Workshop in ENT Coding

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Speaker Disclosure

• I have no commercial relationships to disclose.
Coding Workshop

Clear Instruction

Live Demonstration

Hands-On Practice

Learn by doing

Coding Activities

- ENT E&M
- OFFICE PROCEDURES
Learning Objectives

• Recognize the required components for ENT Specialty Evaluation and Management coding.
• Document appropriately to support medically necessary levels of E&M coding.
• Employ correct codes for ENT office procedures.
Disclaimer

This material is designed to offer basic information for the billing and coding of medical evaluation & management services, using common coding systems. The information presented here is based on the experience, training and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, neither the authors, the proctors, or SPAO-HNS/AAO-HNSF accept any responsibility or liability with regard to errors, omissions, misuse or misinterpretation.

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Some E&M slides adapted from the E&M training program

“Locate your HEM In Time”

With attribution, acknowledgement and great thanks to:

Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CPC-I, CHCC, CENTC
CRN Healthcare Solutions, Inc.
Top coding problems per auditors

1. HISTORY - often incomplete, especially in hospital notes.
2. EXAM - “Check boxes” marked abnormal without detail don’t count as being done. Don’t forget to pull details from EMR to the note.
3. MDM – must be determined by all components, not just by whether an Rx was given, etc. Include orders for labs in plan of care, with a reason. Document status of chronic problems.
4. CODING / DATA ENTRY – Modifiers -25 and -59 are targets. “Superbills” must be kept as part of the record.
5. GENERAL DOCUMENTATION – inconsistencies in current vs. regurgitated EMR details; procedures lacking details
COMMON ERRORS IN DOCUMENTATION

• Chief Complaint missing
• First entry portrays a well patient.
• Insufficient history, tracking of past or current diagnoses, or patient progress
• Exam notes are weak, or mostly abbreviated
• No diagnosis listed
• Medical necessity not supported
• No documentation of reason for tests ordered
• No documentation of counseling time
• Reliance on EMR: “Automation is not documentation.”
E&M: THE BASICS

• E&M means “Evaluation and Management”
• Different E&M codes apply in the office and hospital
• There are two sets of documentation guidelines on E&M: 1995 and 1997. They differ primarily on physical exam documentation.
• MOST times 1997 is same or better for specialties like ENT.
• Procedure coding has its own set of rules.
Documentation Requirements

• Documentation of both E&M and procedures should be *legible* to someone other than the documenting provider and their staff.

• The date of service, name of the patient, and the name of the actual “*rendering*” provider of service should be easily demonstrated by the documentation.

• The documentation should support the nature of the visit and the *medical necessity* of the services rendered.
Another way to think about **Medical Necessity**

- Does this problem pose a threat to life or bodily function within 24-48 hours? **(Level Five)**
- Under what circumstances would you see this patient in follow-up sooner than typically required? **(Level Four)**
- Which patient problems have you very concerned for the patient but do not pose an imminent threat to life or bodily function? **(Level Four)**
- Which problems can commonly be diagnosed on the first encounter and do not usually require a prompt follow-up? **(Level Three)**
- Which problems might you bring a patient back for a quick check, and on doing so discover no further medical management is needed? **(Level Two)**
- Which diagnoses are self-limited and require reassurance with no active medical management? **(Level One)**

*Would a non-friendly medical peer agree with your decisions?*
Other Things to Remember

• If it isn’t documented, *it didn’t happen*.  
• If it didn’t happen, *don’t document it*.  
• Letting your EMR system choose your codes is not a good idea, especially if it pre-populates fields.  
• The provider is ultimately responsible for any errors in coding.  
• *Medical Necessity* is **THE** dominating factor for deciding level of services.
Evaluation & Management
What are E&M Codes?

Evaluation & Management are *provider service* codes used to bill for:
- Office Visits
- Hospital Inpatient, Outpatient, Emergency Room
- Home, nursing facility, etc.

E&M are *Non-procedural* codes that capture elements you can recall by the acronym “**HEM**”

- **History**
- **Exam**
- **Medical Decision-Making**

( **TIME** can also be a factor)
Evaluation & Management

History
### What Determines Level of HISTORY (need 3 of 3)

<table>
<thead>
<tr>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>History Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief (1-3)</td>
<td>N/A</td>
<td>N/A</td>
<td>PF (99201, 99212)</td>
</tr>
<tr>
<td>Brief (1-3)</td>
<td>Problem Pertinent (1)</td>
<td>N/A</td>
<td>EPF (99202, 99213)</td>
</tr>
<tr>
<td>Extended (4+)</td>
<td>Extended (2-9)</td>
<td>Pertinent (1)</td>
<td>D (99203, 99214)</td>
</tr>
<tr>
<td>Extended (4+)</td>
<td>Complete (10+)</td>
<td>Complete (New Patient = 3 of 3, Established = 2 of 3)</td>
<td>C (99204, 99205, 99215)</td>
</tr>
</tbody>
</table>
Evaluation & Management

History

• Three pieces used to determine *level* of History:
  1. **HPI** – History of Present Illness
  2. **ROS** – Review of Systems
  3. **PFSH** – Past, Family, Social History

• Four *levels*
  - **PF** = Problem Focused
  - **EPF** = Expanded Problem Focused
  - **D** = Detailed
  - **C** = Comprehensive
HPI = History of Present Illness

Chief Complaint (example: ear pain)

Plus:
- Location (example: left ear)
- Quality (example: sharp)
- Severity (example: unbearable)
- Timing (example: constant)
- Duration (example: 12 hours)
- Context (example: since air travel yesterday)
- Modifying factors (example: worst lying down)
- Associated signs and symptoms (example: muffled hearing)

*HPI must be collected by the rendering provider!*

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HPI Scoring

- None
- **Brief** = 1 to 3 elements of HPI
- **Extended** = 4 or more elements of HPI
  *or* Status of three chronic illnesses
Examples of HPI

CC: Patient complains of earache

Brief HPI: Dull ache in left ear over the past 24 hours

Extended HPI: Dull ache in left ear over the past 24 hours. Patient states he went swimming 2 days ago. Symptoms somewhat relieved by warm compress and ibuprofen.
HPI Example

CC: Ear problems

HX: This 9-month-old new patient has had multiple episodes of otitis media. These have been persistent the last few months. She also experiences fever and pulling at the ears. Parents think her hearing is okay. No otorrhea. Antibiotics help but only briefly.
HPI Example

CC: Ear problems
HX: This 9-month-old new patient has had multiple episodes of otitis media. These have been persistent the last few months. She also experiences fever and pulling at the ears. Parents think her hearing is okay. No otorrhea. Antibiotics help but only briefly.

