

# **The Essential Guide to Coding in Otolaryngology**

*Coding, Billing, and Practice Management*

**SECOND EDITION**

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# Foreword

The business side of medicine does not receive enough attention during the education and training of physicians. However, the business and financial aspects of medical practice are clearly important. Although a physician in private practice may choose to not personally manage all the business aspects of their practice (for example, equipment leases or employee benefit management) and instead can outsource to an outside vendor such as a Management Services Organization, all physicians must understand and take responsibility for documentation, billing, and coding. Physicians who are employed by large organizations (which are an increasing proportion of contemporary physicians) are typically not expected to manage the underlying business—but even in that setting, they must oversee their own billing and coding.

Many physicians have unfortunately viewed compliance training and billing/coding audits as ordeals to be endured (as seldom as possible), and I believe that is a mistake. The modern physician must understand and embrace these concepts as important aspects of contemporary medical practice. The format of this book is particularly useful as it provides helpful background for all providers, and then is organized into sections on different subspecialties, the office, and the operating room. Thus, the novice and the relative expert can both learn something.

Appropriate coding is important for many reasons. Physicians should receive fair reimbursement for their time, effort, knowledge, training, and the risks associated with delivering health care in a potentially litigious society. Similarly,

health care systems should receive fair reimbursement for the huge expenses (human resources, space, IT, medical equipment, and supplies), as well as the regulatory burden and legal and other risks of contemporary medical practice. Appropriate physician coding helps ensure appropriate reimbursement for the services provided, which is particularly important today because of the financial pressures on providers and health care systems.

Documentation and coding can also help establish case severity and complexity. In addition, with the move toward value-based payments it is clear that medical records, including billing data, will be increasingly used for assessment of the elusive “value” of care delivered, where value is defined as quality divided by cost. Whereas coding is only one aspect, the electronic medical record will clearly be a data source for the assessment of outcome, on which payments may be partially based.

I am so pleased that my colleagues are updating their textbook with this new edition, as there have been recent significant changes in coding regulations. I am also pleased that it is written primarily for the practicing physician and otolaryngologic provider and edited by practicing physicians (Drs. Brown, Setzen, and Tabae) and Kim Pollock, a leading coding/billing expert who has served as a consultant for Otolaryngology-Head and Neck Surgeons with medical billing and coding issues for many years.

With the recent rule changes and the increasing importance of documentation, this book is particularly timely and essential.

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# Foreword

The breadth and complexity of otolaryngology-head and neck surgery makes understanding the coding and documentation requirements in practice especially difficult for clinicians, professional coders, administrators, business office personnel, and even payors. Changing documentation requirements, new codes, and modifications to existing codes seem to be constantly occurring making it difficult to stay up-to-date. Additionally, as our field evolves, coding changes lag innovation thereby creating challenges in practice.

Just as it is complicated to learn and practice otolaryngology-head and neck surgery, coding seems to be equally complicated, technical, and often times imperfect. Nonetheless, understanding the system and utilizing proper coding and documentation is essential while inaccurate coding can have significant consequences. It is

incumbent on the clinician to understand the language of coding and be able to communicate with non-clinicians through their documentation and proper coding (and sometimes even verbally or in written form!).

This volume comes at a critical time to help explain the changes in Evaluation and Management coding, as well as several new codes specific to procedures within our specialty. Fortunately, the editors and authors of *The Essential Guide to Coding in Otolaryngology* have spent many years considering the nuances of our specialty; some have taught thousands of our colleagues and staff how to properly apply these important principles, while others have been directly involved in the creation and valuation of codes. We are fortunate that they have chosen to come together to share their collective wisdom and create this reference for our benefit.

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# Preface

Physicians spend years training for their careers in medicine through medical school, residency, and fellowship. However, little formal training has traditionally been provided in coding, business, and practice management during this path even though these topics are critical for financial success in practice. This lack of knowledge and experience often leads to common, preventable errors and inefficiencies. The potential negative impact of improper coding is significant, including underpayment, overpayment, noncompliance with government and payer guidelines, audits, and financial—sometimes even criminal—penalties. Unfortunately, there is a paucity of available quality, comprehensive resources addressing these topics geared toward practicing otolaryngologists and clinical providers.

