ENT/Allergy/Pulmonology
A comprehensive illustrated guide to coding and reimbursement

2021
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Getting Started with Coding Companion

CPT Codes
For ease of use, evaluation and management codes related to ENT/Allergy/Pulmonology are listed first in the Coding Companion. All other CPT codes in Coding Companion are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT code is followed by its official CPT code description.

Resequencing of CPT Codes
The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum360 Coding Companion series display in their resequenced order. Resequence codes are enclosed in brackets for easy identification.

ICD-10-CM
Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information
One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions
Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

The codes in the appendix are presented in the following order:
- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category II

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edit Updates
The Coding Companion series includes the list of codes from the official Centers for Medicare and Medicaid Services’ National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the Coding Companions series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is http://www.optum360coding.com/ProductUpdates/. The 2021 edition password is: XXXXXXXXX. Log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Index
A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

69501 Transmastoid antrotomy (simple mastoidectomy)
could be found in the index under the following main terms:
Antrotomy
Transmastoid, 69501
OR
Excision
Mastoid, Simple, 69501

General Guidelines

Providers
The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under “Instructions for Use of the CPT Codebook” on page xiii of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies
Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Coding Companion for ENT/Allergy/Pulmonology
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21026  Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)

Explanation
The physician removes dead or infected bone from facial bones. A transoral incision in the maxillary buccal vestibule is the most frequent approach. Facial incisions would only be used for large lesions or for additional surgical access. The physician reflects the overlying mucosa, exposing the dead bone. Drills, saws, and osteotomes are used to remove the bone. The transoral incisions are closed in a single layer. Any cutaneous incision is closed in layers.

Coding Tips
When 21026 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session.

ICD-10-CM Diagnostic Codes
- M27.2  Inflammatory conditions of jaws
- M27.49  Other cysts of jaw
- M27.8  Other specified diseases of jaws
- S01.21XA  Laceration without foreign body of nose, initial encounter
- S01.22XA  Laceration with foreign body of nose, initial encounter
- S01.23XA  Puncture wound without foreign body of nose, initial encounter
- S01.24XA  Puncture wound with foreign body of nose, initial encounter
- S01.25XA  Open bite of nose, initial encounter
- S01.41A  Laceration without foreign body of right cheek and temporomandibular area, initial encounter
- S01.412A  Laceration without foreign body of left cheek and temporomandibular area, initial encounter
- S01.421A  Puncture wound without foreign body of right cheek and temporomandibular area, initial encounter
- S01.422A  Puncture wound without foreign body of left cheek and temporomandibular area, initial encounter
- S01.431A  Open bite of right cheek and temporomandibular area, initial encounter
- S01.451A  Crushing injury of face, initial encounter

Terms To Know
- buccal vestibule. Space in the mouth between the cheek and the teeth and gums.
- osteotomy. Excision of bone.
- osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.
- osteotome. Tool used for cutting bone.
- petrositis. Inflammation occurring in the petrous portion of the lateral region (temporal bone) of the skull.
96365-96368

96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
+ 96366 each additional hour (List separately in addition to code for primary procedure)
+ 96367 additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)
+ 96368 concurrent infusion (List separately in addition to code for primary procedure)

Explanation
A physician or an assistant under direct physician supervision injects or infuses a therapeutic, prophylactic (preventive), or diagnostic medication other than chemotherapy or other highly complex drugs or biologic agents via intravenous route. Infusions are administered through an intravenous catheter inserted by needle into a patient’s vein or by injection or infusion through an existing indwelling intravascular access catheter or port. Report 96365 for the initial hour and 96366 for each additional hour. Report 96367 for each additional sequential infusion of a different substance or drug, up to one hour, and 96368 for each concurrent infusion of substances other than chemotherapy or other highly complex drugs or biologic agents.

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96369-96371

96369 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
+ 96370 each additional hour (List separately in addition to code for primary procedure)
+ 96371 additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)

Explanation
A physician or an assistant under direct physician supervision infuses a therapeutic or prophylactic (preventive) medication other than chemotherapy or other highly complex drug or biologic agent via a subcutaneous route. Indications for subcutaneous infusion may include coma, dysphagia, nausea/vomiting, intestinal obstruction, malabsorption, or extreme weakness. Infusions are administered through a needle inserted beneath the skin; common infusion sites include the upper arm, shoulder, abdomen, and thigh. Report 96369 for infusions lasting longer than 15 minutes and up to one hour. This code includes pump set-up and the establishment of subcutaneous infusion sites. Report 96370 for each additional hour and 96371 for an additional pump set-up with the establishment of new subcutaneous infusion sites. Codes 96369 and 96371 should be reported only once per encounter.

96372-96376

96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96373 intra-arterial
96374 intravenous push, single or initial substance/drug
+ 96375 each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
+ 96376 each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)

Explanation
The physician or an assistant under direct physician supervision administers a therapeutic, prophylactic, or diagnostic substance by subcutaneous or intramuscular injection (96372), intra-arterial injection (96373), or by push into an intravenous catheter or intravascular access device (96374 for a single or initial substance/drug, 96375 for each additional sequential IV push of a new substance, and 96376 for each additional sequential IV push of the same substance after 30 minutes have elapsed). The push technique involves an infusion of less than 15 minutes. Code 96376 may be reported only by facilities.

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97802-97804

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803 re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804 group (2 or more individual(s)), each 30 minutes

Explanation
A dietetic professional provides medical nutrition therapy assessment or re-assessment and intervention in a face-to-face or group patient setting. After nutritional screening identifies patients at risk, preventive or therapeutic dietary...
Correct Coding Initiative Update

Indicates Mutually Exclusive Edit

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CCI Edits

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