ESSENTIALS OF CODING FOR THE NON-CODING MANAGER

Sponsored by:
Association of Otolaryngology Administrators Annual Meeting
Chicago, Illinois

Presented by:
Kim Pollock, RN, MBA, CPC, CMDP

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KIM POLLOCK, RN, MBA, CPC, CMDP
CONSULTANT AND SPEAKER

- Nationally recognized otolaryngology coding and documentation expert
- Expert in analyzing chart documentation and in reengineering practices to enhance the reimbursement process.
- Understands the complexity of coding and reimbursement issues specific to surgeons.
- Improving the revenue cycle for practices having worked with hundreds of practices in her almost 20 years of consulting.
- Former board member of both the Society of Otorhinolaryngology and Head-Neck Nurses and the Ear, Nose and Throat Nursing Foundation
- Recipient of the Presidential Citation from the Society of Otorhinolaryngology and Head-Neck Nurses
- Published coding book author, multiple articles

AGENDA

- Revenue Cycle Best Practices
- How Otolaryngologists Get Paid
- Essentials of Medicare’s Payment System
- Otolaryngology Anatomy You Should Know
- Hot Coding/Billing Topics for Managers
REVENUE CYCLE BEST PRACTICES

Front Desk

Back Office
Revenue Cycle

**Appointment scheduling**
- Billing/collections
- Charge capture
- Surgery/test scheduling

**Insurance verification**
- Reception/check-in
- Patient flow

**Check-out**

**REVENUE CYCLE**

**Front End**
- Scheduling
- Registration
- Eligibility verification
- Referrals/authorizations
- Self-pay collections
- Surgery precertification

**Physicians/Providers**
- Documentation
- Coding

**Back End**
- Charge entry
- Claim submission
- Payment processing
- AR follow-up
- Denials management
- Patient balance collections
- Refunds
right people doing the right job at the right time with the right tools & training

HOW OTOLARYNGOLOGISTS GET PAID
Coding Rules + Payer Reimbursement Rules = Your Collections

TWO TYPES OF CODES

- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
### INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION, CLINICAL MODIFICATION (ICD-10-CM)

- Used to describe diagnoses, conditions and/or symptoms.
- Owned and maintained by the World Health Organization.
- Used for morbidity and mortality tracking around the globe.
- Implemented 10/1/15 in the USA.
- 3-7 character codes that are alphanumeric.

#### INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION, CLINICAL MODIFICATION (ICD-10-CM)

- 1st character is a letter and defines the organ system of the diagnosis:
  - C = malignant neoplasm
  - D = other neoplasms (e.g., benign, uncertain behavior or unspecified behavior neoplasm)
  - H = ear
  - J = respiratory
  - K = digestive
  - R = symptoms
  - S = injury
  - T = foreign body, complications
CURRENT PROCEDURAL TERMINOLOGY® (CPT) CODES

- Used by providers to describe procedures and services rendered.
- Standard service reporting system in the USA, used by all payers.
- Owned and maintained by the American Medical Association (AMA) with input from specialty societies.

Category I codes:
- Anesthesia – 0xxxx
- Surgery – 1xxxx-6xxxx
- Radiology – 7xxxx
- Pathology – 8xxxx
- Medicine (eg, audiology, speech, allergy, sleep) – 9xxxx
- Evaluation/Management – 99xxx

CURRENT PROCEDURAL TERMINOLOGY® (CPT) CODES

- Category II codes: Supplemental tracking codes used for performance measurement
- Category III codes: Temporary codes for emerging technology, services, and procedures
REIMBURSEMENT RULES

Medicare – payment rules generally the same around the country, governing body is the Center for Medicare and Medicaid Services (CMS).

- Resource Based Relative Value System (RBRVS) develops the Medicare Physician Fee Schedule (MPFS).
- Translates CPT codes into values then dollars.
- Many organizations use Medicare’s values (relative value unit – RVU) to track physician productivity for compensation purposes.

REIMBURSEMENT RULES

Medicare – payment rules generally the same around the country, governing body is the Center for Medicare and Medicaid Services (CMS)

- National Correct Coding Initiative (NCCI) - claims processing software to prevent paying for “bundled” codes.

