Fundamentals of Coding

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Coding and Documentation

Document, Document, Document

- If it is not documented, not legible, and contextually does not make sense, it was not done
- Length is not important, but rather the content
- Signatures and attestations

Document, Document, Document

- In the EMR record, documented means it was done on that date of service
  - Be careful with cloned notes
  - Anti-plagiarism software
  - Try not to use the term “today” – use the date itself

What to Document

- How the patient is doing; what is new during the office visit
- Need for unusual, atypical evaluation, labs, or unusual diagnostic tests

What to Document

- Need for frequent visits or higher level of service
- Include observations and supportive data
- Use of CPT language or nomenclature

Evaluation and Management Coding

E/M Codes

- Place of Service
  - Inpatient
  - Outpatient
  - Emergency Department
  - Critical care and other sites
- Type of Service
  - New patient
  - Consultation
  - Follow-up/ established
  - Discharge

Consults

- Rule of the three “R’s”
  - Referral
  - Render an opinion
  - Report back

E/M Codes

- 3 Key Descriptors:
  - History
  - Physical Examination
  - Medical Decision Making
    - Diagnosis/es
    - Data
    - Risk/complexity
- Determine level of code

E/M Codes

- Additional Descriptors:
  - Counseling
  - Coordination of Care
  - Nature of Presenting Problem
  - Time
- Medical Necessity

Medical Necessity

- Much clearer for surgical procedures
- Can set “ceiling” for code.
- Begin to establish by chief complaint
- “How sick is the patient”
- Did the patient really need the extent of history and exam peformed
- Is degree of medical decision making (tests, etc.) justified?

Level of Service

- Established by complexity of history, physical examination, and medical decision making.
- Apply CMS Guidelines
  - 1995 *vs* 1997 guidelines
  - 1997 Offers more specialty specific examination criteria

Level of Service

- 1995 Guidelines:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

- 1997 Guidelines:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

E/M Codes- Key Descriptors

- History and Physical
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive
- Medical Decision Making
  - Straightforward
  - Low Complexity
  - Moderate Complexity
  - High Complexity

E/M Codes

Code	History	Exam	Medical Decision Making
99211	no MD	no MD	no MD
99212	Problem focused	Problem focused	Straightforward
99213	Expanded Problem Focused	Expanded Problem Focused	Low Complexity
99214	Detailed	Detailed	Moderate Complexity
99215	Comprehensive	Comprehensive	High Complexity

Components of History

- HPI
- Past Medical, Family, and Social History
- Review of Systems

Elements of the HPI

HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:

- Location (example: left leg);
- Quality (example: aching, burning, radiating pain);
- Severity (example: 10 on a scale of 1 to 10);
- Duration (example: started three days ago);
- Timing (example: constant or comes and goes);
- Context (example: lifted large object at work);
- Modifying factors (example: better when heat is applied); and
- Associated signs and symptoms (example: numbness in toes).

CMS Evaluation and Management Services Guide, December 2010
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf

Levels of the HPI

A **brief HPI** includes documentation of one to three HPI elements.

In the following example, three HPI elements – location, quality, and duration – are documented:

- CC: Patient complains of earache.
- Brief HPI: Dull ache in left ear over the past 24 hours.

An **extended HPI**:

- 1995 documentation guidelines – Should describe four or more elements of the present HPI or associated comorbidities.
- 1997 documentation guidelines – Should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions.

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Past and Other History

- Past Medical and Surgical History
  - Birth
  - Illnesses, procedures, medications, etc.
- Social History
- Family History

Past and Other History

- May be recorded by ancillary staff or patient.
  - MD must document that it was reviewed
- May mark reviewed/updated if recorded earlier
- **Not needed for:**
  - **Subsequent Hospital care**
  - **Follow up inpatient consult**
  - **Subsequent nursing facility care**

Past and Other History

- Pertinent PMSFH: 1/3
- Complete PMFSH: 2/3 for all follow up
- Complete PMFSH: 3/3 for all new patients

Review of Systems

- Constitutional Symptoms (e.g., fever, weight loss);
- Eyes;
- Ears, Nose, Mouth, Throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and/or breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic; and
- Allergic/Immunologic.

