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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Winning Tips Help You Update Your Turbinate Surgery Coding

Get familiar with the "unlisted" code for middle turbinate procedures

Otolaryngology coders listen up. If you're confused about recent changes to the turbinate codes, rest assured: The changes offer more specificity in reporting. The **American Medical Association** (AMA) made descriptor revisions "to clarify the widespread usage specific to inferior turbinates," according to CPT Changes 2006.

The bottom line: The AMA changed the descriptors of 30130, 30140, 30801, 30802 and 30930 to specify "inferior turbinate(s)" rather than the nonspecific "turbinate(s)." The codes now read:

• 30130--Excision inferior turbinate, partial or complete, any method
• 30140--Submucous resection inferior turbinate, partial or complete, any method
• 30801--Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial
• 30802--...intramural
• 30930--Fracture nasal inferior turbinate(s), therapeutic

So, you have reason to celebrate, but breaking old habits can be a challenge. Follow these four key tips to avoid foreseeable traps.

1. Distinguish inferior turbinate surgeries from "access" surgeries.

The new descriptors should clear up some faulty assumptions.

For instance, when practices billed 30130 or 30140 for excision or submucosal resection of the inferior turbinates, payors often denied claims based on the assumption that the ENT operated on middle turbinates for access to endoscopic sinus surgery, points out **Barbara J. Cobuzzi, CPC, CPC-H, CHBME**, president of **CRN Healthcare Solutions,** a coding and reimbursement consulting firm in Tinton Falls, NJ. Payors frequently bundle procedures of the middle turbinates to same session endoscopic sinus surgery (31240-31294) or even septoplasty (30520)," she explains.

The good news: "Payors can no longer assume your physician operated on middle turbinates for access when the new descriptors clearly state 'inferior turbinate,'" Cobuzzi says. "Now, payors won't have any reason to deny 30130 and 30140 for bundling purposes."

However, some payors may not know about this change, so you must educate them, Cobuzzi says. And once you've raised their awareness, it's more important than ever to link the appropriate diagnosis with the CPT code. This will help show the payor that the procedure warrants its own specific medical necessity.

What to do: When you report 31040 and 31030, make sure you list hypertrophy of the turbinates (478.0) as your primary diagnosis, Cobuzzi recommends. For a septoplasty (30520), use 470 (Deviated septum). Your secondary diagnosis for either procedure can be nasal obstruction (478.1).

2. Use 30999 for middle turbinate surgeries that aren't "access."

The catch: Since doctors do most of their work on the inferior turbinates, the AMA did not include "middle turbinates" in the code descriptors. Now, you'll have to report middle turbinate procedures that aren't access for endoscopic sinus surgery with 30999 (Unlisted procedure, nose), says **Chris Felthauser, CPC, CPC-H, ACS-OH, ACS-OR, PMCC** medical

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coding instructor and coding consultant for **Orion Medical Services** in Eugene, OR.

Example: A patient complaining of frequent congestion sees an ENT for nasal surgery options. After an examination, the physician decides to resect the middle turbinate due to turbinate hypertrophy (478.0) as the primary diagnosis. For this procedure, you would report 30999.

Again, you need to link a primary diagnosis to show medical necessity, and this becomes an even more critical factor when you're reporting unlisted codes.

Experts warn: You can easily run into reimbursement problems with unlisted codes, Felthauser comments. But the best thing you can do is call your contractor and preauthorize the unlisted services ahead of time.

Smart idea: "Let your contracting representative know that you might be using 30999 more frequently and would like to talk to them about setting up a 'rate' for this particular services. And it's better to do this all ahead of time rather than trying to appeal everything later," Felthauser adds.

3. Take extra reporting care with unlisted codes.

If you do end up having to report 30999, remember that with unlisted-procedure codes, you have to provide the payor with full documentation and additional information since it reviews unlisted codes on a case-by-case basis. Here are some tips to get started:

• **Send in a paper claim.** When using an unlisted code, you must submit a paper claim with a full operative report attached, says **Lori Bogan,** administrator of **Ear, Nose & Throat Associates of East Texas** in Tyler

Note: Some payors require an electronic claim as proof of "timely filing." For these payors, file the claim electronically and then submit paper documentation with a cover note or stamp stating, "This is not a duplicate claim. The documentation supports an electronic claim," Cobuzzi recommends.

• **Avoid medical jargon**. Claims reviewers don't always have a high level of medical knowledge or vocabulary, experts note. So part of your job is to act as an intermediary between the physician and the claims reviewer, providing a description of the procedure in layman's terms.

"If the person making the payment decision can't understand what the physician did, there's not much chance that the reimbursement you receive will properly reflect the effort involved," notes **Marvel Hammer, RN, CPC, CHCO,** owner of MJH Consulting in Denver, CO.

Tip: Include diagrams or photographs to help describe the procedure you are billing, and above all, "You should try to keep the description short and simple," Hammer says.

• **Compare the procedure to an existing code.** If you want to gain appropriate payment for an unlisted-procedure claim, you should provide the carrier with an appropriate place to begin. Rather than allow your payor to determine which is the "next-closest" code on which it should base your payment, you should explicitly reference the nearest equivalent listed procedure in your explanatory note. If you don't, the payor may choose a code that reimburses less.

Example: If you're reporting 30999 for an excision of the middle turbinate, be sure to reference 30130 with an explanation of why this is the closest code match and why you had to report the unlisted code.

Likewise, if the doctor did a submucosal resection of the middle turbinate, be sure the explicitly reference 30140, Cobuzzi advises. This code has more RVUs because the procedure is more extensive. Instead of a doing a straightforward excision, the ENT penetrates the mucousa around the turbinate and removes the turbinate bone only, preserving the mucousa.

"But the documentation needs to state that the bone was removed and the mucousa was preserved or else it won't

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count as a submucousal resection," Cobuzzi says.

Warning: Sending in a paper claim "slows things down quite a bit," Felthauser says. Because of this, you need to make sure you monitor these accounts for proper follow-up and reimbursement.

For more details on how to report unlisted codes, see the Dec. 2005 issue of Otolaryngology Coding Alert. For a copy of the information, send an e-mail to
shaylaj@eliresearch.com with "Otolaryngology" in the subject line.

4. Don't mix cautery and excision with submucous resection.

Another thing to watch for is in a parenthetical note following 30801-30802, which instructs you not to report these cautery/ablation procedures with turbinate excision (30130) or submucous resection (30140).

Why: Excision and submucous resection are primary. For example, if an ENT performs both excision and cautery/ablation, the excision is the primary service, and you should report 30130 only, according to CPT Changes 2006. Likewise, if the surgeon performs cautery/ablation with submucous resection as described by 30140, you should claim 30140 only. And, as with 30801-30802, you should not report 30930 with primary procedures 30130 or 30140.

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