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SPECIAL REPORT: Socioeconomic Disparities in Otolaryngology: No Easy Explanations, No Easy Answers



Turn to page 14 for a discussion of socioeconomic factors that affect otolaryngologic conditions, diagnoses, and treatment.

Sialendoscopy: On the Brink of Prime Time in the US?

By Gretchen Henkel

“Sialendoscopy has changed my entire approach to salivary obstructive disease,” said Barry M. Schaitkin, MD, Associate Professor in the Department of Otolaryngology at the University of Pittsburgh School of Medicine. “I think it will take over completely the approach to treating salivary gland stones.”

Indeed, the minimally invasive procedure has been proving to be effective for both diagnosis and management of obstructive salivary gland disorders. After 10 years of expansion in Europe,<sup>1-4</sup> the technique is now gaining purchase in the United States.<sup>5</sup> In properly trained hands, say otolaryngologists and head and neck surgeons, sialendoscopy can be used to effectively manage obstructive salivary gland disorders (especially calculi).

However, cautioned Dr. Schaitkin and two other noted otolaryngologists—one of them a developer of a widely used system—the technique is not a panacea for diagnosing and treating all disorders of the salivary gland, such as salivary tumors. Proper training and careful selection of patients are key to successful outcomes.

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David W. Eisele, MD (left), and his associates perform a sialendoscopic procedure. Its minimally invasive nature means that sialendoscopy will increasingly offer real benefits to patients.

COSM 2008: American Rhinologic Society

Coding: It's All in the Details

By Pippa Wysong

ORLANDO, FL—Getting reimbursed properly for performing procedures is all in the details, especially in areas that can be confusing to code. This was the underlying message at a talk on CPT coding at the American Rhinologic Society (ARS) meeting at the recent annual Combined Otolaryngological Spring Meeting. The aim of the talk was to help residents and fellows improve this part of their practice.

“You need to document in your chart exactly what you do, why you did it, and how you did it,” said Michael Setzen, MD, Clinical Associate Professor of Otolaryngology at New York University School of Medicine, who practices in Long Island. He described how to code for several areas that can be confusing to code for, such as image-guided work, septoplasty, postoperative debridement, and other rhinologic procedures.

The three most important elements to keep in mind are documentation, medical necessity, and accurate coding, he said.

Don't simply mark down “I did nasal endoscopy,” he said. Explain why it was done. “Say you did nasal endoscopy because you wanted to evaluate the osteomeatal complex, you were looking for polyps, you saw pus exuding from the

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## Coding

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area. You want to document what you saw and what you did so that an insurance carrier can see a complete reason why you did the nasal endoscopy," he said.

Codes need to be correct, too. "You need to code appropriately, fairly, and diligently. Because if not, you can get audited, and there are significant penalties. If CMS [the Centers for Medicare and Medicaid Services] or the government audits you, it's like

***Getting reimbursed properly for performing procedures is all in the details, especially in areas that can be confusing to code.***

an IRS audit—it's pretty severe," he said.

The coding needs to match the CPT code (the procedure code), and it needs to match appropriately with ICD-9 codes (the diagnosis codes). If a modifier is used, then that needs to be appended to the procedure code. For instance, if endoscopic sinus surgery (ESS) was done bilaterally, then a procedure code is needed for the left side, and a modifier is needed to show that the right side was also done.

"Modifiers are there for you to notify the insurance carriers, so they can ultimately reimburse you," he said. Left and right side applies to other procedures, too. In short, all the information needs to be there.

Dr. Setzen cautioned doctors to code properly. "If you code inappropriately, and *upcode*, you can make a lot of money. But if you get audited... there are significant penalties, and you can go to jail."

### Image-Guided Surgery

One tricky area to code for is image-guided surgery (IGS), largely because it is still often considered experimental and not standard care. According to expert opinion, IGS enhances endoscopic surgery, but there are few outcome studies because it is difficult to get large enough patient populations for them (about 50,000 patients are needed in outcomes studies to show statistical and clinical meaningfulness).

If a carrier says there are not enough studies to justify coverage, let them know that the studies cannot be done. However, the AAO-HNS Position Statement for IGS states that IGS is not considered experimental within the profession, and that there is sufficient expert consensus and published studies supporting its use.

Sometimes carriers don't want to cover an IGS procedure performed by an otolaryngologist, and say that it would have been eligible if it were performed by a neurosurgeon. The AAO-HNS Guidelines for IGS state that appropriately indicated procedures should be reimbursed regardless of the physician's specialty. Otolaryngologists can use the guidelines to support what was done.