The provider documented timing, duration, associated S/S and modifying factors. (=4 elements)

This HPI is Extended.

*P.S. Use hearing and otorrhea in your ENT ROS
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History – 2. **ROS**
14 systems

- Constitutional
- Eyes
- Ears, Nose, Throat, Mouth
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal

- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematology/Lymphatic
- Allergic/Immunologic

***NOTE:*** Pertinent negatives count too!
CC: Earache.

**Problem pertinent ROS** discusses only the system of the complaint: 
*Positive for left ear pain. Denies dizziness, tinnitus, aural fullness.*

**Extended ROS covers 2+:** In this example, two systems are reviewed:
*Positive for left ear pain. Denies dizziness, tinnitus, aural fullness.*

*Chronic allergies are asymptomatic at present.*

**Complete ROS covers ALL (10+)**- inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of ten) organ systems.

*Positive for left ear pain. Denies dizziness, tinnitus, aural fullness.*

*Chronic allergies are asymptomatic at present. No cough or GI symptoms. All other systems were reviewed and are negative.*
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ROS Example

“ROS: No cough or GI symptoms, and all other systems reviewed and negative.”

The following systems are reviewed:

- Respiratory
- Gastrointestinal
- All other systems reviewed and negative

This ROS is complete.
History - 3. PFSH

• PFSH – 3 aspects
  – Past History – past medical history, prior major illnesses, operations, current meds, allergies, etc.
  – Family History – health status or cause of death of parents, siblings and children, etc. (**NO credit for “noncontributory”)
  – Social History – marital status, employment, use of drugs, alcohol and tobacco, sexual history, living arrangements, etc.

• 3 possible scores
  – None
  – Pertinent (1 or 2)
  – Complete (all 3)
Past, Family, & Social History (PFSH)

*Pertinent* = One item from *one* of the elements

*Complete* (New patient) = one item from *each* of the three elements

*Complete* (Established patient) = one item from *two* of the three elements
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PFSH Example

“PMH: No asthma or diabetes.
MEDS: None
ALLERGIES: NKDA”

The provider documents 3 elements of the past medical history, but no Family or Social history.

This PFSH is *pertinent.*
What about “Interval History?”

• Linking prior histories while indicating what has changed and not changed will provide documentation for the same history level that was documented in the linked visit.

• Adequate documentation of interval history would be a statement similar to:
  – “Reviewed history of 9/23/14 and there are no remarkable changes” OR
  – “Reviewed history of 10/3/2014 which only showed the following changes
    • D/C Dymista
    • Congestion increased from 2/5 to 4/5”
### Determine level of HISTORY (3of3)

<table>
<thead>
<tr>
<th></th>
<th>HPI</th>
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</table>
Evaluation & Management

Exam
**Documentation Guidelines on Exam**

**DG:** Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented and described.

*A notation of “abnormal” without elaboration is insufficient.*

**DG:** A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to *unaffected area(s) or asymptomatic organ system(s).*
Physical Exam

The 1995 Guidelines

• General Multi-System
• Single Systems – referred to, but not defined

The 1997 Guidelines

• General Multi-System
• 10 Single Organ Systems Bulleted Specialty Exams, including ENT
Both 1995 and 1997 EXAM Guidelines recognize the same 10 body areas:

1) Head, including face
2) Neck
3) Chest, including breast and axillae
4) Abdomen
5) Genitalia, groin, buttocks
6) Back, including spine
7-10) Each extremity
Both ‘95 & ‘97 Guidelines recognize the same 12 organ systems:

| 1) Constitutional                      | 7) Genitourinary       |
| 2) Eyes                                | 8) Musculoskeletal     |
| 3) Ears, nose, mouth, & throat         | 9) Skin                |
| 4) Cardiovascular                      | 10) Neurologic         |
| 5) Respiratory                         | 11) Psychiatric        |
| 6) Gastrointestinal                    | 12) Hematologic, lymphatic, & immunologic |
Exam

• 4 possible levels

P = Problem focused

EPF = Expanded problem focused

D = Detailed

C = Comprehensive  ***allows you to count only Organ Systems, not Areas - for level 4 & 5 new patient, level 5 recheck
‘95 Guidelines

• **Problem Focused**: a limited examination of the affected body area or organ system (1 area/system)

• **Expanded problem focused**: a limited examination of the affected body area or organ system and other symptomatic or related organ system(s). (2 to 7 areas or systems)*

• **Detailed**: an extended examination of the affected body area(s) and other symptomatic or related organ system(s). (2 to 7 areas or systems)*

• **Comprehensive**: a general multi-system examination of 8+ **systems**, or a **complete** examination of a single organ **system**. (Don’t use areas for Comprehensive.)

*NOTE: Watch for possible future changes in numerical definitions by local carriers.*
(some Local Carriers allow “4x4” count for Comprehensive ‘95 Exam)
‘95 vs. ‘97 Guidelines

• There were questions on how to figure out the difference between Expanded Problem Focused vs. Detailed in ‘95... (both ask for 2 to 7 )

• Some LCDs have concept of 2-7 “Limited” systems vs. 2+ “detailed” systems as “Extended” on ‘95

• ‘97 Guidelines were developed when specialists complained they couldn’t hit ‘95 requirements on General Exam

• Then ‘97 Guidelines gave us specialty EXAM guidelines as well as new General Exam. These are bulleted so you can count up the elements to determine the “score.”
1997 EXAM Documentation Guidelines

• General Multi-System Examination

• Single Organ System
  – Cardiovascular Examination
  – Ear, Nose & Throat Examination
  – Eye Examination
  – Genitourinary Examination
  – Hematologic/Lymphatic/Immunologic Examination
  – Musculoskeletal Examination
  – Neurological Examination
  – Psychiatric Examination
  – Respiratory Examination
  – Skin Examination
**Evaluation & Management**