To address this educational need, the editors and authors of this book have spent significant time independently, and often together, educating peers, physicians, residents, fellows, and other coding professionals. This book is a compilation of our ideas, teaching, and teamwork to provide a text that is specifically geared to practicing otolaryngologists but in depth enough for coding

professionals to find useful. Enlisting the help of some of not only the most recognizable names in otolaryngology and otolaryngology coding and practice management, but also physicians and clinical practitioners with an expertise in coding made the second edition of this book a reality. Building on the success of the first edition, *The Essential Guide to Coding in Otolaryngology, Second Edition* provides the reader a comprehensive and readable resource for navigating the challenges of an ever-evolving landscape of guidelines and regulations. Included in this second edition are coding and billing updates for general and subspecialty otolaryngology in both the office and operating room settings. A framework for effective practice management and understanding the foundations of coding and billing is presented by leading experts in the field. The most recent ICD-10-CM and CPT® updates are discussed in detail. Finally, a detailed guide to effectively billing for office visits reflecting the 2021 changes is explored. We feel confident you will find this second edition even more useful in your practice endeavors now and in the future.



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## About the Editors



**Seth M. Brown, MD, MBA**, is a practicing rhinologist in Connecticut at ProHealth Physicians, part of OptumCare. He is a graduate of the University of Connecticut School of Medicine, and completed his Otolaryngology training at the Albert Einstein College of Medicine, followed by a fellowship in rhinology and endoscopic skull base surgery at the Weill Medical College of Cornell University. He is active in the otolaryngology residency at the University of Connecticut as an Associate Clinical Professor, Chief of Otolaryngology at St. Francis Hospital and Medical Center, and Medical Director of Specialty Services and Chief of Otolaryngology at ProHealth Physicians. He has been active in the American Rhinologic Society for 15 years in various leadership positions. He lectures extensively on coding, business development, and practice management.

**Kimberley J. Pollock, RN, MBA, CPC, CMDP**, is a consultant with KarenZupko & Associates, Inc. For almost 25 years, she has helped otolaryngology group practices, of all types and sizes, improve coding, collections, and efficiency. She is an expert in analyzing otolaryngology documentation for accurate coding and in reengineering practices to enhance the reimbursement process. Ms. Pollock has published extensively on coding and practice management topics. Ms. Pollock is a former otolaryngology nurse and served as administrator in the Department of Otorhinolaryngology, and as the Associate Vice President for Cancer Programs, at the University of Texas Southwestern Medical Center in Dallas. She is the recipient of the prestigious Presidential Citation Award from the Society of Otorhinolaryngology and Head-Neck Nurses as well as an Honor Award from the American Academy of Otolaryngology-Head and Neck Surgery. Ms. Pollock holds a master's of business administration degree from the University of Dallas and a bachelor's of science degree in nursing from the University of Wisconsin.



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## Office Laryngology

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### Introduction

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Advances in office-based procedures in laryngology present a unique opportunity to provide patients advanced, safe, comfortable, and cost-effective care of laryngeal conditions.<sup>1</sup> The procedures are well tolerated with a high completion rate and high level of patient satisfaction.<sup>2</sup> The rise in the number of office-based laryngology procedures necessitates the need for a practical guide on how to consider the most appropriate coding and billing for these procedures. The billing and coding process for office-based laryngology procedures advanced with the creation of new codes for vocal fold injection and office-based laser treatments.

The process can be quite challenging when one is establishing a laryngology practice in a region where insurance companies are unfamiliar with advances in the field of laryngology. This often requires persistence and patience with prior authorizations, denied claims and education of the payers. Providing appropriate journal articles can also be very helpful, especially during peer-to-peer reviews of prior authorizations and appeals for denied claims. Most issues can be resolved in peer-to-peer reviews; specifically requesting a review by an otolaryngologist can be helpful. Including the medical director of the insurance company in these communications can also reduce or eliminate a duplicative process.

