2 Clues Shed Light On Labyrinthotomy Coding Revisions in 2011

Bill 69801 more than once per day, and you’d be throwing away a potential $202 pay.

Having problems with patient complaints when billing 69801 lately? Are your payers not paying for subsequent injections after the first? If you didn’t catch how 69801’s global days shifted to zero from 90 days, then you might find yourself ensnared in confusion between patient, payers, and your practice.

Examine the scenario described by Ann Blake, CPC, which describes the current problem that other coders commonly encounter:

**Scenario:** We billed labyrinthotomy (a.k.a. gentamicin injection) on a patient who got five injections on different visits. The patient has filed a complaint to the Department of Justice, stating that when she began gentamicin treatments, on the first day, the physician made an incision in her inner ear, and inserted a tube into which he administered gentamicin drops. On four subsequent visits, the physician used a needle to perfuse the drops into the middle ear through the tube. On the claim, we reported 69801 five times (one time for each service, listing each date of service) and the J code for the gentamicin, J1580 times the appropriate number of units for each date of service.

**Conflict:** The patient disagrees with the charges for four additional labyrinthotomies when the physician merely perfused drops into the ear. The doctor’s office maintains the bill reflects the procedures that took place.

Which side is correct? The following clues should lead you to the right answer.

**Clue 1: 69801 Applies To Perfusion Treatment, As Well As Labyrinthotomy**

Supercoder.com (www.supercoder.com) categorizes 69801 (Labyrinthotomy, with perfusion of vestibuloactive drug[s]; transcanal) under the surgery/operating microscope section. It also describes labyrinthotomy as a surgical incision into the labyrinth (the inner ear). However, the code’s physician responsibility part specifically states that “69801 can also be used with in-office procedures because it includes perfusion of drugs. For example, if a transtympanic injection of a steroid is done in the office, with no incision, it is a perfusion treatment of the inner ear and should be coded with 69801.”

Although 69801 has traditionally applied to gentamicin injections for Meniere’s disease (386.00-386.04), you can also use the code to apply to steroid injections for Meniere’s disease, autoimmune inner ear disease, and sudden hearing loss.
### Shift To H81.09 For Ménière’s Disease in 2013

The ICD-10 code for hearing loss will retain its old descriptor. 

When a patient suffers from Ménière’s disease (386.00, *Ménière’s disease unspecified*), she would usually present to the office complaining of hearing loss, pressure in the ear, tinnitus, severe imbalance, and vertigo. This symptoms result from nonsuppurative disease of the labyrinth; swelling of the endolymph-containing structures is the main pathologic finding. Beginning Oct. 1, 2013, you will report this condition with ICD-10 code H81.09 (*Ménière’s disease, unspecified ear*).

#### ICD-10-CM difference:
*Ménière’s disease’s unspecified ICD-9-CM and ICD-10-CM codes share the same descriptor, with H81.09 deriving from its parent code H81.0x (*Ménière’s disease*) the applicability to labyrinthine hydrops, and Ménière’s syndrome or vertigo. Additional three codes under H81.0 (besides H81.09) describe the condition in greater detail:

- H81.01 — ... right ear
- H81.02 — ... left ear
- H81.03 — ... bilateral

#### Warning:
As with ICD-9, you should avoid reporting unspecified codes as much as possible. Submitting H81.09 (an unspecified code) tells the payer you’re not sure if the Ménière’s disease occurred in the right ear, left ear, or both. That may signal an audit.

#### Coding tips:
Be on the lookout for other names that your physician may use to refer to Ménière’s disease. These include: endolymphatic hydrops, Lermoyez syndrome, Ménière’s syndrome (if secondary to known cause).

All these terms should lead you to the same ICD-10 code: H81.0x.
As in the case of the given scenario, labyrinthotomy procedures usually require several treatments, and you should report 69801 only once per day. For this year, however, you should be extra careful when billing 69801 because the code now carries a zero-day global period (from the original 90 days), reminds Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J.

What's the catch: This change on the number of global days means you can now report subsequent perfusions separately if performed on different dates. Don’t forget to include the drug supply code when reporting subsequent perfusions. “This was important, because it was difficult to report the drug when a physician administered subsequent injections during the global period prior to this change,” Cobuzzi adds. This is no longer a problem, because now you have access to a billable injection CPT® and a drug J code for each injection administration.

“You can pull up the global days for 69801, and it will show it has zero,” reaffirms Julie Keene, CPC, CENTC, otolaryngology coding and reimbursement specialist, UC Department of Otolaryngology-Head and Neck Surgery in Cincinnati, OH. Billing the code one unit per visit (as indicated in the scenario) should not pose any problem as long as you document your claim properly.