**‘97 EXAM**

**Ear, Nose & Throat**

**Specialty Examination**

<table>
<thead>
<tr>
<th>System / Body Area</th>
<th>ELEMENTS OF ENT EXAMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>Measurement of any three of the following seven vital signs: 1) sitting or standing BP, 2) supine BP, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight</td>
</tr>
<tr>
<td></td>
<td>General appearance of patient (e.g., development, nutrition, body habitus, deformities, grooming)</td>
</tr>
<tr>
<td></td>
<td>Assessment of ability to communicate (e.g., use of sign language or other aids), voice quality</td>
</tr>
<tr>
<td>Head and Face</td>
<td>Inspection of head and face (e.g., overall appearance, scars, lesions and masses)</td>
</tr>
<tr>
<td></td>
<td>Palpation and/or percussion of face with notation of presence or absence of sinus tenderness</td>
</tr>
<tr>
<td></td>
<td>Examination of salivary glands</td>
</tr>
<tr>
<td></td>
<td>Assessment of facial strength</td>
</tr>
<tr>
<td>Eyes</td>
<td>Test ocular motility including primary gaze alignment</td>
</tr>
<tr>
<td>Ears, Nose, Mouth,</td>
<td>Otoscopic examination of external auditory canals and tympanic membranes including pneumo-otoscopy with notation of mobility of membranes</td>
</tr>
<tr>
<td>Throat</td>
<td>Assessment of hearing with tuning forks and clinical speech reception thresholds (e.g., whispered voice, finger rub)</td>
</tr>
<tr>
<td></td>
<td>External inspection of ears and nose (e.g., overall appearance, scars, lesions and masses)</td>
</tr>
<tr>
<td></td>
<td>Inspection of nasal mucosa, septum and turbinates</td>
</tr>
<tr>
<td></td>
<td>Inspection of lips, teeth and gums</td>
</tr>
<tr>
<td></td>
<td>Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces)</td>
</tr>
<tr>
<td></td>
<td>Inspection of pharyngeal walls and periform sinuses (e.g., pooling of saliva, asymmetry, lesions)</td>
</tr>
<tr>
<td></td>
<td>Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords and mobility of larynx (not required in children)</td>
</tr>
<tr>
<td></td>
<td>Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (not required in children)</td>
</tr>
<tr>
<td>Neck</td>
<td>Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)</td>
</tr>
<tr>
<td></td>
<td>Examination of thyroid (e.g., enlargement, tenderness, mass)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Examination of chest including symmetry, expansion and/or assessment of respiratory effort</td>
</tr>
<tr>
<td></td>
<td>Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)</td>
</tr>
<tr>
<td>Cardiovasc.</td>
<td>Auscultation of heart with notation of abnormal sounds and murmurs</td>
</tr>
<tr>
<td></td>
<td>Examination of peripheral vascular system by observation and palpation</td>
</tr>
<tr>
<td>Chest/breasts</td>
<td>Palpation of lymph nodes in neck, axillae, groin and/or other location</td>
</tr>
<tr>
<td>GI, GU</td>
<td>Palpation of lymph nodes in neck, axillae, groin and/or other location</td>
</tr>
<tr>
<td>Lymphatic</td>
<td>Palpation of lymph nodes in neck, axillae, groin and/or other location</td>
</tr>
<tr>
<td>Musculoskel.</td>
<td>Test cranial nerves with notation of any deficits</td>
</tr>
<tr>
<td></td>
<td>Brief assessment of mental status including orientation x 3, mood and affect</td>
</tr>
</tbody>
</table>

**Exam Level:**

- **Problem Focused**
  - Perform and Document One to Five Bulleted elements (99201, 99212)

- **Expanded Prob. Focused**
  - Perform and Document At Least Six Bulleted elements (99202, 99213)

- **Detailed**
  - Perform and Document At Least Twelve Bulleted elements (99203, 99214)

- **Comprehensive**
  - Document every element in each box with a shaded border and at least one element in each system with an unshaded border. (99204, 99205, 99215)

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**PF = 1 to 5 bullets**

**EPF = At least 6**

**D = At least 12**

**C = All bullets in shaded, plus one in each system with unshaded border**

-compared to **1997 General Exam**

**Comprehensive = 2 bullets in each of 9 systems**
Q. Do you have to perform every part listed in each bullet?

A. Not unless a numerical requirement (i.e., “perform 3 of 7” under Vitals) is listed.

Q. Which is better for ENT: the General ‘95 exam, the General ‘97 exam, or the Specialty ‘97 exam?

A. Almost always, the Specialty ‘97 Exam will be easier than General ‘97 for ENT documentation, especially for levels 4 & 5. General ‘95 is open to auditor and carrier interpretation of what constitutes a “complete ENT exam.”
Evaluation & Management

Medical Decision Making
Medical Decision Making

≠

RISK
Medical Decision Making

3 pieces

1. DMO = # of Diagnoses, or Management Options***
2. Data
3. Risk see E&M Table of Risk

4 possible levels or scores (2 of 3 table)

—Straightforward
—Low Complexity
—Moderate Complexity
—High Complexity

***NOTE: Watch for possible changes in DMO definitions by local carriers
### Evaluation & Management

**MDM: 1. DMO**

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved, or worsening) Max = 2</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established problem (to patient); stable, improved</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established problem (to patient); worsening</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>New problem (to patient); no additional workup planned Max = 1</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New problem (to patient); additional workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>
## MDM: 2. Data Review

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider.</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
</tr>
</tbody>
</table>
MDM: 3. Risk

- The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter. (example: chest pain)

- The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment.

- The highest level of risk in any one category determines the overall risk.
# Evaluation & Management

## MDM: 3. Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| Minimal       | • One self-limited or minor problem, e.g., cold insect bite, tinea corporis | • Laboratory tests requiring venipuncture | • Rest  
• Gargles  
• Elastic bandages  
• Superficial dressings |
|               |                       | • Chest X-rays                   |                             |
|               |                       | • EKG/ EEG                      |                             |
|               |                       | • Urinalysis                    |                             |
|               |                       | • Ultrasound, e.g., echo        |                             |
|               |                       | • KOH prep                      |                             |
| Low           | • Two or more self-limited or minor problems  
• One stable chronic illness, e.g., well controlled hypertension or noninsulin 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  
• Noncardiovascular 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 |
|               | • 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 | | |
| Moderate       | • One or more chronic illness 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 catheter  
• 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 identified risk factors)  
• Prescription drug management (continuation & new prescription)  
• Therapeutic drug monitoring  
• IV fluids with additives  
• Closed treatment of fracture or dislocation without manipulation |
|               |                       | • Cardiovascular imaging studies with contrast with identified risk factors  
• Cardiac electrophysiological tests  
• Diagnostic endoscopies with identified risk factors  
• Discography | |
|               |                       | • Electrocardiographic studies  
• Diagnostic endoscopies with identified risk factors  
• Discography | |
| High          | • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
• Acute or chronic illnesses or injuries that may 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 or sensory loss | | • Elective major surgery (open, percutaneous or endoscopic with identified risk factors)  
• Emergency major surgery (open, percutaneous or endoscopic)  
• Parental controlled substances  
• Drug therapy requiring intensive monitoring for toxicity  
• Decision not to resuscitate or to de-escalate care because of poor prognosis |
### Calculating MDM (2 of 3)