- Problem pertinent: one system related to HPI
- Extended: 2 systems beyond HPI
- Complete: all systems
- Can say “all others negative” (honor system)

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Level of History

HPI	ROS	PFSH	Type of History
Brief	N/A	N/A	**Problem Focused**
Brief	Problem Pertinent	N/A	**Expanded Problem Focused**
Extended	Extended	Pertinent	**Detailed**
Extended	Complete	Complete	**Comprehensive**

Physical Exam

- **1995 vs 1997 Guidelines**
  - 1995 “general” body areas/systems
  - 1997 offers “specialty specific” examinations
  - 1997 likely more useful for OTO

Physical Exam- 1997 Guidelines

Single Organ System Examination Criteria

- **Cardiovascular**
- **Ears, Nose, Mouth, and Throat**
- **Eyes**
- **Genitourinary (Female)**
- **Genitourinary (Male)**
- **Hematologic/Lymphatic/Immunologic**
- **Musculoskeletal**
- **Neurological**
- **Psychiatric**
- **Respiratory**
- **Skin**

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

ENT Exam- 1997 Guidelines

Ear, Nose and Throat Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming) • Assessment of ability to communicate (eg, use of sign language or other communication aids) and quality of voice
Head and Face	• Inspection of head and face (eg, overall appearance, scars, lesions and masses) • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness • Examination of salivary glands • Assessment of facial strength
Eyes	• Test ocular motility including primary gaze alignment
Ears, Nose, Mouth and Throat	• Otoscopic examination of external auditory canals and tympanic membranes including pneumo-otoscopy with notation of mobility of membranes • Assessment of hearing with tuning forks and clinical speech reception thresholds (eg, whispered voice, finger rub) • External inspection of ears and nose (eg, overall appearance, scars, lesions and masses) • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx (eg, asymmetry, lesions, hydration of mucosal surfaces) • Inspection of pharyngeal walls and pyriform sinuses (eg, pooling of saliva, asymmetry, lesions) • Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords and mobility of larynx (Use of mirror not required in children) • Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (Use of mirror not required in children)

System/Body Area	Elements of Examination
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	• Inspection of chest including symmetry, expansion and/or assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	
Skin	
Neurological/ Psychiatric	• Test cranial nerves with notation of any deficits Brief assessment of mental status including • Orientation to time, place and person, • Mood and affect (eg, depression, anxiety, agitation)

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ENT Exam- 1997 Guidelines

- Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords and mobility of larynx (Use of mirror not required in children)

- Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (Use of mirror not required in children)

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ENT Exam- 1997 Guidelines

	Content and Documentation Requirements
Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

E/M Codes- Key Descriptors

- History and Physical
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive
- Medical Decision Making
  - Straightforward
  - Low Complexity
  - Moderate Complexity
  - High Complexity

Medical Decision Making

- Three primary descriptors
  - Number of diagnoses or management options
  - Amount/complexity of data reviewed
  - The risk associated with the patient's care

Medical Decision Making

TYPE OF DECISION MAKING	NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS	AMOUNT AND/ OR COMPLEXITY OF DATA TO BE REVIEWED	RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Two of the three elements must be met or exceeded

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Medical Decision Making

- What do to document: Diagnosis and Management Options
  - Use ICD nomenclature when possible
    - Code can be written in note, but must be consistent
  - For new problems:
    - May list differential as “possible,” “probable,” or “rule-out”
  - For established problems:
    - Improved, well controlled, resolving/resolved
    - Inadequately controlled, worsening, failing to change as expected