“Patients who get gentamicin treatments have to remain in the office for at least 15-20 minutes after every injection to be monitored before they can leave. That is time and money to the practice, hence why this code has a relatively high RVU,” Keene explains. You will notice that the new 2011 RVUs for 69801 are about one third the value of the 2010 RVUs with the change to zero global days.

Fee Schedule: You should expect a payment of $201.82 (5.94 RVUs multiplied by the 2011 conversion factor of 33.9764) when the doctor performs 69801 in a nonfacility setting.

Some would argue on using modifier 52 (Reduced services) for 69801 subsequent visits, but you actually don’t need the modifier. “CPT 69801 may or may not include the tube, so modifier 52 is not included,” says Cobuzzi. For some services you do more work (for example, putting in the tube which cannot be charged separately), and for some services the work is less. The RVUs are based on averages, she adds.

The American Academy of Otolaryngology/Head and Neck Surgery has posted a guidance article for coding and billing these labyrinthotomy services to assist you whenever you run into any problems such as encountered by Ann. To access the letter, you can go to: http://www.entnet.org/Practice/CPT4ENT69801.cfm#.Tp9DNUjeNrc.facebook.

Don’t Overlook These 2012 Observation Care Coding Updates

Additional time guides will supplement 99218-99220 descriptors beginning Jan. 1.

If you’re barely familiarizing yourself with 2011 new codes for subsequent observation care 99224-99226, brace yourself for a couple of fresh reports about how to report these codes, and reimburse for your deserved dollars.

CMS Renders Finality To 99224-99226 RVUs

Current Procedural Terminology (CPT®) introduced codes for subsequent observation care, 99224 (Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity); and 99226 (Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity) beginning Jan. 1, 2011. During the public comment period, the American College of Physicians (ACP) questioned the relative values the Centers for Medicare and Medicaid Services (CMS) assigned for these codes. In July, however, the CMS released a clarification rendering the present relative values for 99224-99226 as final, according to the ACP Internist...
article “ACP disputes federal valuation of primary care observation codes” (see www.acpinternist.org/archives/2011/09/coding.htm).

CMS maintains that the following value units are final at the disputed levels, and will determine the payment levels for subsequent observation care under the Medicare fee schedule for 2011 and following years:

- 99224 — 0.82
- 99225 — 1.45
- 99226 — 2.17

Note: The actual payment amount will change in 2012 if the conversion factor changes.

‘Treating Physician’ Gets Exclusive Rights To Use 99224-99226

CMS has also clarified that only treating physicians can report subsequent observation care. The agency notes that subsequent observation care pay includes “all the care rendered by the treating physician on the day(s) other than the initial or discharge date,” according to MLN Matters article MM7405, with an implementation date of Nov. 28, 2011. Any other physicians evaluating or consulting on the observation care patient “must bill the appropriate outpatient service codes,” and not the subsequent observation care codes.

The clarification stems from prior confusion about exactly who could report subsequent observation care. You can check out the complete MLN Matters article, visit www.cms.gov/MLNMattersArticles/Downloads/MM7405.pdf.

Pick Out Appropriate Observation Code Based On Time

Hospital observation care codes 99224-99226 and 99218-99220/99217 apply to an otolaryngologist when a patient gets admitted to observation (as opposed to inpatient), and gets discharged either on the same day or on two calendar days.

“Should you base your code on counseling and/or coordinating care, you now can select your observation code based on time instead of the documented history exam and medical decision making,” explains Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, NJ. For instance, the codes may apply to a trauma patient who needs stabilization before discharge; a patient who has an epistaxis and you do not want to send them home after the control of the bleed, so you admit them to observation; or an allergy patient who had an adverse reaction to their regular immunotherapy shot and you admit them for observation.

Tell the difference: If you’re confused about the distinct functions of 99224-99226 and another set of observation codes 99218-99220/99217, remember that the difference lies on when the service is rendered/completed.

Codes 99224-99226 describe observation care for a patient who is admitted to and discharged from observation on the same calendar day. In this case you would use only one code to represent both services of the admission and the discharge from observation.

On the other hand, you would look at reporting 99218-99220/99217 when a patient gets admitted and discharged from observation on two calendar days. This time, you would report two codes — one for admission to observation (99218-99220, New or established patient initial hospital observation care services), and one the next calendar day, when the patient is discharged (99217, Observation care discharge day management).

The difference between 99224-99226 and 99218-99220/99217 is that with the first set, the patient is admitted to and discharged from observation on the same calendar day. One code, 99224-99226 represents both services of the admission and the discharge from observation. With the second set of codes, the patient is admitted and discharged from observation on two calendar days. Two codes are used, one for admission to observation, 99218-99220 and one the next calendar day, when the patient is discharged, 99217.