<table>
<thead>
<tr>
<th></th>
<th>Number diagnoses or treatment options</th>
<th>Amount and Complexity of Data</th>
<th>Highest Risk</th>
<th>MDM</th>
</tr>
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<td>2 Limited</td>
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<td>3 Moderate</td>
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<td></td>
<td>2 Limited</td>
<td>3 Multiple</td>
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<td></td>
<td></td>
<td>4 Extensive</td>
<td>High</td>
<td>High Complexity</td>
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Circle applicable scores. Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the second circle from the left.

**Moderate Risk doesn’t automatically mean moderate level MDM.**
Choosing the right E&M code

OK, so we have the “HEM”... Now what?
Evaluation & Management

3 Main Steps to determine the E&M code

1. Determine correct category / subcategory
   – This is about STATUS of the patient: Inpatient, Outpatient, New, Established, Consult, etc.

2. Utilize the HEM levels

3. Determine the visit level (“Leveling”)
   – Need 3 out of 3 HEM for New patient
   – Need 2 out of 3 HEM for Established patient
Step 1. Category: New vs. Established

• New if not seen by same specialty & subspecialty in same practice (same tax ID & taxonomy) within 3 years
• Concept of “new” patient codes applies to outpatient E&M services only
  — If they had a flu shot from your practice in January, then came in May for their first E&M visit, code them as a new patient

Q: Our physician in saw a patient in the hospital last week for the first time and now the patient presents at our office for an office visit. The hospital visit was coded as initial hospital care that includes new or established patients. Will the office visit code be new or established?

A: Established.
MEDICARE SPECIALTY CODE: 04
MEDICARE PROVIDER/SUPPLIER TYPE: Allopathic & Osteopathic Physicians/Otolaryngology

TAXONOMY CODE - CLASSIFICATION, SPECIALIZATION

- 207Y00000X - Otolaryngology
- 207YS0123X - Otolaryngology/Facial Plastic Surgery
- 207YX0602X - Otolaryngic Allergy
- 207YX0905X - Otolaryngology/Facial Plastic Surgery
- 207YX0901X - Otology & Neurotology
- 207YP0228X - Pediatric Otolaryngology
- 207YX0007X - Plastic Surgery within the Head & Neck
- 207YS0012X - Sleep Medicine
Specialty and Taxonomy codes for PAs and NPs

- 50 Nurse Practitioner
- 89 Certified Clinical Nurse Specialist
- 97 Physician Assistant

363A00000X - Physician Assistant
363AM0700X - Physician Assistant, Medical

NO Otolaryngology specialty taxonomic codes for APPs

APPs don’t trigger a “2nd new visit” by MD after they’ve seen the patient first time.
Step 1: Category / Subcategory

• Outpatient & Office
  – If a patient is not admitted to “inpatient” status, then they are an outpatient

• Consults (non-Medicare)
  – The “3 R’s must be met
    • Request for Opinion
    • Rendering of an opinion
    • Reporting of the opinion back to requesting physician
    • “5 Rs” include Reason, Return)
Step 1: Category / Subcategory

• Emergency
  – Must be open 24 hours
  – Contrary to popular belief more than one physician can bill an ER code if different specialties

• Critical Care, Neonatal Care
  – Documentation must show that the patient is indeed critical – not just in a critical care unit – refer to definition in CPT
Step 1. Category / Subcategory

- Nursing Facility
  - Assessments vs. problem oriented visits
- Domiciliary, Rest Home or Custodial Care
  - Also used for Assisted Living
- Prolonged Services
  - Add on codes when extra service is greater than 30 minutes more by a single provider
  - Medicare seems to be the only payer that will pay for this
  - Can be appended to E&M or procedures
Step 2. Determine the HEM

• **History & Exam Levels (Scores)**
  – Problem Focused
  – Expanded Problem Focused
  – Detailed
  – Comprehensive

• **Medical Decision Making Levels (Scores)**
  – Straightforward
  – Low
  – Moderate
  – High
Step 2. Determine the HEM – use a scorecard if you need to

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</table>
E&M Step 3. Leveling “pearl”

• When 3 of 3 required, code the lowest
• When 2 of 3 required, drop the lowest
(and score the other 2)

Let’s see what differs in “3 of 3” situation vs. a “2 of 3” situation...
Evaluation and Management

New Patient

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
- an expanded problem focused history;
- an expanded problem focused examination; and
- straightforward medical decision making.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
- a detailed history;
- a detailed examination; and
- medical decision making of low complexity.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Established Patient

99211 Office or other outpatient visit for the evaluation and management of an established patient, which may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- a problem focused history;
- a problem focused examination;
- straightforward medical decision making.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- an expanded problem focused history;
- an expanded problem focused examination;
- medical decision making of low complexity.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- a detailed history;
- a detailed examination;
- medical decision making of moderate complexity.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- a comprehensive history;
- a comprehensive examination;
- medical decision making of high complexity.
A few words about 99211...

- Not usually performed by a provider
- Documents something, such as chief complaint, constitutional signs
- Needs to be medically necessary, face to face
- Follows Incident-to Guidelines
  - Provider in the office (Bill under that person, not necessarily patient’s original provider)
  - Provider did plan of care
  - Incident-to personnel = employee of practice
Evaluation & Management

Time
When to use Time-based E&M Coding

When counseling or coordination of care by the provider requires more than 50% of the office FACE-to-FACE time with the patient, or more than 50% of entire floor time* at the hospital.

