

INGENIX®

Coding Companion for ENT/ Allergy/Pulmonology

A comprehensive illustrated guide to coding and reimbursement

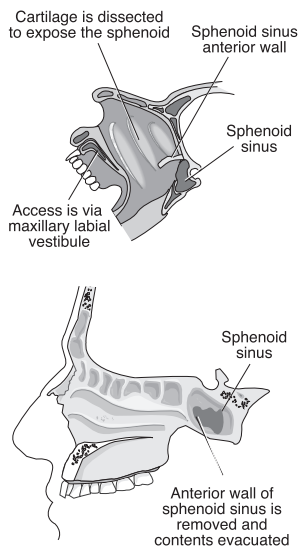
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31050-31051

31050 Sinusotomy, sphenoid, with or without biopsy;

31051 with mucosal stripping or removal of polyp(s)



Explanation

The physician enters the diseased sphenoid sinus. While open, biopsies may be taken of the sphenoidal masses. The sinus mucosa or mucosal polyps are removed in 31051. Due to its location deep within the skull, the sphenoid sinus surgery is accessed through structures overlying the sinus. Most commonly, an intraoral incision is made in the maxillary labial vestibule. The nasal septal cartilage is dissected from the nasal floor and is detached from the anterior nasal spine. The anterior cartilaginous septum is displaced and dissection continues to the bony nasal septum. The physician uses rongeurs to remove the bony septum, exposing the sphenoid region. The anterior wall of the sphenoid sinus is also removed with rongeurs. The physician then uses an operating microscope to remove sinus contents. The nasal midline is reestablished and the cartilage is reattached to the nasal spine. Transseptal sutures are placed. The intraoral incision is closed in a single layer. The nose is packed and external nasal dressings may be placed.

Coding Tips

Nasal packing is removed within 48 hours. For frontal sinusotomy, see 31070.

ICD-9-CM Procedural

21.31 Local excision or destruction of intranasal lesion

22.12 Open biopsy of nasal sinus

22.52 Sphenoidotomy

Anesthesia

00160

ICD-9-CM Diagnostic

160.0 Malignant neoplasm of nasal cavities

160.5 Malignant neoplasm of sphenoidal sinus

197.3 Secondary malignant neoplasm of other respiratory organs

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

231.8 Carcinoma in situ of other specified parts of respiratory system

235.9 Neoplasm of uncertain behavior of other and unspecified respiratory organs

239.1 Neoplasm of unspecified nature of respiratory system

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

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

461.9 Acute sinusitis, unspecified — (Use additional code to identify infectious organism)

471.1 Polypoid sinus degeneration

471.8 Other polyp of sinus

471.9 Unspecified nasal polyp

472.0 Chronic rhinitis — (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)

478.0 Hypertrophy of nasal turbinates

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

730.18 Chronic osteomyelitis, other specified sites — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)

748.8 Other specified congenital anomaly of respiratory system

784.0 Headache

784.2 Swelling, mass, or lump in head and neck

905.0 Late effect of fracture of skull and face bones

Terms To Know

dissection. Separating by cutting tissue or body structures apart.

late effect. Abnormality, dysfunction, or other residual condition produced after the acute phase of an illness, injury, or disease is over. There is no time limit on when late effects can appear.

polyp. Small growth on a stalk-like attachment projecting from a mucous membrane.

sinus. 1) Open space, cavity, or channel within the body. **2)** Abnormal cavity, fistula, or channel created by a localized infection to allow the escape of pus.

CCI Version 15.3

31002, 31075-31090, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64470, 64475, 64479, 64483, 64505-64530, 69990, 92502, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150, J2001

Also not with 31051: 31050

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

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Assist
31050	13.2	13.2	90	N/A
31051	17.37	17.37	90	N/A

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

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 (includes use of computer-assisted device); 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 the tone that 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 that are produced electronically and transferred through an earphone or bone conduction vibrator, hearing sensitivity is measured separately in each ear. In one method, masking noise is provided 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 onscreen 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 2010 but will not be printed in the official AMA CPT book until 2011.

0210T-0211T

0210T Speech audiometry threshold, automated (includes use of computer-assisted device);

0211T with speech recognition

Explanation

Automated speech audiometry thresholds are performed using a computer-assisted device. Causes of hearing loss may often be diagnosed through the use of 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 0210T. This process occurs in 0211T, in addition to a discrimination test. The word discrimination score is the percentage of spondee 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.

Coding Tips

These codes are new for 2010 but will not be printed in the official AMA CPT book until 2011.

0212T

0212T Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated (includes use of computer-assisted device)

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 the tone that 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. The word discrimination score is the percentage of spondee 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.

Coding Tips

This code is new for 2010 but will not be printed in the official AMA CPT book until 2011.

70100-70110

70100 Radiologic examination, mandible; partial, less than 4 views

70110 complete, minimum of 4 views

Explanation

The lower jaw bone is x-rayed. In 70100, three or less projections are taken for a partial view of the bone structure and in 70110, four or more projections are taken for a complete view of the bone structure.

70120

70120 Radiologic examination, mastoids; less than 3 views per side

Explanation

Films are taken of the mastoid processes, or lower portion of the temporal bone of the skull, which protrudes just behind the ear. Both mastoid processes are always examined for comparison purposes, and it is essential that the radiographs be exact duplicates in both positioning of the site and technical quality. Several varying views may be taken, but the key element of this procedure is that it reports less than three views per side.

70130

70130 Radiologic examination, mastoids; complete, minimum of 3 views per side

Explanation

Films are taken of the mastoid processes, or lower portion of the temporal bone of the skull, which protrudes just behind the ear. Both mastoid processes are always examined for comparison purposes, and it is essential that the radiographs be exact duplicates in both positioning of the site and technical quality. Several varying views may be taken, but the key element of this procedure is that it reports a complete exam, or minimum of three views per side.

70134

70134 Radiologic examination, internal auditory meati, complete

Explanation

Films are taken of the petrous portions of the skull to demonstrate internal auditory meati, or organs of hearing. Several different views may be taken, both with varying angulation of the x-ray beam, as well as varying the position of the patient's skull.

70140

70140 Radiologic examination, facial bones; less than 3 views

Explanation

X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, less than three views of the facial bones

Evaluation and Management

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
- Hospital inpatient services—initial care

- Hospital inpatient services—subsequent care
- 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 99234-99236 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