99218-99220 Joins The Time Guide Bandwagon

Also for 2012, fresh time guides on the initial observation care codes 99218-99220 will make its debut come Jan. 1:

- 99218 — ...Physicians typically spend 30 minutes at the bedside and on the patient’s hospital floor or unit

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“There are only two ways that you can use time as a basis for selecting an E/M code,” says Cobuzzi. “If counseling/coordination of care takes up 50 percent or more of the visit, and if the code has a typical time associated with it. So by these codes now having a time reference, it sounds like we may have a way to reference time used if counseling or coordination of care takes up at least 50 percent of a visit. In addition, this could open the door to collecting for prolonged service times if the time the doctor spends exceeds 30 minutes more than the allotted time, and the visit notes are documented as such,” Cobuzzi adds.

You Be the Coder

Use ‘Reconsideration’ Step When Appealing 31575’s LCD Deficiencies

Question:
I have received numerous denials of medical necessity on fiberoptic laryngoscopy (31575) for globus because the code, apparently, is not on local coverage determination (LCD). How can I reverse this policy to our favor?

New Jersey Subscriber

Answer: See page 86.

CPT® 2012


Find out why this isn’t all good news.

Reserve a place for a few changes in 2012 if your practice performs services for hearing disorders.

When a patient suffers from an unobstructed outer ear canal, the audiologist would likely perform an otoacoustic emission testing (OAE) to screen hearing and determine cochlear status. During an evoked OAE, the normal inner ear generates acoustic signals in response to outside stimuli.

New code 92558 (Evoked otoacoustic emissions, screening [qualitative measurement of distortion product or transient evoked otoacoustic emissions], automated analysis) will describe the automated analysis of evoked OAE.

The following revised codes will be listed after it:

» 92587 — Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report

» 92588 — ...comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report.

“I am glad CPT® has a definition to 92587 and 92588. I’m not happy about the reimbursement (or lack of) that they will be receiving, especially 92588,” remarks Debbie Abel, Au.D., director of reimbursement and practice compliance, American Academy of Audiology in Reston, VA.

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**Reader Questions**

**Supersede 31231, 31575 Edits With Modifier 59**

**Question:**

*What is the correct way to code for nasal endoscopy and laryngoscopy procedures performed in the office on the same day?*

**Answer:**

Idaho Subscriber

You may report 31231 (Nasal endoscopy, diagnostic, unilateral or bilateral [separate procedure]) appended by modifier 59 (Distinct procedural service), and 31575 (Laryngoscopy, flexible fiberoptic; diagnostic), and get separate reimbursement for each code — but in very rare instances. (See the article “31231, 92511 and 31575: Weigh Your Code Selection Options Based On Complaints,” which appeared on October 2011 Otolaryngology Coding Alert, discussing the same topic.)

The National Correct Coding Initiatives (CCI) specifically indicates, “CMS will not modify the modifier indicators for these edits continuing to allow use of NCCI-associated modifiers. A provider should not report both codes of a code pair edit if the nasal endoscopy can be performed with the same flexible endoscope utilized for the laryngoscopy. However, we understand that there are very occasional circumstances where it is medically reasonable and necessary for a provider to perform the nasal endoscopy with a separate rigid endoscope. In the latter scenario, a provider may report both codes of a code pair edit utilizing an NCCI-associated modifier.”

**Background:** In 2008, CCI and Centers for Medicare and Medicaid Services (CMS) put an end to the confusion by rendering a final decision to maintain the ability to override the edits with modifier 59 for 31231.

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**You Be the Coder**

**Use ‘Reconsideration’ Step When Appealing 31575’s LCD Deficiencies**

**Answer:**

You can try for an appeal. You will probably lose at redetermination level (the first level) because carriers just look at the LCD, but you might win at the next level, reconsideration. Medicare carriers have to use a panel of physicians when it is a medical necessity issue. You want to make your case by providing literature and clinical references and reasons why it is medically necessary to perform the scope for globus, (784.99, *Other symptoms involving head and neck*), a feeling of a lump in the throat.

The physician has to visualize the larynx and surrounding structures to check if there is anything creating that sensation in the patient and the only way to get adequate visualization is usually a flexible laryngoscopy (31575, *Laryngoscopy, flexible fiberoptic; diagnostic*). The physician must document the medical necessity for performing the scope, with an indication that he “does not have adequate visualization on manual inspection with a mirror”, or the “patient has a gag reflex on mirror exam”, etc. Make sure you do not use the ICD-9 code for globus hystericus (300.11, *Conversion disorder*), which is a psychiatric diagnosis, and not related to the complaint your throat patient is coming to your otolaryngology practice for diagnosis.