When coding, "you need at least a couple of sentences on what you did...and show the medical necessity as to why you did it," Dr. Setzen said.

If an insurance carrier denies coverage of IGS, appeal it. Send a copy of the operative report to the carrier. If there is no response, send a copy to the commissioner for insurance of the state.

"You can also contact the different committees of the Academy, or the sister societies," Dr. Setzen said. For instance, the ARS has a patient advocacy committee that may be able to offer advice and help. "Don't just do one appeal; do repeated appeals because you should be reimbursed," he said. And include a copy of the AAO-HNS Position Statement on IGS.

### Endoscopic Sinus Surgery

Endoscopic sinus surgery can also be tricky to code for. Documentation needs to include whether the procedure was open or endoscopic, unilateral or bilateral (CPT

codes are unilateral unless otherwise specified), total or partial, and whether or not tissue was removed.

A sinusotomy and diagnostic endoscopy are included in all surgical endoscopies, and gaining access to the surgical site (using the endoscope) is included in the ESS code. One tricky aspect is that an endoscopic resection of a separately identifiable concha bullosa may be coded, “but getting paid is difficult,” he said.

Also, nasal polypectomy is included in all surgical endoscopies. “It is not a separate charge unless it’s done as the only procedure,” he said.

Modifiers 59 or 51 should be appended to a functional ESS (FESS) code to indicate the separate sinus; CPT codes differ depending on whether or not there was tissue removal from the maxillary or sphenoid sinus; append modifiers 59 or 51 on turbinate codes if performed at the time of FESS.

“When billing for endoscopic sinus surgery, we recommend that you start with the procedure that has the most value. In the New York area, I usually find that’s a complete ethmoidectomy—so I put that at the top. And then, in descending order, list the procedures with lesser value,” he said.

### Postop Debridement

Postoperative debridement is another controversial issue. “There’s been a little abuse on this—be very, very careful as to how many times you debride,” Dr. Setzen said.

On average, four debridements are reasonable, with up to six in complex cases. Document what tissue was removed, which sinuses were entered, which landmarks were preserved, the local anesthetic that was used, and any bleeding or pain. Details should be written up in a separate operative report that is kept in the medical record.

“If you do get audited, you’ve at least got good documentation as to what you did, why you did it, and how you did it. It looks like a real little procedure that you did, it’s not just a simple cleaning out of the nose,” he said.

### Balloon Sinuplasty

There have been problems across the country with coding for balloon sinuplasty. Many carriers consider it experimental and don’t want to cover it, he said. Otolaryngologists, however, are well aware of the advantages of the procedure. “It’s catheter-based, it’s minimally invasive, it assists one as a technology to do endoscopic surgery,” Dr. Setzen said.

To help battle the resistance to reimbursement, the AAO-HNS Position on Coding for Sinus Balloon Catheterization was published in March 2007. It provides information regarding coding and reimbursement when this technology is used. Otolaryngologists can use this document when appealing denials.

There is one caveat though. The position statement provides two criteria for balloon sinuplasty: one, that a sinus endoscope must be used to position the balloon prior to and during the cannulation of the ostia, and confirming dilation with the balloon; and two, that bone and mu-

cosa be moved in such a way as to significantly enlarge the ostium of the sinus that is treated.

If these two criteria are not met, “then you need to use an unlisted code,” Dr. Setzen said. A downside of unlisted codes is they generate a lot of paperwork.

### Other Coding Issues

Revision ESS is also problematic because there is no CPT code for it. “It’s basically the same CPT code as the primary endoscopic procedures. But if you feel it’s over

and above the work that you do on a primary procedure, you can append modifier 22, which lets the carrier know that this was unusual service, unusually difficult,” Dr. Setzen said.

For the patient who comes in with two different diagnoses, such as chronic sinus disease and reflux, otolaryngologists can now bill two separate procedures provided that two different scopes are used: a rigid scope for examining the nose, and a flexible scope for the larynx.

He cautioned physicians to be careful

when doing this so as not to raise a red flag. “This is new information, and we’re concerned that this is going to be abused,” he said. Using two scopes should be reserved for rare situations. “We all know that you can look at the osteonasal complex with a flexible scope, and then you can look at the larynx as well,” he said.

Regardless of the diagnosis or treatment, when it comes to CPT coding, make sure it is well documented and that medical necessity for the procedure is shown. **ENT**