1) Procedure-to-Procedure edits (PTP)
2) Medically Unlikely Edits (MUE)
REIMBURSEMENT RULES

Medicaid – payment rules differ by state.

Managed Care – health maintenance organization (HMO), preferred provider organization (PPO), and others.

Commercial – include Blue Cross Blue Shield, Cigna, Aetna, United HealthCare and others; all may also have managed care products.

Workers Comp – some states govern payment rules.

ESSENTIALS OF MEDICARE'S PAYMENT SYSTEM
ESSENTIALS OF MEDICARE’S PAYMENT SYSTEM: 
RBRVS AND RVUS

1. **Physician Work RVU** (RVUw): Value of physician work, time training, expertise, etc.; generally about 40-50% of the RVUt.

2. **Practice Expense RVU** (RVUpe): Value of expenses incurred maintaining a practice; generally about 40-50% of the RVUt.

3. **Malpractice Expense RVU** (RVUm): Value of expense associated with malpractice insurance/risk.

WHAT’S IN AN RVU?

Example: 99203 New patient visit (in a physician office, or place of service 11, non-facility or NF)

<table>
<thead>
<tr>
<th>Physician Work RVU (RVUw)</th>
<th>Practice Expense RVU (RVUpe) Non-Facility</th>
<th>Malpractice Expense RVU (RVUm)</th>
<th>Total RVU (RVUt)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.42 (46.5%)</td>
<td>1.48 (48.5%)</td>
<td>0.15 (5%)</td>
<td>3.05</td>
</tr>
</tbody>
</table>
NON-FACILITY VS FACILITY PRACTICE EXPENSE RVU

Facility examples: hospital outpatient department (22), ambulatory surgery center (24), emergency department

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Facility peRVU</th>
<th>Non-Facility peRVU</th>
<th>mRVU</th>
<th>Facility tRVU</th>
<th>Non-Facility tRVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>1.42</td>
<td>0.60</td>
<td>1.48</td>
<td>2.17</td>
<td>3.05</td>
</tr>
</tbody>
</table>

Facility RVUpe are lower because the facility incurs the overhead expense.

TURNING RVUS INTO DOLLARS

1. Each component RVU is multiplied by the corresponding component Geographic Practice Cost Index (GPCI).

\[
((RVU_w \times GPCI_w) + (RVU_{pe} \times GPCI_{pe}) + (RVU_m \times GPCI_m)) = RVU_{ta}
\]

2. The RVUta is multiplied by a dollar Conversion Factor (CF) to achieve the dollar amount of your local payment. The CF in 2016 is $35.8043.

Total adjusted

\[
RVU \times CF \text{ of } $35.8043 = Medicare \text{ local allowable}
\]
WHAT’S INCLUDED IN THE CMS PAYMENT FOR A SURGERY CPT CODE?

Example: 30520 Septoplasty

Includes:

- Preoperative visit
- Intraoperative service
- Postoperative care for 90 days (including 4 office visits)

Postop 11%
Intraop 79%
Preop 10%

OTOLARYNGOLOGY ANATOMY YOU SHOULD KNOW
OTORHINOLARYNGOLOGY

PRONUNCIATION: (oh-toh-ry-no-lar-ing-GOL-uh-jee)

MEANING:

*noun*: The branch of medicine dealing with the ear, nose, and throat. Also known as otolaryngology.

ETYMOLOGY:
The word is coined so that one is forced to use all three -- ear, nose, and throat -- to be able to pronounce it. Either that, or it's from Greek oto- (ear) + rhino- (nose) + laryngo- (larynx) + -logy (study).

EAR ANATOMY
NOSE ANATOMY

SINUSES

Frontal sinus
Sphenoid sinus
Ethmoid Air cells
Maxillary sinus
NOSE AND THROAT ANATOMY

- Frontal Sinus
- Nasal Septum
- Nose
- Nostril
- Hard Palate
- Lips
- Genioglossus Muscle
- Mandible
- Hyoid Bone
- Epiglottis
- Thyroid Cartilage
- Cricoid Cartilage
- Middle Turbinate
- Inferior Turbinate
- Sphenoidal Sinus
- Adenoid
- Soft Palate
- Tongue
- Tonsil
- Vertebral Bodies
- Vocal Cords
- Esophagus
- Trachea

