Coding Companion for ENT/Allergy/Pulmonology

A comprehensive illustrated guide to coding and reimbursement
# Contents

- Getting Started ................................................................. i
- Skin/Integumentary ............................................................ 1
- Repair .................................................................................. 24
- Destruction .......................................................................... 59
- General Musculoskeletal .................................................. 67
- Head .................................................................................... 77
- Neck/Thorax ......................................................................... 162
- Nose ................................................................................... 167
- Accessory Sinuses ............................................................. 200
- Larynx .................................................................................. 231
- Trachea/Bronchi ................................................................. 264
- Lungs/Pleura ........................................................................ 302
- Arteries/Veins ...................................................................... 318
- Lymph Nodes ...................................................................... 328
- Lips ...................................................................................... 341
- Vestibule of Mouth .............................................................. 355
- Tongue/Floor of Mouth ....................................................... 369
- Dentoalveolar ........................................................................ 401
- Palate/Uvula .......................................................................... 415
- Salivary Gland ....................................................................... 435
- Pharynx/Adenoids/Tonsils .................................................. 457
- Esophagus ............................................................................ 479
- Stomach ................................................................................ 511
- Thyroid .................................................................................. 514
- Parathyroid ............................................................................ 525
- Nervous ................................................................................ 529
- Ocular .................................................................................... 536
- External Ear .......................................................................... 540
- Middle Ear ............................................................................ 556
- Inner Ear .............................................................................. 608
- Temporal Bone ...................................................................... 616
- Operating Microscope .......................................................... 620
- Appendix ............................................................................... 621
- CCI ....................................................................................... 676
- Evaluation and Management ............................................... 677
- Index ..................................................................................... 699
ICD-9-CM Procedural

21.61 Turbinectomy by diathermy or cryosurgery

21.69 Other turbinatectomy

Anesthesia

00160

ICD-9-CM Diagnostic

160.0 Malignant neoplasm of nasal cavities

170.0 Malignant neoplasm of bones of skull and face, except mandible

197.3 Secondary malignant neoplasm of other respiratory organs

198.5 Secondary malignant neoplasm of bone and bone marrow

212.0 Benign neoplasm of nasal cavities, middle ear, and accessory sinuses

213.0 Benign neoplasm of bones of skull and face

231.8 Carcina in situ of other specified parts of respiratory system

235.9 Neoplasm of uncertain behavior of other and unspecified respiratory organs

238.0 Neoplasm of uncertain behavior of bone and articular cartilage

239.1 Neoplasm of unspecified nature of respiratory system

239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin

327.20 Organic sleep apnea, unspecified

327.29 Obstructive sleep apnea (adult) (pediatric)

375.22 Epiphora due to insufficient drainage

461.3 Acute sphenoidal sinusitis — (Use additional code to identify infectious organism)

461.8 Other acute sinusitis — (Use additional code to identify infectious organism)

470 Deviated nasal septum

472.0 Chronic rhinitis — (Use additional code to identify infectious organism)

472.2 Chronic nasopharyngitis — (Use additional code to identify infectious organism)

473.0 Chronic maxillary sinusitis — (Use additional code to identify infectious organism)

473.1 Chronic frontal sinusitis — (Use additional code to identify infectious organism)

473.2 Chronic ethmoidal sinusitis — (Use additional code to identify infectious organism)

473.3 Chronic sphenoidal sinusitis — (Use additional code to identify infectious organism)

473.8 Other chronic sinusitis — (Use additional code to identify infectious organism)

473.9 Unspecified sinusitis (chronic) — (Use additional code to identify infectious organism)

477.9 Allergic rhinitis, cause unspecified — (Use additional code to identify infectious organism)

478.0 Hypertrophy of nasal turbinates

478.19 Other diseases of nasal cavity and sinuses — (Use additional code to identify infectious organism)

780.51 Insomnia with sleep apnea, unspecified

780.57 Unspecified sleep apnea

786.09 Other dyspnea and respiratory abnormalities

802.0 Nasal bones, closed fracture

802.1 Nasal bones, open fracture

905.0 Late effect of fracture of skull and face bones

CCI Version 18.3

0213T, 0216T, 0228T, 0230T, 12001-12007, 12011-12057, 13100-13153, 30110, 30115, 30130, 30140, 30620

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

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MUE: 30130 30140

Medicare References: None
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.

0210T-0211T
0210T 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 spondees words is called the speech reception threshold. The threshold is recorded for each ear in 0210T. This process occurs in 0211T, in addition to a discrimination test. The word discrimination score is the percentage of spondees 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.

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 spondees words is called the speech reception threshold. The threshold is recorded for each ear. The word discrimination score is the percentage of spondees words that a patient can repeat correctly at a given intensity level above his or her speech reception threshold. This is also measured for each ear.

0232T
0232T Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed

Explanation
The physician injects a tube with sensors (approximately 1 cm apart) into the patient's nose or mouth and down into the stomach to perform an esophageal motility study. In high resolution esophageal pressure topography, the data is collected and displays a representation of the pressure pattern and pressure dynamics throughout the entire esophagus, obtaining information regarding anatomy and pressure gradients, along with the contractile activity. In 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. Report 0241T in addition to the motility study code when the motility study is combined with stimulation and/or acid or alkali perfusion. The mechomyol provocation test determines the severity of bronchial hypersensitivity, as well as the cause and effectiveness of treatment for bronchospasm. Varied doses of methacholine chloride solution are administered to the patient, following a scheduled protocol of gradually increasing concentration. The patient performs breathing as instructed, and test measurements are taken by spirometry, both before and three minutes after the inhalation challenge of gradually increasing, aerosolized methacholine chloride/diluent solution. A provocative acid perfusion study, also called a Bernstein test, may be administered to attempt to replicate the type of chest pain the patient has been experiencing. This aids in diagnosing the pain as non-cardiac, due to esophageal reflux. Both hydrochloric acid and an alternate saline control solution are infused one after the other via the nasogastric tube, without the patient being aware of the identity of the solution. The symptoms of chest pain are recorded as the patient identifies them.

0243T
0243T Intermittent measurement of wheeze rate for bronchodilator or bronchial-challenge diagnostic evaluation(s), with interpretation and report
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 $32 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.

**Providers**

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under “Instructions for Use of the CPT Codebook” on page x 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).

The use of the phrase “physician or other qualified health care professional” (OQHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual “qualified by education, training, licensure/regulation (when applicable), and facility privileges (when applicable)” State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines.

The qualified health care professional may report services independently or under incident-to guidelines. The professionals within this definition are separate from “clinical staff” and are able to practice independently. CPT defines clinical staff as “a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.” Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

**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 or other qualified health care provider’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 or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient’s encounter is classified as it would have been by the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient’s attending physician or other qualified health care provider may not bill a new patient code unless the attending physician or other qualified health care provider reported the visit.