Must document:
- Total face-to-face time at office, or total floor time at the hospital per CPT (AMA) codes.
  *Medicare, however, still requires direct face-to-face time for both inpatient and outpatient services
- % of time spent on counseling/coordination of care (i.e. “>50%"
- Full description of counseling/coordination activities
- Must document medical decision making
- H&P not necessarily needed

Be careful - Don’t *estimate* times!
Time-based Coding Example:

New office patient
- An E&M that had a problem focused history and exam and straightforward MDM would be a 99201 which usually averages 10 minutes.
- If counseling and coordination of care was 20 minutes, making the total session 30 minutes, you could bill based on time which would be a 99203.
## Time Thresholds for E&M Services

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</table>
ADD-ON Services *check with your payers!

- **99050**: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (i.e., holidays, Saturday or Sunday), in addition to basic service.
- **99051**: Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.
- **99053**: Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service.
- **99056**: Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service.
- **99058**: Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.
- **99060**: Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.
Let’s change channels...

ICD-10
A Quick Tutorial

- ICD-10 codes can be 3, 4, 5, 6 or 7 characters
- Your coder needs at least right/left/bilat. info
- Initial encounter (A) now means in active treatment for that problem
- Subsequent encounter (D) now means healing phase/routine care for that problem
- Sequela needs its own code, plus identify the original problem with the (S) indicator
- “Grace period” of learning ICD-10 is over. We are required to code to highest specificity for diagnosis.
ICD-10 requires more detail on...

- **TYPE of condition**
  For example, Otitis Externa: noninfective, actinic, chemical, contact, eczematoid, infective (?organism), reactive, malignant

- **TIMING of condition**
  acute, persistent, chronic, recurrent

- **CONTRIBUTING FACTORS**
  allergy, trauma, drug induced, etc.

- **ASSOCIATED WITH /COMPLICATED BY**
  Sleep disorders, alcohol use, tobacco use, immunosuppression, etc.
Choosing a diagnosis

- **Other specified codes** = You know what the diagnosis is, but there is no specific code for it.
- **Unspecified code** = You don’t know what the diagnosis is. “Unspecified” codes indicate to an auditor that information in the medical record is insufficient or not detailed well enough to use a more specific code. *Hint: they often end with a 9.*

\[ J34.9 \]
Z codes

• Remember there are Z codes to describe encounters in which there is nothing specifically wrong with the patient *during that visit*.

*Examples:*

• Z43.0 *Encounter for attention to tracheostomy*
• Z01.100 *Encounter for hearing examination following failed hearing screening*
On next...

PROCEDURES
Coding Procedures

- Wax
- Mastoid Bowl Cleanout
- M&T
- Scopes
- I&D PTA
- Allergy
- Others...
OFFICE PROCEDURES

Follow same *documentation* rules as E&M.

- Date and sign
- Document thoroughly – see suggested template items
- Using a separate procedure form is recommended.
- Suggestions: wax, mastoid debridements, epistaxis, PTA, scopes, FNA, TNE, videostroscopy
- Remember to support an E&M code (if used) as a separately identifiable service. Modifier -25 on the E&M.
- It is OK to use same diagnosis code for visit on same day as a procedure. But using different codes is better.
Procedure Note Template - Example

- Patient Name and D.O.B.
- Surgeon’s Name
- Date of Procedure
- Procedure Performed
- Pre-Op Diagnosis
- Post-Op Diagnosis

- Indications for Procedure
- Operative Findings
- Procedure Details
- Signature
- Date of Signature

(Graphics are helpful)
How do you code cleaning wax out of ears?
Procedure Coding: WAX

• Use **69210** when the ear is *impacted* such that the TM cannot be visualized at all, and the removal is done via instrumentation under scope or microscope. (Use 69209 for removal by irrigation.) It is OK to bill if the impaction prevents exam for Chief Complaint.

• Use ONCE for one or both ears of a Medicare patient. May be considered a unilateral code by some payers, so add -50 or use code once with 2 units.

• Use -25 modifier on E&M with CC diagnosis, and 69210 with wax diagnosis code H61.2_
69210 and audios

- 69210 is NOT billable just to clear the ear for Medicare-billable audiometric testing. It must be done and documented by MD or APP, not by audiologist, and use code G0268.
- It is OK to bill 69210 for MD/NPP clearing ears before HA evaluation or for HA fitting, as Medicare does not cover Hearing aid evaluations or services.
69209 = Lavage

- Use 69209 to remove impacted cerumen via lavage.
- 69209 is a unilateral code; specify R/L/Bilat

- Removing wax that is NOT impacted should be reported with an E&M code regardless of method.
Procedures

CMS Requirements for 69210 Plus E&M

• The initial reason for the patient’s visit was separate from the cerumen removal.
• Otoscopic examination of the tympanic membrane is not possible due to the impaction;
• Removal of the impacted cerumen requires the expertise of the physician or APP and is personally performed by him or her;
• The procedure requires a significant amount of time and effort; and
• All of the above criteria are clearly documented in the patient’s medical record.
Procedures

Mastoid Bowl Cleanout

- Use code 69220 – unilateral, simple
- Use code 69222 – unilateral, complex, +/- anesthesia
M & T (local anesthesia)

• Use 69433

• This is a unilateral code, so use -50 modifier if bilateral

• Removal of previous tube during this procedure is incidental, not billable.
Gentamycin Instillation

• Code 69801 -allowed ONCE per DAY
• Includes payment for placing a tube in that ear.
• Includes any steroid placement too.
• NO Global for this procedure.
• Do not bill with 69420 /21/33/36 same ear.
Procedures

Epley

• Use 95992, allowed once per day
Use of Microscope: To Charge, or not to Charge?

• If microscope required to complete exam, bill code 92504, binocular microscopy.

• *This code is not paid for routine use.* It is considered a separate diagnostic procedure.

• You can bill microscope, or cerumen, but you should NOT bill both. (check your payers)

• 92504 is considered a bilateral code, so specify if ONE ear or both.
Add on code 69990, *Microsurgical techniques, requiring use of operating microscope*

*(List separately in addition to code for primary procedure)*

This is a surgical code that **should not** be reported in office procedures.
Tube Removal in Office

• This does not qualify as a procedure, not even “removal foreign body.” (Code 69424 is to be used only for tube removal under general anesthesia.)
• Use an appropriate E&M code.

