seminar a few years ago that we could not do this. What should we report?  

South Carolina Subscriber

Answer:
You cannot ever bill 99211 with 96372. You have two options:

Option 1: You bill 96372 for the injection if a supervising provider is present in the office.

Option 2: You bill 99211 instead if no supervising provider is present in the office. You should interpret “supervising provider” to mean any qualified supervising care giver who can bill in their own right. This rule would only apply when a registered nurse (RN) is giving the injection, not the ENT, nurse practitioner (NP), or physician assistant (PA).

Heads up: You will also incur another problem if the RN gives the injection and you have no one who can supervise or is qualified to supervise if something goes wrong (called malpractice risk). And if this patient was a Medicare patient and you have no supervision, you should count this visit as a nonbillable event.

You Be the Coder

31295, 31256: Different Sides Warrant Modifier 59

Question:
My ENT doctor did bilateral frontal sinuplasty and nothing else on the frontal sinuses, so I was thinking 31296-50 should be the correct code. But in his operative report, he states bilateral maxillary sinuplasty with partial removal of uncinctomy on the left. Am I correct in thinking he cannot charge for the sinuplasty because he did the partial uncinctomy on the left? Can he charge a 31295 for the right and a 31256 on the left?  

Kentucky Subscriber

Answer: See page 7.
Find Out If You Can Submit 31238 and 31231 Together

**Question:**
Can I report 31238 and 31231 together and be paid for both?

**California Subscriber**

**Answer:**
No, the Correct Coding Initiative (CCI) bundles these codes. Code 31231 (Nasal endoscopy, diagnostic, unilateral or bilateral [separate procedure]) is a separate procedure, which means that it is inclusive with any other procedure done in the sinuses. Additionally, a diagnostic scope is considered inclusive to control of epistaxis, any method. That includes any functional scope procedures (such as 31238, Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage).

The only reason a payer would pay for both these codes is if you indicate that these procedures took place at separate session. For instance, suppose the ENT does the diagnostic scope in the morning, and then he sees the patient for the epistaxis in the ER in the evening and uses the scope to control the bleed. In that case, you can bill both codes because the physician performed them at different session. You would have to apply modifier 59 (Distinct procedural service). You would bill 31238, 31231-59 since 31231 is the column 2 code.

**Note:** You cannot apply modifiers RT, LT (Right side, Left side) to break the bundle, because 31231 is “unilateral or bilateral,” according to the descriptor.

Check CMS For Bilateral Status Indicator

**Question:**
Can I bill 69801 bilaterally?

**Florida Subscriber**

**Answer:**
Yes. Code 69801 (Labyrinthotomy, with perfusion of vestibuloactive drug[s]; transcanal) is a valid bilateral procedure, meaning you can apply modifier 50 (Bilateral procedure). If you check CMS, you will see 69801’s bilateral status is “1,” and the description for Status 1 is “150% payment adjustment for bilateral procedures applies.”

No Exact ICD-9 Code? Refer to Closest Diagnosis Equivalent

**Question:**
My otolaryngologist saw a patient for “ciliary dyskinesia.” This condition occurs in the nasal passages and leads to problems with chronic sinus infections. What diagnosis code should I report?

**South Carolina Subscriber**

**Answer:**
You won’t find an exact diagnosis code for this condition. Everything in ICD-9 about ciliary is linked to the eye, neoplasms, or syphilis. Therefore, you should use either chronic sinusitis (473.x) and/or 478.19 (Other diseases of the nasal cavity and sinuses).

Count ‘No Fever’ in ROS

**Question:**
I have found information and heard at seminars conflicting information regarding the Associated Signs and Symptoms in the HPI section of the 1997 audit guidelines. Does a negative response count toward the HPI points? Example: A patient presents with complaint of sinus pain. The note states that the patient has no fever. Because the provider asked about the symptom and the response was negative, should I check the associated signs and symptoms box, or should I assign no credit?

**Colorado Subscriber**

**Answer:**
The lack of fever represents a pertinent negative in this example, but not under the history element you think it does. The 1997 “Documentation Guidelines for E/M Services” does not reference pertinent negatives in the context of the history of present illness (HPI). Instead, it references pertinent negatives in the context of the review of systems (ROS).
Impact: When the note contains a pertinent negative, such as the patient has no fever, do not check the associated signs and symptoms box of HPI. Instead, you should count the statement toward the review of the relevant system (constitutional symptoms, e.g., fever in this example) under the ROS because this is a pertinent negative for ROS.

Tackle This Tonsillectomy and Adenoidectomy Scenario

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

Answer: No. Regardless of whether the patient previously had adenoids removed, you should instead use a tonsillectomy and adenoidectomy (T&A) code based on the patient’s age:

- 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 consider separately reporting the procedures using a tonsillectomy and an adenoidectomy code — such as 42825 (Tonsillectomy, primary or secondary; younger than age 12) and 42835 (Adenoidectomy, secondary; younger than age 12) — unbundling. You only code a secondary adenoidectomy for removal of secondary regrowth when the secondary adenoidectomy is the only procedure performed, and the tonsils are not removed.

Correct

In the article, “CPT® 2012: Is Your Audiologist Performing OAE Testing? Check Out New Code” featured in the Otolaryngology Coding Alert, volume 13, number 12, you’ll see a typo.

Debbie Abel, Au.D., director of reimbursement and practice compliance, American Academy of Audiology in Reston, VA, references new code 92558 (Evoked otoacoustic emissions, screening [qualitative measurement of distortion product or transient evoked otoacoustic emissions], automated analysis) that will describe the automated analysis of evoked OAE.

She says, “I’m not happy about reimbursement (or lack of) that they will receive, especially 92588.” This quote is supposed to refer to the reduction for the new code for automated OAE (92558) only, not 92587 and 92588. Their reimbursement remains the same.

To add some further information, the new code for 2012 (92558) is for automated analysis, which gives a pass/fail result. This service will probably be performed in a pediatrician’s or family practitioner’s office. Patients with a “fail” result will then be referred to an otolaryngologist for further evaluation.
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Mary Compton, PhD, CPC
maryc@codinginstitute.com
Editorial Director and Publisher

Suzanne Leder, BA, M.Phil., CPC, COBGC
suzannel@codinginstitute.com
Executive Editor

Jennifer Godreau, CPC, CPMA, CPEDC
jenniferg@codinginstitute.com
Content Director

Barbara J. Cobuzzi, MBA, CENTC,
CPC-H, CPC-P, CPC-I, CHCC
Consulting Editor

Suzanne Leder, BA, M.Phil., CPC, COBGC
suzannel@codinginstitute.com
Executive Editor

Mary Compton, PhD, CPC
maryc@codinginstitute.com
Editorial Director and Publisher

Jennifer Godreau, CPC, CPMA, CPEDC
jenniferg@codinginstitute.com
Content Director

Barbara J. Cobuzzi, MBA, CENTC,
CPC-H, CPC-P, CPC-I, CHCC
Consulting Editor

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