This chapter and the medical literature will often refer to procedures as “office-based.” Alter-

natively, these procedures can be described as “Awake Laryngeal Surgery.” Despite the term “office-based,” these laryngology procedures can be performed in a variety of settings. These settings include an exam room, a clinic procedure room, or a procedure room at an outpatient surgery center. “Office-based” procedures refer to procedures typically performed under local anesthesia only, with the patient in an upright and seated position, with or without sedation. Some surgeons choose to incorporate sedation along with local anesthesia for select patients and select procedures in the appropriate setting.

It is important to know your site of service and if you are billing office-based laryngology procedures from a facility/hospital-based setting/clinic (eg, place of service code 11) versus a non-facility/non-hospital-based setting/clinic (eg, place of service code 22). Site of service has important implications for reimbursement for supplies, medications, laser fibers, and vocal fold injection implant materials. Whether the equipment, such as the electromyography machine or laser machine is hospital-owned or department-owned, can have some implications for billing as well.

Healthcare Common Procedure Coding System (HCPCS II) J codes are supply codes used to report injectable drugs that ordinarily cannot be self-administered; for example, botulinum toxin A, cidofovir, or injectable steroid. Facility/hospital-based settings allow the billing of a separate facility fee that involves the use of J codes and other HCPCS II codes for certain implant materials, supplies, medications, and disposables.

Non-facility/non-hospital-based clinic settings do typically get to bill separately for the J codes (injectable medications) but other supplies such as needles are not separately coded as their cost is included in the reimbursement for the billed CPT® codes or alternatively paid by the patient if allowed by the payer. The cost of laser fibers, implant materials, and disposables may make one setting for performing the procedure more appropriate than the other for different practices, clinical situations, insurances, and locations. Understanding the site of service and different reimbursement for these procedures at different “sites of service” is crucial to the successful reimbursement for the work provided by a Laryngologist.

Linking of ICD-10-CM diagnoses codes to appropriate Current Procedural Terminology (CPT) procedural codes is essential to ensure timely and adequate reimbursement for the care delivered and the procedures performed. Properly linking codes will help to ensure reimbursement especially when multiple diagnostics or therapeutic procedures are performed at the same clinical visit. One must also consider appropriate linking of speech pathology CPT codes with appropriate ICD-10-CM codes when speech pathology procedures are billed in association with a clinical visit. Please refer to the chapter on billing and coding for speech pathology for more detailed information (Chapter 16).

### Key Points

- Many laryngeal codes are for use in the operating room only, as these assume general anesthesia is used. It is not appropriate to use these particular codes in the office setting.
- Do not use the flexible esophagoscopy code (43200) for transnasal esophagoscopy, as specific transnasal esophagoscopy codes exist (43197, 43198).
- Botox injection codes changed in 2013. CPT 64617 was added for percutaneous injection and 64613 was deleted.
- When performing Botox injections, it is helpful to understand the HCPC

code (J0585) for the units used and the HCPC modifier (JW) for the units wasted.

- Specific office-based laryngology codes for flexible laryngoscopy with laser treatment (31572), with therapeutic injection (31573), and with vocal fold injection augmentation (31574) provide exact coding for these common procedures. These codes should be used as opposed to the previously used unlisted code of larynx 31599.

### Key Procedure Codes

#### Laryngeal Diagnostic Procedures: Flexible Laryngoscopy and Stroboscopy

- 31575** Laryngoscopy, flexible; diagnostic  
*wRVU 0.94; Global 0*
- 31576** with biopsy(ies)  
*wRVU 1.89; Global 0*
- 31577** with removal of foreign body(s)  
*wRVU 2.19; Global 0*
- 31578** with removal of lesion(s), non-laser  
*wRVU 2.43; Global 0*
- 31579** Laryngoscopy, flexible or rigid telescopic, with stroboscopy  
*wRVU 1.88; Global 0*

#### Therapeutic Vocal Fold Injection Procedures

Performing therapeutic laryngeal injections (31573) with flexible laryngoscopy can be performed transoral, percutaneous (transcervical), or through the working channel of the flexible scope. This also includes when done through the mouth using a rigid 70-degree scope. This code is a unilateral code and can be reported for bilateral procedures using modifier 50 for patients that require bilateral injections. Therapeutic injections may include but are not limited to steroids, botulinum toxin A, vascular growth factor inhibitors, or anti-viral medi-

cations. Therapeutic injections do not include the injection of saline or local anesthetic for evaluation of the integrity of the lamina propria. The site of these therapeutic injections can be any location within the larynx, most commonly the true or false vocal folds.