• Not billable if removal to be followed by TM patch; it is considered incidental to the patch (code 69610).
• Microscope use is considered included in patch code.
ENT Procedure code changes for 2017: SCOPES

- The word “fiberoptic” was removed from all flex scope descriptors
- Multiple revised procedural flex scope codes
- Multiple revised trach and bronch codes
- Multiple revised esophagoscopy codes
Coding SCOPES

- 31231 = diagnostic rhinoscopy, one or both sides
- 92511 = flex scope nasal exam, one or both sides
- 31575 = flex nasolaryngoscopy, one or both sides
- 31579 = flex scope with stroboscopy
- 43197/8 = TNE. Do not bill w/31575
- 31237 = rigid scope with debridement, unilateral
  Bill with -79 modifier if for sinus surgery with septo
- 31238 = nasal endoscopy with control nasal hemorrhage, unilateral
Coding I&D PTA

- 42700 = I&D peritonsillar abscess.
- Can use RT or LT modifier.
- Use E&M code with -25 modifier ONLY if work beyond exam and history pertinent to the PTA is performed and is medically necessary.
- CD10 = J36 (excludes quinsy, cellulitis, tx abscess)
- Use additional code B95-97 to identify the infectious agent.
Coding FNA

- [https://www.findacode.com/articles/nine-new-codes-for-fine-needle-aspirations-fna-34463.html](https://www.findacode.com/articles/nine-new-codes-for-fine-needle-aspirations-fna-34463.html)

- Because it is common to aspirate a single lesion more than once during the same operative session to obtain enough specimen for the pathologist, no matter how many times the needle is introduced into the same lesion, it can only be reported with a single unit of service.
Current FNA codes

Deleted

• 10022  FNA biopsy with imaging

Revised

• 10021  FNA biopsy without imaging, first lesion

Added

• FNA biopsy, without imaging guidance: 10021 first lesion, 10004 each additional FNA biopsy, ultrasound guidance: 10005 first lesion, 10006 each additional lesion
• FNA biopsy, fluoroscopic guidance: 10007 first lesion, 10008 each additional FNA biopsy, CT guidance: 10009 first lesion and 10010 for each additional lesion
• FNA biopsy, MRI guidance: 10011 first lesion, 10012 each additional lesion

Providers should be updated on the documentation requirements for these new codes including:

• Type of image guidance used (none, CT, MRI, US, or Fluoroscopy)
• Number and location of lesions biopsied
Coding ALLERGY: 95115 - 95199

• TESTING:
Prick/scratch/puncture =95004 (list #tests)
Intradermal =95024 (list #tests)
S.E.T. =95027 (airborne allergen) (list #tests)

• ALL above codes include physician work RVUs to interpret and report. Any additional E&M must qualify for -25 modifier.

• Physician (not APP) must be in office for testing by non-provider, per Medicare supervision rules. APPs may test unsupervised and bill under their own NPI.

• Other insurance payer supervision rules for allergy testing may vary.
Coding ALLERGY: 95115 - 95199

INJECTIONS and VIALS:

- 95115 (single) & 95117 (2 or more) injection codes do not include vial preparation.
- Medicare pays for 95165 (vial prep) and the injections.  
  =10cc/"10 dose" vial regardless of # of doses.
- Other payers may follow Medicare rules, or use 95120-95134, which include vial prep & injection.
- Use 95144 (list #vials) if you prep single-dose vials for someone else to do the shots elsewhere.
- If you inject from vial patient brings in, code 95115 or 95117.
- If practice buys vials and gives the injections, code 95120.
Coding ALLERGY: Supervision Rules

• It is important to understand that allergy testing supervision is based on diagnostic testing supervision guidelines, not incident-to guidelines.

• 95024 requires direct supervision.

• Some allergy testing requires more than just direct supervision by Medicare. Some testing codes require personal supervision, meaning the physician is in the exam room with the nurse and the patient. These codes include 95060, 95070, 95071, 95075, and 95078.
Procedures

Coding ALLERGY: Supervision Rules

• The Physician must be in the office to supervise RN doing skin testing (diagnostic services). PA/NP can do skin testing or mixing without MD supervision, if allowed by their state laws.

• PA/NP can supervise office personnel giving allergy shots (therapeutic services), or mixing vials, but not skin testing (diagnostic service).
Coding ALLERGY: ICD-10 and Venoms

• According to the AAAAI, if the patient is not receiving active treatment and is simply providing historical information then a "Z" code should be assigned.

  Example:  Z91.030 Bee allergy status

• If the patient is receiving active treatment (like acute reaction to bee sting) a "T" code would be used.

  Example:  T63 Toxic effect of venom
Coding ALLERGY- examples by various payers in one (unnamed) state

**UHC:** 4 claims each with 75 units consecutive days (Patient does not need to be present for billing) so it would look like this:
- 01/02/2014 95165 times 75 units
- 01/03/2014 95165 times 75 units
- 01/04/2014 95165 times 75 units
- 01/05/2014 95165 times 75 units

**AETNA:** 1 claim (They will only pay for 120 units for first year treatment)

**HUMANA:** 3 claims each 100 units totaling 300 consecutive days

**TRICARE:** 3 claims each 100 units totaling 300 consecutive days

**MEDICARE:** 7 claims each with 20 units consecutive days

Remember each insurance carrier may also have a set limit of units they will pay for, either by year or by month. Medicare will only pay for 20 units per claim billed every 30 days. Humana is 100 units per claim billed every 30 days ... it would be advised to check with your allergy carrier who supplies the serum for billing guidelines as well. They should provide you with that information.
Modifier -25 is added to the E&M code when it is done with another office service, same day.

*Remember* that payment for all procedures (like scopes and cerumen disimpaction) already INCLUDE some RVUs for history/exam/ MDM pertinent to that procedure.

*The E&M must be separately identifiable from the procedure.*

“If you don’t have a HEM, don’t bill an E&M.”
FYI: “Practitioner labor” of 31575 (flex scope exam)

<table>
<thead>
<tr>
<th>Pre-Service</th>
<th>Intra-Service</th>
<th>Post-Service</th>
<th>Total Time*</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>5</td>
<td>5</td>
<td>24 min</td>
</tr>
</tbody>
</table>
FYI: “Practitioner labor” of 42700 (I&D PTA)

<table>
<thead>
<tr>
<th>Pre-Service</th>
<th>Intra-Service</th>
<th>Post-Service</th>
<th>Total Time*</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>15</td>
<td>11</td>
<td>53 min</td>
</tr>
</tbody>
</table>
As of January 5, 2015, CPT instructions state that the -59 modifier (distinct separate service/procedure) should not be used when a more descriptive modifier is available. Do NOT append to an E&M code.