Medical Decision Making

- What do to document: Diagnosis and Management Options
  - Initiation of treatment
  - Changes in treatment
  - Instructions given by MD or staff
  - Referrals/ consultations made

Medical Decision Making

Number of Diagnoses/ Management Options	Points
Self-limited or minor; stable, improved, or worsening **maximum 2 points for these conditions**	1 point
Established problem; stable/improved	1 point
Established problem; worsening	2 points
New problem; no additional workup planned **Maximum 3 points in this category***	3 points
New problem; additional workup (eg. admit/transfer)	4 points

Point total determines level

Medical Decision Making

- What do to document: Amount/ Complexity of Data
  - Type of diagnostic service ordered/planned/scheduled
  - Review of any diagnostic test
    - Write in note or initial and date report
    - Document if discussed with performing/interpreting physician
  - *Decision to* obtain old records or additional history from source other than patient

Medical Decision Making

- What do to document: Amount/ Complexity of Data
  - Relevant information actually obtained from old records or other source
    - If information not relevant, say so
  - Results of discussions with other health providers
  - Images/tracings/specimens personally reviewed

Medical Decision Making

Amount and/or Complexity of Data Reviewed	Points
Lab ordered and/or reviewed (regardless of quantity)	1 point
X-ray ordered and/or reviewed (regardless of quantity)	1 point
Medicine section (90701-99199) ordered and/or reviewed	1 point
Discussion of test results with performing physician	1 point
Decision to obtain old records and/or obtaining history from someone other than patient	1 point
Review and summary of old records and/or obtaining history from someone other than patient	2 points
Discussion with other health provider	2 points
Independent visualization of image, tracing, or specimen (not simply review of report)	2 points

Point total determines level

Medical Decision Making

- What do to document: Risk of significant complications/morbidity/mortality
  - Comorbidities/underlying diseases that *increase the risk of the prescribed treatment*
  - Any surgeries or invasive diagnostic procedures ordered, planned, or scheduled
  - Any surgeries or invasive diagnostic procedures performed
  - Urgency of decision to refer for/ perform surgery or invasive diagnostic procedure

Medical Decision Making

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	• One self-limited or minor problem (e.g., cold, insect bite, tinea corporis)	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound (e.g., echocardiography) • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness (e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (e.g., cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (e.g., pulmonary function tests) • Non-cardiovascular imaging studies with contrast (e.g., barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives

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Medical Decision Making

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (e.g., lump in breast) • Acute illness with systemic symptoms (e.g., pyelonephritis, pneumonitis, colitis) • Acute complicated injury (e.g., head injury with brief loss of consciousness)	• Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization) • Obtain fluid from body cavity (e.g., lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) • An abrupt change in neurologic status (e.g., seizure, TIA, weakness, sensory loss)	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

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Medical Decision Making

	Straightforward	Low	Moderate	High
Number of diagnosis or treatment options	1	2	3	4
Amount/complexity of data reviewed	1	2	3	4
Risk of complications/morbidity/Mortality	Minimal	Low	Moderate	High

- E/M level determined by highest 2/3
- MDM *must* be clearly delineated in the "Assessment and Plan" portion of the note

Medical Decision Making

Medical decision making:

Images viewed:
Perihilar infiltrate on Chest xray.

Laboratory data: PCO2 55 on CBG. CBG is otherwise normal

Case discussed with: Drs. Melissa Roy and Steven Levine concerning possibility of chronic laryngitis, reflux, and underlying pulmonary process given CO2 retention. Infection is also a possibility.

Diagnosis

Chronic cough- new problem warranting further work up. Possibilities include aspiration, reflux, chronic laryngitis, or a primary pulmonary process.