**31573** Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral  
*wRVU 2.43; Global 0*

**31574** Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral  
*wRVU 2.43; Global 0*

Vocal fold augmentation is aimed at addressing glottal insufficiency of a variety of etiologies. There are a variety of different augmentation materials involved in this procedure. This code is a unilateral code and can be reported for bilateral procedures by appending modifier 50 for patients that require bilateral injections. Medicare's allowable for 31574, in the non-facility/physician office setting (POS 11), includes payment for the substance injected. It would not be accurate to separately report a J code for the injectable as is done with 31573.

### Vocal Fold/Larynx Laser-Based Procedures (31572)

Office-based flexible lasers commonly used in laryngology include KTP and CO<sub>2</sub> lasers. These lasers are used to treat a variety of laryngeal conditions such as recurrent respiratory papillomatosis, airway stenosis, benign and neoplastic lesions, vascular lesions and ectasias, and benign mucocoeles. The office setting versus an operating/procedure room setting may be selected based on the clinical severity and patient comorbid conditions. This code is a unilateral code and can be reported for bilateral procedures by using modifier 50 for patients that require bilateral laser treatment. Site of service can affect the reimbursement for dis-

posable laser fibers and facility fees. A facility/hospital-based setting/clinic (eg, place of service code 22) is more likely to receive reimbursement for supplies and equipment versus a non-facility/non-hospital-based setting/clinic (eg, place of service code 11) in which those costs may be absorbed. The laser should be owned or rented by the appropriate place of service that is billed, so that the cost of operation and maintenance is accounted for with the reimbursement.

**31572** Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral  
*wRVU 3.01; Global 0*

### Botulinum Toxin Injection of Laryngeal Muscles

**64617** Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed  
*wRVU 1.90; Global 10*

Botulinum toxin injection of the larynx can be performed for a variety of conditions: most commonly spasmodic dysphonia, but also may be necessary for the treatment of other laryngeal conditions such as essential tremor, laryngeal spasm, laryngeal dyspnea disorders including refractory paradoxical vocal fold motion disorder, laryngeal synkinesis, and refractory false vocal fold hyperfunction causing dysphonia. CPT 64617 includes all laryngeal botulinum toxin injections performed **percutaneously**, despite method for (for either adductor or abductor spasmodic dysphonia) guidance; EMG, or point-touch technique.<sup>3</sup> Bilateral injections of botulinum toxin are often required for the management of spasmodic dysphonia and other conditions; append a modifier 50 when bilateral injections are performed. Do not include 95874 for needle electromyography guidance, as this is already included in 64617. Refer to Chapter 11 for more information on when to use modifier 25.

### **Botulinum Toxin Injection of Salivary Gland, Facial Muscles, Oral Muscles, Neck Muscles, (excluding muscles of the larynx)**

For 64611, append modifier 52 if fewer than four salivary glands are injected. Report 95874 for needle electromyography guidance when used, noting that absence of the EMG signal confirms placement in salivary gland. For 64612 and 64616 append modifier 50 for bilateral procedures and report 95874 for needle electromyography guidance when used.

- 64611** Chemodenervation of parotid and submandibular salivary glands, bilateral  
*wRVU 1.03; Global 10*
- 64612** Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)  
*wRVU 1.41; Global 10*
- 64616** neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)  
*wRVU 1.53; Global 10*
- +95874** Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)  
*wRVU 0.37; Global ZZZ*

### **HCPCS II Code**

**J0585** Injection, onabotulinumtoxin A, 1 unit

### **Instrumental Swallowing Tests and Esophageal Testing**

All codes listed below include the flexible fiberoptic laryngoscopy so do not separately report 31575. Also, all recording codes listed below require permanent images be saved.