- **-XE** Separate Encounter: A service that is distinct because it occurred during a separate encounter
- **-XS** Separate Structure: A service that is distinct because it was performed on a separate organ/structure
- **-XP** Separate Practitioner: A service that is distinct because it was performed by a different practitioner
- **-XU** Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service
Let’s Practice some coding.

“I’m in a paperwork mood, let ‘er rip.”
E&M Leveling, New vs. Recheck

- **PEL** *(Problem focused History, Expanded problem focused Exam, Low MDM)*
  - New (3 of 3) = Level 1 (99201)
  - Est. (2 of 3) = Level 3 (99213)

- **CCM** *(Complete History and Exam, Moderate MDM)*
  - New (3 of 3) = Level 4 (99204)
  - Est. (2 of 3) = Level 5 (99215)

- **CCS** *(Complete History and Exam, Straightforward MDM)*
  - New (3 of 3) = Level 2 (99202)
  - Est. (2 of 3) = Level 5 (99215) ?*Medically necessary?*
E&M Question
Shared / Split services in the Office

A PA sees a new Medicare patient in the office, and gets the CC, HPI, and Exam. The Physician then steps in, reviews the PA’s work, and approves the plan of care. Are both providers’ services payable?

A. Yes, billed under physician NPI
B. Yes, billed under physician NPI via incident-to.
C. No, you can only bill for a new Medicare patient under the physician NPI.
D. No, this must be billed under the PA.
How do you bill?

The correct answer is D.
E&M Question Discussion
Shared / Split services in the Office

In an *office* setting the APP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service.

If the “incident to” requirements are not met, the service must be reported using the APP’s UPIN/PIN.

Section 30.6.7
Procedures Coding Question

Cerumen

A new patient is seen for chief complaint of vertigo. To examine the TMJs, the provider must disimpact wax from both sides, using alligator, suction, and irrigation. How do you code appropriately to get paid for the wax?

A. Just the wax, 69209 x2
B. Just the E&M, because it includes disimpaction for examination or audio.
C. E&M with a -25 modifier, plus 69210
D. E&M with a -25 modifier, plus 69210 x2

The correct answer is c.
Procedures Coding Question  Discussion:  

Cerumen

A.  69209 x 2  Incorrect.  
69209 x 2 would be correct if ONLY bilateral irrigation was used.  This is the new 2016 procedure code for “Removal impacted cerumen using irrigation/lavage, unilateral.” Do not report 69209 with 69210 (removal wax using instrumentation, unilateral) when performed on the same ear.

B.  Just the E&M, because it includes disimpaction for examination or audio. NOPE.  
Separately identifiable E&M service would be done to complete the vertigo evaluation and can be billed.

C.  E&M with a -25 modifier, plus 69210.  CORRECT.

D.  E&M with a -25 modifier, plus 69210 x2.  Incorrect.  
Despite the fact that 2016 AMA CPT calls 69210 a unilateral code, it has been deemed bilateral by Medicare so we are seeing no payers will pay it as unilateral. The claim will be rejected if you bill with a -50 modifier.

ICD-10 Question
Coding Sinusitis

A 35 year old female presents with 2 weeks of symptoms and findings consistent with bilateral maxillary and left ethmoid sinusitis. How do you code this?

A. J01.01 Acute recurrent maxillary sinusitis
B. J01.00 Acute maxillary sinusitis plus
   J01.20 Acute ethmoid sinusitis, unspecified
C. J01.80 Other acute sinusitis
D. J01.40 Acute pansinusitis, unspecified
ICD-10 Question
Coding Sinusitis Discussion

A. J01.01 Acute recurrent maxillary sinusitis is incorrect because by this information we don’t know if it’s recurrent and it leaves out the ethmoid.

B. J01.00 Acute maxillary sinusitis plus J01.20 acute ethmoid sinusitis, unspecified is technically correct, but ICD-10 directs the user to other sinusitis codes if more than one kind of sinus is involved.

C. J01.80 Other acute sinusitis is CORRECT. This defines the condition of more than one, but less than all, sinuses involved on one or both sides.

D. J01.40 Acute pansinusitis, unspecified is incorrect because ICD-10 defines pansinusitis as involving all sinuses on one or both sides.

The correct answer is C.
ICD-10 Question
Still Coding Sinusitis

This same 35 year old female presents four months later having had 2 other “sinus episodes,” and continued nasal obstruction despite nasal steroids. CT confirms maxillary, ethmoid and sphenoid disease. How do you code this?

A. J01.81 Other acute recurrent sinusitis
B. J01.41 Acute recurrent pansinusitis
C. J32.4 Chronic pansinusitis
D. J32.8 Other chronic sinusitis
ICD-10 Question
Still Coding Sinusitis Discussion

*Acute* is <4 weeks

*Subacute* is 4-12 weeks

*Recurrent acute* = 4+ acute episodes per year

*Chronic* is >12 weeks *with or without acute exacerbation*
ICD-10 Question
Still Coding Sinusitis Discussion

Timing: total over four months
Type: chronic with 2 acute exacerbations
Associated findings: positive CT maxillaries, ethmoids and sphenoids. Not frontals, so...

How do you code this?

A. J01.81 Other acute recurrent sinusitis
B. J01.41 Acute recurrent pansinusitis
C. J32.4 Chronic pansinusitis
D. J32.8 Other chronic sinusitis

The correct answer is D.
ICD-10 Question

Still Coding Sinusitis. Really.

ICD-10 coding for chronic sinusitis requires additional coding. What for?

A. To identify alcohol use
B. To identify tobacco use/exposure
C. To identify immunocompromise
D. To identify the causative organism

Correct answer: B.
Procedures Coding Question
Assisting in the O.R.

What is the correct way to bill for an NPP assisting on a total thyroid?

A. 60240 –AS, under surgeon’s NPI
B. 60240 –AS, under NPP’s NPI
C. 60240 -80, under surgeon’s NPI
D. 60240 -80, under NPP’s NPI

The correct answer is B.
Procedures Coding Question Discussion: Assisting in the O.R.