THYROID GLAND

- Larynx
- Thyroid Gland
- Isthmus
- Trachea
**HOT CODING/ BILLING TOPICS FOR MANAGERS**

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### REMOVAL OF IMPACTED CERUMEN

<table>
<thead>
<tr>
<th>CPT Description</th>
<th>69210</th>
<th>NEW: 69209</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT Description</strong></td>
<td>Removal impacted cerumen requiring instrumentation, unilateral</td>
<td>Removal impacted cerumen using irrigation/lavage, unilateral</td>
</tr>
</tbody>
</table>
| **RVUs** | 0.61 wRVUs 0.94 tRVU-F 1.40 tRVU-NF (was 1.39 in 2015) | 0 wRVUs  
Payment not likely in the hospital setting 0.36 tRVU-NF |
| **Modifier 50 (Bilateral Procedure)** | - CPT says to use modifier 50 for bilateral procedures.  
- Medicare says the 150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.  
- Some private payors DO allow modifier 50 to be paid | - CPT says to use modifier 50 for bilateral procedures.  
- CMS will apply the 150% payment adjustment for bilateral procedures. |
NASAL ENDOSCOPY

**31231 Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)**

- Evaluation of the nasal passages
- Notice the parenthetical statement “(separate procedure)”; included in all nasal/sinus endoscopy codes (e.g., 31237-31276, 31295-31297).

ENDOSCOPIC SINUS DILATION PROCEDURES

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2016 RVU</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>31295</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium, transnasal or via canine fossa</td>
<td>4.74 F 58.44 NF</td>
<td>• Do not report with 31233, 31256 or 31267 for the same sinus.</td>
</tr>
<tr>
<td>31296</td>
<td>with dilation of frontal sinus ostium</td>
<td>5.68 F 59.57 NF</td>
<td>• Do not report with 31276 for the same sinus.</td>
</tr>
<tr>
<td>31297</td>
<td>with dilation of sphenoid sinus ostium</td>
<td>4.64 F 58.53 NF</td>
<td>• Do not report with 31235, 31287, or 31288 on the same sinus.</td>
</tr>
</tbody>
</table>
# Endoscopic Sinus Surgery

## Maxillary Sinus Procedures

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31256</td>
<td>Nasal/sinus endoscopy, surgical with maxillary antrostomy;</td>
</tr>
<tr>
<td>31267</td>
<td>with removal of tissue from maxillary sinus</td>
</tr>
</tbody>
</table>

## Ethmoid Sinus Procedures

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31254</td>
<td>Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)</td>
</tr>
<tr>
<td>31255</td>
<td>with ethmoidectomy, total (anterior and posterior)</td>
</tr>
</tbody>
</table>

## Frontal Sinusotomy

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31276</td>
<td>Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus</td>
</tr>
</tbody>
</table>

## Sphenoid Sinus Procedures

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31287</td>
<td>Nasal/sinus endoscopy, surgical with sphenoidototomy;</td>
</tr>
<tr>
<td>31288</td>
<td>with removal of tissue from the sphenoid sinus</td>
</tr>
</tbody>
</table>
### Inferior Turbinates Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30801</td>
<td>Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g., electrocautery, radiofrequency ablation, or tissue volume reduction); superficial</td>
</tr>
<tr>
<td>30802</td>
<td>Intramural (i.e., submucosal)</td>
</tr>
<tr>
<td>30930</td>
<td>Fracture nasal inferior turbinate(s), therapeutic</td>
</tr>
<tr>
<td>30130</td>
<td>Excision inferior turbinate, partial or complete, any method</td>
</tr>
<tr>
<td>30140</td>
<td>Submucous resection inferior turbinate, partial or complete, any method</td>
</tr>
</tbody>
</table>

### Flexible Fiberoptic Laryngoscopy

**31575** Laryngoscopy, flexible fiberoptic; diagnostic

- Evaluation of the nose, nasopharynx, pharynx, and larynx
- Procedures performed using a distal chip scope are reported using the appropriate flexible fiberoptic laryngoscopy code (31575-31578) for the procedure performed
- Physician Time (28 minutes) for 31575 per CMS
### COMMONLY PERFORMED ENDOSCOPY PROCEDURES