Plan/ Work-up/ Risk

1. Continue ranitidine
2. Consider adding a proton-pump inhibitor
3. Airway fluoroscopy
4. Modified barium swallow
5. Flexible fiberoptic laryngoscopy

Time Based Coding

- Independent of documented history, physical exam, and MDM
- Outpatient:
  - More than 50% of the face to face time must be spent in *counseling*
- Inpatient:
  - More than 50% of total visit time must be spent *coordinating care* (ie floor/unit work)

Time Based Coding- Office

- “I spent a total of ____ minutes face-to-face with the patient; ___minutes of which were spent on counseling the patient about _____ (nature of counseling)
- Name and Signature of Attending Physician:

  _____

  Date_____

Time Based Coding- Inpatient

- “I spent a total of ____ minutes careing for the patient; ____ minutes of which were spent performing coordination of care activities, including _____ (nature of coordination)

- Name and Signature of Attending Physician: _____

  Date_____

Summary of E/M Coding

- Level based solely on what is documented
- Establish medical necessity
- History, Physical, MDM
- 3/3 for new and 2/3 for established
- Remember time qualifications
- Avoid internal contradictions in notes

Global Periods, NCCI and Office Modifiers

Global Period

- Include pre-op, intra-op, and post-op work
  - 0-10 day global: begins day of procedure
  - 90 day global: begins day of procedure
    - **Includes pre-op H/P (Medicare)**
- Includes all E/M related to the procedure during the defined post-operative period
  - Office visits for routing follow-up
  - Admission for complications
  - Does not include return to OR
- Audiograms are billable in postop global period

Modifiers

- Source of confusion
- Tell carriers there is something atypical about the service
  - Document!
  - Incorrect use affects payment
- "Money" (CPT) *vs* Informational (HCPCS)
  - Use only when necessary

NCCI Edits

- Embedded in CPT (eg, “separate procedure” or parenthetical)
- Define allowable code pairings (column 1, 2)
- CMS edits: MUE, NCCI processes
- *CPT Assistant* articles, Q&As
- *http://www.cms.hhs.gov/NationalCorrectCodInitEd/*

-59 Modifier

- **Distinct Procedural Service:**
  - Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.
  - Modifier 59 is used to identify procedures or services, other than E/M services, that are *not normally reported together* but are appropriate under the circumstances.
  - Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day…
  - Use for NCCI edit of "1"

-59 Modifier

- **Examples:**
  - Direct laryngoscopy and bronchoscopy, when both are indicated, using *two different scopes for two different diagnoses:*
    - 31525
    - 31622-59
  - R total/ L partial ethmoidectomy
    - 31255
    - 31254-59

Key E/M Modifiers

- 24: *Unrelated* E/M service during PO global period (separate diagnosis)
- 25 E/M service same day as minor procedure (separate service, 0-10 day global)
- 50: Bilateral procedure
- 57 E/M service with *decision for surgery* (90 day global period procedure)
- 79 *Unrelated* procedure during PO global period

-25 Modifier

- **Append to E/M code**
  - **9920X-25**
- **Indicates that *decision to perform* procedure was made at that E/M visit**
- **Applies to all minor procedures**
  - **0-10 day global period**
- Remember:
  - Link the diagnosis (may be the same) to each service
  - Know what the payer requires of documentation, ie, always send or only if requested or on appeal

31575 (RUC database 2014)

Pre service

Review patient's record with particular attention to sinonasal, breathing, vocal, and swallowing history. Review anatomy. Note any radiographic studies or nasal endoscopic findings. Discuss procedure with patient and/or family and answer questions. Obtain informed consent and check equipment. Position patient. Scrub and glove hands.

Intra service

Perform vasoconstriction on nose and anesthetize topically. Allow adequate time (usually five minutes) for medications to work. Pass the flexible laryngoscope through the selected nostril and note any nasal abnormality. Examine the nasopharynx with particular attention to the fossa of Rosenmueller bilaterally, the posterior wall, looking for masses or abnormal adenoid size, palatal elevation, and closure and lateral wall movement. Then examine the oropharynx, looking at palatal/uvular length, tonsillar size, any masses present, and airway competency. Examine the hypopharynx next, looking at the base of tongue,

Post service

Discuss findings with the patient and/or family and review and implement treatment options. Dictate a procedure note along with a letter to the referring physician. Arrange appropriate referrals, testing, and follow-up.