• Use the modifier "AS" for assistant at surgery services provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS).
• Bill under the NPP’s NPI.
• The provider must accept assignment. Medicare allows 85% of the 16% for the assistant at surgery services provided by a PA, NP, or CNS.
• -80 modifier is usually reserved for MD 1st assist. There are very few local carrier exceptions.
Medicare Coding for PA services in the O.R.

1. The procedure code must have an indication for “assistant at surgery.” Indicator “2” applies. “0” may apply if documentation submitted shows medical necessity.

2. Use the modifier “-AS” for assistant at surgery services provided by a Physician Assistant (PA) or Nurse Practitioner (NP). The provider must accept assignment. Medicare allows 85% of the 16% for the assistant at surgery services (which equals 13.6% of the surgeon’s fee) if provided by a PA or NP.

3. Other payers may require a different modifier.
Procedures Coding Question Discussion: Assisting in the O.R.

How do you know if a surgical assistant is covered? You can look it up.

http://www.ic.nc.gov/ncic/pages/asst surg.htm

This is helpful if your practice is telling you that they are not getting paid for your first assists. When you know that code allows an assist, then you also know the claim might not have been filed (or appealed) properly.

ACS, AAPC, Find-A-Code etc. have a similar service to track first assist codes, globals, etc.
Pre-Operative Clearance (non-Medicare)

- Must meet consultation criteria
- At the request of surgeon
- Medically Necessary
Pre-Operative Clearance...  
The Diagnosis

• List the V Code first based on the appropriate rationale for the exam
  – V72.8X
    • V72.81 - Preoperative cardiovascular examination
    • V72.82 - Preoperative respiratory examination
    • V72.83 - Other specified preoperative examination

  – ICD10:
    • Z01.810 - Encounter for preprocedural cardiovascular exam
    • Z01.811 - Encounter for preprocedural respiratory examination
    • Z01.818 - Encounter for other preprocedural examination
Pre-Operative Clearance...
The Diagnosis

• List any signs, symptoms or abnormal diagnostic studies that support medical necessity for the consultation.

• List the reason for surgery second.

• List any pertinent findings from the encounter.
• Some extra info slides to follow...
Questions to think about...

• Do you know how to choose what codes to use for your services?
• Does someone else code on your behalf?
• Do you know if your services are billed under your own provider number, or your supervisor’s?
• Do you know how much revenue you generate?
• Do you know how many patients you see?
NECCESITIES FOR BILLING

• NPI number = National Provider Identifier
  Every PA & NP should have their own.
• Register as a Medicare Provider.
• Register as a Medicaid Provider.
• Apply to be credentialed by payers that require NPPs to have
  their own provider number. AAPA can assist in finding out
  which ones do, and whether they have different requirements,
  in your state.
• Make sure your practice understands that PA services should
  not always be billed under the physician.
Understanding “Incident-to” Billing

• It applies ONLY to OFFICE visits of MEDICARE patients. Other payers must specify if they recognize incident-to billing.

• It allows NPPs to get paid at the higher Physician rate IF: It is in follow-up of the physician’s patient, under the physician’s Plan of Care, AND that physician or one of the physicians in the group is in the same suite of offices.

• You bill under the NPI of the physician who is present.

• It does NOT apply to other sites of care, or new problems / new patients seen by the NPP, or when no supervising physician is physically available during a recheck. Those should be billed with the NPP’s provider number.
Shared or Split services

• According to the Centers for Medicare and Medicaid Services (CMS), shared/split visits are applicable for services rendered in the following settings:
  • Hospital inpatient or outpatient
  • Emergency department
  • Hospital observation
  • Hospital discharge
  • Office or clinic: *when “incident-to” requirements are met, bill either NPI. If not, bill NPP’s NPI.*
Shared or Split services

• A shared/split visit can only be utilized if the NPP and physician are from the same group practice. *Some LCDs require the same specialty. APPs are never same specialty as MDs, per our provider type #s.

• The NPP and physician must both perform and document their face-to-face encounter with the patient.

• The portion of the E/M service performed and documented by both the NPP and physician must be substantive, which includes part or all of the history, exam or medical decision making.

**Note:** The physician must personally document his/her involvement in the patient’s care and cannot leave his/her documentation of the visit to the NPP.
Shared or Split services are not allowed:

- In a skilled nursing facility or nursing facility setting
- For consultation services
- For critical care services
- For procedures
- In a patient’s home or domiciliary site
- For prolonged services, per some Local carriers.
Shared or Split services for other than Medicare?

- Check with your commercial carriers to see if they recognize the shared/split visit guidelines, specifically those carriers who credential NPPs. For carriers who do not credential APPs, the shared/split visit guidelines would not apply, and all APP visits would need to be billed under the physician’s PIN.
Inpatient split/shared services

• It is especially important to remember that notes documented by the NPP for E&M services performed independently within a facility, and later reviewed and co-signed by the physician, depict neither a scribe situation nor an appropriate split/shared visit.

• Also, "incident to" guidelines do not apply to services in an inpatient setting. In the above situation, the service should be billed under the APP's provider number, and would be reimbursed at the established rate for that provider.
Inpatient Shared or Split services

• For a split-shared visit, there must be documentation of the face-to-face portion of the E/M encounter between the patient and the physician. *Look up your LMDs to see examples of what they accept.*

• The medical record should also clearly identify the part(s) of the E/M service which were personally provided by the physician, and which were provided by the APP.

• In the absence of such documentation, the service may only be billed under the APP's provider number. This applies to the initial history and physical examination, the discharge summary, and subsequent hospital visits.

  *-per CMS IOM Publication 100-04, Chapter 12, Section 30.6.1 (B)*
Compliance Tools

- CPT (from AMA) for Procedure Codes
- ICD-10 for Diagnosis Codes
- RBRVS (from CMS) for RVUs and Globals
- National Coverage Determinations and Local Coverage Determinations
- CMS Internet-Only Manual
- www.ENTcodingtoday.com
- Encoder Pro, Pick A Code, or other web tools, by subscription
- Otolaryngology Coding Alert, by subscription
Resources

- [www.aapa.org](http://www.aapa.org)
  - the PA/APN information is in Booklet ICN901623
  - the current E&M guidelines are in Booklet ICN006764
- [www.cms.gov](http://www.cms.gov) for fee schedules, ICD 10 info, etc.
- AMA for “crosswalking”
- [www.ahima.org](http://www.ahima.org)
- AAPC, AAO-HNS, AAO, AAOA