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Direct Laryngoscopy</th>
<th>Microsuspension Laryngoscopy</th>
<th>Bronchoscopy</th>
<th>Rigid Esophagoscopy</th>
<th>Flexible Esophagoscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>31525</td>
<td>31526</td>
<td>31622</td>
<td>43191</td>
<td>43200</td>
</tr>
<tr>
<td>Biopsy(s)</td>
<td>31535</td>
<td>31536</td>
<td>31625</td>
<td>43193</td>
<td>42302</td>
</tr>
<tr>
<td>Dilation</td>
<td></td>
<td></td>
<td>31630</td>
<td>43195</td>
<td>43200</td>
</tr>
<tr>
<td></td>
<td>Initial</td>
<td></td>
<td></td>
<td>43196</td>
<td>43213</td>
</tr>
<tr>
<td></td>
<td>31528</td>
<td></td>
<td></td>
<td></td>
<td>43214</td>
</tr>
<tr>
<td></td>
<td>Subsequent</td>
<td></td>
<td></td>
<td></td>
<td>43220</td>
</tr>
<tr>
<td></td>
<td>31529</td>
<td></td>
<td></td>
<td></td>
<td>43226</td>
</tr>
<tr>
<td>Removal of Foreign Body(s)</td>
<td>31530</td>
<td>31536</td>
<td>31635</td>
<td>43194</td>
<td>43215</td>
</tr>
<tr>
<td>Excision of Tumor</td>
<td>31540</td>
<td>31541</td>
<td>31640</td>
<td>43194</td>
<td>43211</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>31641 (or relief of stenosis)</td>
<td></td>
<td>43216</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>43217</td>
</tr>
<tr>
<td>Injection(s)</td>
<td>31570</td>
<td>31571</td>
<td></td>
<td>43192</td>
<td>43201</td>
</tr>
</tbody>
</table>
INTRAOPERATIVE MONITORING:
Is it billable for the surgeon?

CPT guidelines now state: “When the service is performed by the surgeon or anesthesiologist, the professional services are included in the surgeon’s or anesthesiologist’s primary service code(s) for the procedure and are not reported separately.” CPT codes +95940, +95941 are not billable by the surgeon.

MODIFIER 25 UTILIZATION:
PAYORS ARE WATCHING!
OFFICE VISIT AND PROCEDURE ON THE SAME DAY

- HOT topic
- All minor procedure (0 and 10-day postop global period) CPT codes include an E/M service on the same day as the procedure (e.g., nasal endoscopy-31231, flexible fiberoptic laryngoscopy-31575)
- What was done “above and beyond” that included E/M service? Documentation must support both.

OTOLARYNGIC ALLERGY SERVICE BILLING: CMS RULES

- TESTING
  - Billing guidelines fall under the CMS Physician Supervision of Diagnostic Testing rules (not Incident-to billing guidelines).
  - If performed by a nurse or MA: billed by the on-site supervising physician (may not necessarily be the ordering physician).
  - A non-physician provider (e.g., PA, NP) may not bill Medicare for testing performed by a nurse/MA.
OTOLARYNGIC ALLERGY SERVICE BILLING: CMS RULES

- TREATMENT (vial prep, immunotherapy/injections)
  - Billing guidelines fall under the Incident-to billing* rules.
  - On-site billing provider (e.g., physician, PA, NP) may bill for the vial prep performed by a nurse or MA.
  - On-site billing provider (e.g., physician, PA, NP) may bill for the injections performed by a nurse or MA.

  *Must meet all “Incident-to Billing” rules.

AUDIOLOGY BILLING: CMS RULES

- Medicare requires audiologists to have their own provider NPI and bill “direct” using their own NPI for all services.

- In other words, all claims to Medicare for services performed by audiologists MUST be billed by the audiologist (not by a physician).
AUDIOLOGY BILLING: CMS RULES

- **Non-audiologists** (e.g., MA, audiology technician): Cannot bill directly to Medicare. However, they are allowed to perform a small subset of services which can be billed by the on-site supervising physician (not an audiologist or non-physician provider).
  - What can they do? Tests that do **not** require a response to a stimulus.
  - Yes: Tympanogram, the technical component of an ENG
  - No: Audiogram
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