Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Avoid Bundling Pitfalls for Clean Tonsillectomy Claims

Take this modifier 50 tip to the bank.

When billing tonsillectomy and/or adenoidectomy, you need to avoid some common mistakes if you want to get payment for your surgeon's work.

With age factors, combination codes, bilateral issues, bundling restrictions, and possible post-op bleeding, you have a lot to consider if you want to code your surgeon's work correctly. Read on for steps you can take to sort it all out.

Determine Patient's Age

Both tonsillectomy and adenoidectomy codes divide among two age groups: under 12 years, or age 12 and over, as follows:

- 42820 Tonsillectomy and adenoidectomy; younger than age 12
- 42821 ...age 12 or over
- 42825 Tonsillectomy, primary or secondary; younger than age 12
- 42826 ...age 12 or over
- 42830 Adenoidectomy, primary; younger than age 12
- 42831 ...age 12 or over
- 42835 Adenoidectomy, secondary; younger than age 12
- 42836 ...age 12 or over.

Watch CCI edits: The latest version of Medicare's Correct Coding Initiative (CCI), effective April 1, adds 12 edit pairs among the preceding codes for tonsillectomy and adenoidectomy. The bundled codes include each of the age pairs (either under age 12, or age 12 and over). "To me, you cannot ever code these together because either the patient is 12 years old or over, or the patient is younger than 12," says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. "She can't be both, so the descriptors will never coexist."

Understand Primary and Secondary

Sometimes tonsil or adenoid tissue grows back following a tonsillectomy or an adenoidectomy. That's the source of the terms "primary" and "secondary" in the codes. The term "primary" refers to the initial removal of the tonsil or adenoid. "Secondary" refers to a second surgery to remove portions of the tonsil or adenoid missed during the primary procedure.

Earn $15: CPT® provides different codes for primary or secondary adenoid removal. That means you must determine from the surgeon's documentation whether he performed a primary or secondary adenoidectomy. Billing a secondary adenoidectomy when the surgeon performed a primary could cost you pay $15 to be exact (42830 pays $215 and 42835 pays $200 using the national facility relative value units and the current conversion factor: 35.7547).

Choose And/Or

The combination adenoidectomy/tonsillectomy codes (42820-42821) present an additional coding pitfall you'll need to avoid.

If the surgeon performs both a tonsillectomy and adenoidectomy during the same surgery, you must use the combined tonsillectomy/adenoidectomy codes. "If you were to report 42826 (for tonsillectomy) and 42836 (for secondary adenoidectomy) separately, for instance, you would be committing an unbundling," says **Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC,** internal audit manager with PeaceHealth in Vancouver, Wash.

Don't ever report a stand-alone tonsillectomy or adenoidectomy code in addition to one of the combination codes (42820-42821). CCI creates bundles for all those code pairs, with no option to override the edits.

Snare: But what if the surgical note specifies that the adenoidectomy is primary or secondary shouldn't you use the more specific adenoid code and separately report a tonsillectomy code?

No: "Regardless of documentation about primary or secondary excision, if the surgeon performs a tonsillectomy and adenoidectomy at the same session, you must use the appropriate combination code, 42820 or 42821, based on the patient's age," Bucknam says.

CCI 21.1 affirms this bundling rule by creating edit pairs for each separate tonsillectomy code (42825-42826) with each separate adenoidectomy code (42830-42836). These edit pairs have a modifier indicator of "0" you cannot override the bundles with a modifier.

Beware "Bilateral" Modifier

When your surgeon removes tonsils and/or adenoids on both sides, should you bill the appropriate code with modifier 50 (Bilateral procedure) to indicate the surgeon's work?

Again, no: "Modifier 50 does not apply to tonsillectomy and adenoidectomy codes (42820- 42836), because the codes assume bilateral surgery," Bucknam says.

On the other hand, if your surgeon removes a single tonsil and/or a single adenoid, you should bill the appropriate code using modifier 52 (Reduced services).

Consider Separate Bleeding Control Charge

When the surgeon controls post-tonsillar or post-adenoidal bleeding during the 90-day global period of the surgery, you may be able to charge separately for the service for non-Medicare payers that follow AMA guidelines.

CPT® supplies six codes to describe post-tonsillar or postadenoidal bleeding:

- 42960 Control oropharyngeal hemorrhage, primary or secondary (e.g., post-tonsillectomy); simple
- 42961 ...complicated, requiring hospitalization
- 42962 ...with secondary surgical intervention
- 42970 Control of nasopharyngeal hemorrhage, primary or secondary (e.g., postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery
- 42971 ...complicated, requiring hospitalization
- 42972 ...with secondary surgical intervention.

The AMA designed 42960-42972 knowing that surgeons would use the codes during the postoperative period, and CPT® guidelines dictate, "Postoperative complications ... are not included in the surgical package. ... Postoperative complications included conditions such as wound dehiscence, infection and bleeding."

Translation: For payers that follow AMA guidelines, you should report 42960-42972 separately.

For example: An 11-year-old patient undergoes primary tonsillectomy and adenoidectomy. Four days later, the surgeon must treat the child in the office for post-operative bleeding in the area of the nose and throat.

In this case, you should report 42820 for the tonsillectomy/adenoidectomy and report 42970 for the control of bleeding. Append modifier 79 (Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period) to the follow-up procedure (42970) to indicate that this was an unrelated procedure during the global period of the tonsillectomy/adenoidectomy. The payer should recognize and reimburse for both codes.

CCI payers require OR: Because Medicare does not follow the CPT® surgical package for complicated postoperative care, you should not report 42960 or 42970 (control of bleeding) for Medicare payers. "These are simple procedures, usually performed in the surgeon's office, and Medicare bundles all care of postoperative complications that do not require a return to the operating room," Bucknam says.

If the bleeding does require a return to the OR, you can bill the bleeding-control code to Medicare. In that case, you must use modifier 78(Unplanned Return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period) to the follow-up procedure, instead of modifier 79.