- 92611** Motion fluoroscopic evaluation of swallowing function by cine or video recording  
*wRVU 1.34; Global XXX*

Also known as video fluoroscopic swallow study, VFSS, or modified barium swallow study, MBS. For radiologic supervision and interpretation, only use 74230.

- 92612** Flexible endoscopic evaluation of swallowing by cine or video recording;  
*wRVU 1.27; Global XXX*

Commonly referred to as FEES.

- 92613** interpretation and report only  
*wRVU 0.71; Global XXX*

This code is typically reported by the physician

- 91010** Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;  
*wRVU 1.28; Global 0*
- 91034** Esophagus, gastroesophageal reflux test: with nasal catheter pH electrode(s) placement, recording, analysis and interpretation  
*wRVU 0.97; Global 0*
- 91035** with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation  
*wRVU 1.59; Global 0*
- 91037** Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;  
*wRVU 0.97; Global 0*
- 91038** prolonged (greater than 1 hour, up to 24 hours)  
*wRVU 1.10; Global 0*

### **Transnasal Esophagoscopy**

CPT 43197 describes a diagnostic transnasal esophagoscopy while 43198 is for a biopsy, when performed. There is also a code for performing a tracheoesophageal fistula, 31611. Some otolaryngologists and laryngologists perform creation of the tracheoesophageal fistula for placement of a laryngeal speech prosthesis/tracheoesophageal prosthesis (TEP valve) under local anesthesia in the office-based setting.<sup>4,5</sup> The procedure is safe

and effective for secondary TEP placement in patients who underwent laryngectomy. The procedure requires a channeled transnasal esophagoscopy (TNE) scope with insufflation. Use 31611 when this is done. The transnasal esophagoscopy should not be billed separately when this is done, even if used for visualization.

**43197** Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)  
*wRVU 1.52; Global 0*

**43198** with biopsy, single or multiple  
*wRVU 1.82; Global 0*

**31611** Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)  
*wRVU 6.00; Global 90*

### Esophagoscopy with Injection and Dilation Procedures

**43201** Esophagoscopy, flexible, transoral; diagnostic, with directed submucosal injection(s), any substance  
*wRVU 1.72; Global 0*

**43220** with transendoscopic balloon dilation (less than 30 mm diameter)  
*wRVU 2.00; Global 0*

**43214** with dilation of the esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)  
*wRVU 3.40; Global 0*

**43450** Dilation of esophagus, by unguided sound or bougie, single or multiple passes  
*wRVU 1.28; Global 0*

(dilation without endoscopic visualization or radiological supervision and interpretation)

**43453** Dilation of esophagus, over guide wire  
*wRVU 1.41; Global 0*

(dilation without endoscopic visualization or radiological supervision and interpretation)

Typically, a diagnostic CPT code is included in a therapeutic/treatment CPT code. However, one exception is that 43450 may be separately reported with the diagnostic service codes 43191 or 43200.

### Flexible Bronchoscopy for Diagnosis

**31615** Tracheobronchoscopy through established tracheostomy incision  
*wRVU 1.84; Global 0*

**31622** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)  
*wRVU 2.53; Global 0*

**31623** with brushing or protected brushings  
*wRVU 2.63; Global 0*

### Airway Dilation for Stenosis

**31528** Laryngoscopy direct, with or without tracheoscopy; with dilation initial  
*wRVU 2.37; Global 0*

**31529** with dilation, subsequent  
*wRVU 2.68; Global 0*

**31630** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture  
*wRVU 3.81; Global 0*

### Key Modifiers

#### **JW Drug amount discarded/not administered to any patient:**

This is an HCPCS II modifier that can be used to indicate when botulinum toxin was wasted/discarded and the entire vial was not used on the patient. For example: a patient receives 1.25 units of botulinum toxin in each vocal fold for a total of 2.5 units administered and 2.5 units discarded on that patient (a total of 5 units was drawn up