The National Correct Coding Initiatives (CCI) specifically indicates, “CMS will not modify the modifier indicators for these edits continuing to allow use of NCCI-associated modifiers. A provider should not report both codes of a code pair edit if the nasal endoscopy can be performed with the same flexible endoscope utilized for the laryngoscopy. However, we understand that there are very occasional circumstances where it is medically reasonable and necessary for a provider to perform the nasal endoscopy with a separate rigid endoscope. In the latter scenario, a provider may report both codes of a code pair edit utilizing an NCCI-associated modifier.”

**Background:** In 2008, CCI and Centers for Medicare and Medicaid Services (CMS) put an end to the confusion by rendering a final decision to maintain the ability to override the edits with modifier 59 for 31231.
However, when you do code 31231 and 31575 separately, make sure you provide satisfactory documentation that explains the need for using two different endoscopes on the same date of service.

**Big risk:** If the payer finds out that every time you perform a nasal endoscopy and a laryngoscopy you use modifier 59, and have a template paragraph for medical necessity, they will be suspicious of the true support for coding both these codes and the modifier. Each patient should have documented medical documented unique to their conditions.

Should you need support for your coding and use of these codes, you can find an article on the American Academy of Otolaryngology/Head and Neck Surgeons website at www.entnet.org/Practice/Reporting-Nasal-Endoscopy-and-Laryngoscopy-CPT-Codes.cfm.

### Ear Tube Insertion: Stick To Reason For Surgery When Reporting Follow-Up Exams

**Question:**

*If a pressure equalizing tube is not considered a foreign body, what is the correct ICD-9 code for examinations in follow-up visits (i.e., five or six months after surgery)?*

**Answer:**

For follow-up visits post-op ear tube surgery (i.e., 69436, *Tympanostomy requiring insertion of ventilating tube, general anesthesia*), you should link the ICD-9 code that describes the reason you did the surgery to begin with, even if the tubes resolved the problem. You are making sure the tubes are ok and the problem is staying resolved — that is the original complaint. So, if the physician put in tubes for chronic otitis media (382.4), you would use 382.4 for the follow up visits even though the patient is no longer experiencing chronic OM.

### Implant Unlisted Code Applicability For Cochlear Device Removal

**Question:**

*What CPT® code applies to cochlear device explants/implant surgery? I’m gearing towards 69717, but the word “replacement” in its descriptor makes me doubtful.*

**Answer:**

Bill an unlisted code (69949, *Unlisted procedure, inner ear [removal of cochlear implant]*) when you’re just explanting without reimplanting at the same time. Otherwise, you should report 69930 (Cochlear device implantation, with or without mastoidectomy) because you have to remove the cochlear device to replace it.

### Dodge Jail Time By Following Incident To Billing Rules

**Question:**

*Can we bill under the physician even if she’s not in the office when the speech language pathologist (SLP) performs video strobe or therapy service? Our SLP has no credential with some insurance companies. Will the insurance companies reimburse the SLP’s service even without “supervision”?*

**Answer:**

It all depends upon the payer. Keep in mind that to bill something you did not do — in this case a service (70371, *Complex dynamic pharyngeal and speech evaluation by cine or video recording*) under a physician’s name who did not perform the service and was not even present in the office — would be fraudulent. However, this practice is quite common for non physician practitioners (NPPs) because the payers don’t want to credential them.

**What to do:** It’s safer to get each payer’s ruling on this matter in writing to avoid potential problems. For instance, you should find out from each payer if they allow incident to billing (which they probably do since they do not credential the SLP), and if they do allow it, do they require direct supervision (the physician in the office suite). If they require a doctor in the suite (direct supervision), make sure your claim comes from the doctor doing the supervision, not the doctor who ordered the services. Always get the information in writing on the payer’s letterhead, because years later when the payer comes after your practice, the person who gave you the information will not be there and you will have nothing to back you up.

**Important:** Always check the Medicaid guidelines in each state that you practice, and submit to their rules. Every state is different. For example, Kansas does not allow any incident to billing for NP and PAs and requires them to be billed out under their own NPI. They do not follow Medicare’s rules. You cannot assume that any payers, including Medicaid, Tricare or any private payer follows Medicare’s rules. Sometimes a state’s Medicaid web site would specifically state that NPPs cannot bill incident to. If a doctor bills for the NPP under his name, he could end up in jail.

Medicare does not allow you to bill out your SLP incident to when the physician is not present in the office suite. The Medicare incident to rules must be followed which includes direct supervision.

*Answers to You Be the Coder and Reader Questions reviewed by Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CENTC, CHCC, president of New Jersey-based CRN Healthcare Solutions.*
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