-25 Modifier

- Write a distinct note for procedure
- Do not include findings of procedure with the E/M service!
- At end of E/M:
  - Impression: Deferred, or use presenting complaint plus possible differential diagnoses
  - Plan: Write that patient needs procedure to determine potential path (polyps, masses, etc)
  - Order the procedure in EHR

-57 Modifier

- Decision for Surgery:
  - An E/M service that resulted in the initial decision to perform surgery….
  - Append to E/M when “major” procedure ordered (90-day global or defined by payer)
    - Incision and drainage of abscess
    - *Complicated* control of post-tonsillectomy bleed
    - If in doubt, look up the global period
  - DO NOT USE TO BILL FOR PRE-OP H/P

Common Office Procedures

Office Procedures

- Pre-certify/authorize prn
- Same documentation as OR
- Legible
- Account for attending
- Templates

Office Procedure Documentation

- Can bill with an E/M if they are separate services
- Documentation must support this
  - If procedure and E/M are related, include order/recommendation for procedure in MDM of E/M
  - In unrelated, make sure documentation reflects this
  - Document procedure on a separate note
- Append appropriate modifier

Office Procedures

- Procedure note SHOULD NOT be included in the clinic note
- List procedure as the “plan” in the clinic note
- Any decisions based on procedure findings are listed in the “post” section of the procedure note

Office Flexible Endoscopy Procedure Note

Procedure Performed:

- ❑ Flexible nasal endoscopy (unilateral / bilateral)
- ❑ Flexible nasopharyngoscopy
- ❑ Flexible laryngoscopy

Indication:

- ❑ Nasal obstruction
- ❑ Hoarseness
- ❑ Stridor
- ❑ Other_____

Findings:

1. Nasal Endoscopy

Nasal vestibule: nl; other_____

Crusting (yes / no) _____

Nasal Mucosa: nl; dry; erythematous; boggy; edematous;

other_____

Inferior turbinates: nl; enlarged; other_____

Middle turbinates: nl; enlarged; paradoxical;

other_____

Polyps: yes / no; right / left / bilateral

_____

Nasal septum: nl; deviated (right / left); spur (right / left)

Superficial septal vessels (yes / no); (right / left / bilateral)

Other_____

2. Nasopharynx:

Adenoids: nl; enlarged; absent

Choana: nl; stenosis (R / L / B); atresia (R / L / B)

Eustachian tube tori: nl; other_____

Velopharyx closure: nl; patent; other_____

Other: _____

Office Endoscopy

- 31231 Diagnostic nasal endoscopy
- 31575 Diagnostic flexible laryngoscopy
  - ***Read introductory language in CPT and document mirror exam***
  - Can bill with E/M using modifier -25 if *the two services are separate!*
- Example: New hoarseness patient
  - Report E/M with -25 for hoarseness evaluation
  - Order endoscopy in "plan" section of note
  - Report endoscopy on a separate note
- Example: Cancer surveillance
  - Bill only 31575 unless *distinct and separate* E/M provided

Cerumen Removal

- 69210 Removal impacted cerumen requiring instrumentation, unilateral
  - Q&A article in October 2013 AMA *CPTAssistant*
  - Requires presence of cerumen impaction and documented instrumentation used for its removal
  - If reporting with E/M, document need for the E/M and 69210. Append modifier -25 to the E/M.
  - *Must be separate services to bill both*

Impacted Cerumen

- Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
- Qualitative considerations: Extremely hard, dry, irritating cerumen causing symptoms such as pain, itching, hearing loss, etc.
- Inflammatory considerations: Associated with foul odor, infection, or dermatitis.
- Quantitative considerations: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills.

