Coding Companion for ENT/Allergy/Pulmonology

A comprehensive illustrated guide to coding and reimbursement
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21555-21556
(21552, 21554)
21555 Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm
21552 3 cm or greater
21556 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm
21554 5 cm or greater

Explanation
The physician removes a tumor from the soft tissue of the neck or anterior thorax (chest) that is located in the subcutaneous tissue in 21552 or 21555 and in the deep soft tissue, below the fascial plane or within the muscle, in 21554 or 21556. With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects down to the tumor. The extent of the tumor is identified and a dissection is undertaken all the way around the tumor. A portion of neighboring soft tissue may also be removed to ensure adequate removal of all tumor tissue. A drain may be inserted and the incision is repaired with layers of sutures, staples, or Steri-strips. Report 21555 for excision of subcutaneous tumors whose resected area is less than 3 cm and 21552 for excision of subcutaneous tumors 3 cm or greater. Report 21556 for excision of subfascial or intramuscular tumors whose resected area is less than 5 cm and 21554 for excision of subfascial or intramuscular tumors 5 cm or greater.

Coding Tips
Codes 21552 and 21554 are resequenced codes and will not display in numeric order. For bone biopsy, see 20220–20251; muscle, see 20200–20206.

ICD-9-CM Procedural
83.32 Excision of lesion of muscle
83.39 Excision of lesion of other soft tissue
83.49 Other excision of soft tissue
86.3 Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue

Anesthesia
21552 00300, 00400
21555 00300
21556 00300

ICD-9-CM Diagnostic
171.0 Malignant neoplasm of connective and other soft tissue of head, face, and neck
171.4 Malignant neoplasm of connective and other soft tissue of thorax
171.8 Malignant neoplasm of other specified sites of connective and other soft tissue
195.0 Malignant neoplasm of head, face, and neck
195.1 Malignant neoplasm of thorax
209.32 Merkel cell carcinoma of the scalp and neck
209.35 Merkel cell carcinoma of the trunk
209.75 Secondary Merkel cell carcinoma
215.0 Other benign neoplasm of connective and other soft tissue of head, face, and neck
215.4 Other benign neoplasm of connective and other soft tissue of thorax
238.1 Neoplasm of uncertain behavior of connective and other soft tissue
782.2 Localized superficial swelling, mass, or lump
784.2 Swelling, mass, or lump in head and neck
786.6 Swelling, mass, or lump in chest

Medicare Edits
Fac Non-Fac FUD Assist
21552 13.41 13.41 90
21554 22.0 22.0 90
21555 9.02 11.98 90 N/A
21556 15.15 15.15 90 N/A

Medicare References: 100-2,15,260; 100-4,12,30; 100-4,12,90.3; 100-4,14,10

See Coding Companion for ENT/Allergy/Pulmonology
Appendix

0168T
0168T Rhinophototherapy, intranasal application of ultraviolet and visible light, bilateral

Explanation
The physician treats allergic rhinitis by exposing nasal tissue to ultraviolet and visible light. A light wand connected to a specialized light source is fitted with a disposable nasal tip and inserted into the nasal cavity of the patient for three minutes or less. During the treatment, the physician rotates the light source to continually pan the nasal cavity to ensure the treatment reaches all nasal tissue. The light inhibits histamine release from mast cells and induces apoptosis in T cells and eosinophils. The process is repeated in the contralateral nostril. The patient is instructed to use vitamin B oil as a salve after the treatment. This code reports one treatment course of rhinophototherapy.

0208T-0209T
0208T Pure tone audiometry (threshold), automated; air only
0209T air and bone

Explanation
Pure tone audiometry is performed using a computer-assisted audiometer. Many causes of hearing loss have characteristic threshold curves. In pure tone audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold, which is the lowest intensity of tone the patient can hear 50 percent of the time, is recorded for a number of frequencies on each ear. For pure tone signals, which are single-frequency tones produced electronically and transferred through an earphone or bone conduction vibrator, hearing sensitivity is measured separately in each ear. In one method, noise is masked to the non-test ear when it is determined by the computer that masking is necessary. Through touch-screen operation, the patient self-administers the tests while following verbal and on-screen instructions. Report 0208T for automated audiometry including the air conduction mode only and 0209T for automated audiometry including air and bone conduction modes. The air and bone thresholds are compared to differentiate between conductive, sensorineural, or mixed hearing losses.

Coding Tips
These codes are new for 2011 and were implemented at an earlier date by the AMA.

0211T
0211T Speech audiometry threshold, automated; 0211T with speech recognition

Explanation
Automated speech audiometry thresholds are performed using a computer-assisted device. Causes of hearing loss can often be diagnosed through tests using an audiometer. Many causes of hearing loss have characteristic threshold curves unique to that specific diagnosis. In speech audiometry, earphones are placed and the patient is asked to repeat bisyllabic (spondee) words. The softest level at which the patient can correctly repeat 50 percent of the spondee words is called the speech reception threshold. The threshold is recorded for each ear in 0211T. This process occurs in 0211T, in addition to a discrimination test. The word discrimination score is the percentage of spondee words a patient can repeat correctly at a given intensity level above his or her speech reception threshold. This is also measured for each ear.

Coding Tips
These codes are new for 2011 and were implemented at an earlier date by the AMA.

0212T
0212T Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated

Explanation
Automated comprehensive audiometry threshold evaluation and speech recognition is performed with the use of a computer-assisted device. Causes of hearing loss can often be diagnosed through tests using an audiometer. Many causes of hearing loss have characteristic threshold curves. In comprehensive audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold, which is the lowest intensity of tone the patient can hear 50 percent of the time, is recorded for a number of frequencies on each ear. Bone thresholds are obtained in a similar manner except a bone oscillator is used on the mastoid or forehead to conduct the sound instead of tones through earphones. The air and bone thresholds are compared to differentiate between conductive, sensorineural, or mixed hearing losses. With the earphones in place, the patient is also asked to repeat bisyllabic (spondee) words. The softest level at which the patient can correctly repeat 50 percent of the spondee words is called the speech reception threshold. The threshold is recorded for each ear.

Coding Tips
This code is new for 2011 and was implemented at an earlier date by the AMA.

0240T-0241T
0240T Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with 3-dimensional high resolution esophageal pressure topography
0241T with stimulation or perfusion during 3-dimensional high resolution esophageal pressure topography study (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)

Explanation
The physician inserts a tube with sensors into the patient's nose or mouth and down into the stomach to perform an esophageal motility study (0240T). The muscles of the esophagus and/or the gastroesophageal junction, which propel food and water into the stomach, are studied to measure the pressure of the contraction waves and diagnose abnormalities in the esophageal muscle that affect swallowing. The tube is slowly withdrawn and stopped at different points along the esophagus. The patient is directed to swallow a little amount of water at each stopping point and the contraction wave pressure and swallowing action are measured and graphed. This procedure utilizes three-dimensional, high resolution esophageal pressure topography. In 0241T, the motility study is combined with stimulation and/or acid or alkali perfusion. The methyldipropylammonium test determines the severity of bronchial hypersensitivity, as well as...
This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Types of E/M Services
When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient’s attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician “admitting” the patient for observation.

Codes 99224-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported. If the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99223, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting physician. (If a physician other than the admitting physician