CMS Guidelines for Procedures

- Minor Procedure of < 5 minutes
  - Must be present for the entire procedure
  - Pre- and Post- work
- Endoscopies
  - Teaching Physician must be present for entire viewing including insertion and removal (scope in – scope out)

Surgical Documentation

Operative Reports

- Use CPT terminology, but not numbers
- All CPT services must have corresponding ICD-9 (10) diagnosis code
- If a procedure is to be billed as unusual (-22), document why
- Document presence (of attending)
- Pertinent findings *and indications/rationale*

OPERATIVE REPORTS

- **Diagnosis**
  - **A Chronic Sinusitis (specific sinuses involved)**
  - **B Septal deviation with airway obstruction**
  - **C Turbinate hypertrophy with airway obstruction**
- **Procedures**
  - **A Sinus Surgery (specific procedures, sides)**
  - **B Septoplasty**
  - **C Inferior turbinoplasty (specific terminology)**
  - **D Computer Assisted Image-Guidance (link A)**
- **Indications and Findings**
- **Operative Note Detail**

Spell out anything unusual!

Unlisted Procedures

Unlisted Procedures

- Common in pediatric airway surgery!
  - Supraglottoplasty (if only AE fold division performed)
  - Endoscopic cleft repair
  - Endoscopic anterior cricoid split
  - Endoscopic posterior graft placement
  - *Any* endoscopic procedure not described in CPT 31525-31571

Unlisted Procedures

- Frequent cause of coding confusion
- Deal directly with carrier with written prior approval
- Submit operative note
- Comparator codes (this is key- may use open codes)
- Submit on (paper) CMS 1500 form
- Account for payment delay
- Sample letter: http://www.entnet.org/Practice/Appeal-Template-letters.cfm

Use of an Unlisted Code

Do:

- Use when there is **no CPT code** to describe the procedure.
- Obtain **written prior authorization** for elective cases.
- Send claim on paper CMS 1500 form with operative note and cover with letter attached (**payor specific claim submission rules may vary**).
- Consider sending **"comparison code"**
- Expect **payment variability and delays**.

Don't:

- Use because you don't like the payment for existing codes.
- Use a **modifier 22** on unlisted procedure codes.
- **Report more than one** unlisted procedure code per operative session.

Unlisted Procedures

Q: Are there steps I should take to increase the likelihood my unlisted code will be paid?

A: Yes, best practices for using unlisted codes include, but are not limited to, the following:

- Obtain prior authorization or certification for elective cases.
- Learn what the carrier needs to process the unlisted code; many request the following: Submit your claim on a CMS 1500 claim form with an operative note and cover letter outlining how you are using the unlisted code and how you've selected your "base code". Access the Academy's sample unlisted code cover letter here: http://www.entnet.org/Practice/Appeal-Template-letters.cfm
- Select a base code that is SIMILAR to the procedure you performed. The code should represent surgery on the same area of the body and utilize a similar approach and exposure to the procedure you performed.
- In your cover letter, list 2-3 things that make the unlisted procedure more or less difficult than the comparator CPT code.
- List the RVUs of the similar code to be sure it reflects a fair value for the work you have performed. If it does not, select a different base code.
- Use your normal fee for the comparison code. Note that the payer will then adjust this up or down from their fee schedule, not your charge.

Q: Are there any other areas to be cautious about, or to avoid?

A: Yes, keep the following in mind when using unlisted codes:

- As is the case with all claims, do not unbundle procedures that are included in a global surgery;
- Do not use modifier 22 on unlisted procedure codes;
- Do not report more than one unlisted procedure code per operative session;
- Payment delays are likely, as the payer may perform a more detailed review of your claim when an unlisted code is submitted.
- Make certain your documentation is fully supportive of the service and clearly describes the work performed, especially if "deserves" a significantly higher reimbursement than the base code.

http://www.entnet.org/Practice/How-to-effectively-utilize-unlisted-CPT-codes.cfm

Thank you