CPT 2012 Code Update for Otolaryngology: An Overview of Evaluation and Management Code Changes

Kim Pollock, RN, MBA, and Mary LeGrand, RN, MA

There are several Current Procedural Terminology® (CPT) code changes for 2012 applicable to otolaryngologists. This article provides a high-level overview of Evaluation and Management (E/M) code changes and is not meant to be an all-inclusive discussion.

Evaluation and Management Services Guidelines

The new and established patient definitions in the Evaluation and Management Guidelines were revised to again include the statement “A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.” Additionally, CPT now says “An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.”

While CPT reintroduces these statements (deleted in 2011) of reporting a new patient code when your partner of a different subspecialty sends you a patient, the guidelines offer no specific definition as to what constitutes a “specialty” and “subspecialty.” The new patient versus established patient decision tree, also removed in 2011, has returned to the CPT codebook to illustrate the point. This, however, leaves otolaryngologists in a quandary. Can you, Dr. Neuro-otologist, report a new patient code (9920x) when your partner, Dr. Head and Neck sends you a patient? The CPT changes for 2012 lead you to believe so, although CPT offers no definition of specialty/subspecialty or even a specific example of a specialty/subspecialty.

However, Medicare and many other payers identify physicians according to their specialty rather than fellowship-training or board certifications subspecialty. In otolaryngology, Medicare does not have any separate subspecialty codes as they do for other specialties, such as orthopaedic surgery. Although CPT directs users to consider the physician’s subspecialty when choosing a new or established patient E/M code, again, CPT does not define the terms specialty and subspecialty. Furthermore, the vast majority of payers do not recognize physician subspecialties, such as those pertinent to otolaryngology (e.g., neuro-otology, rhinology, and laryngology).

Check with your payers to determine their policy on this issue and report accordingly.

Initial Observation Care

The typical time allocated for each of the three initial observation care codes, 99218-99220, was added to each code’s description.

Refer to the CPT codebook for specific new guidelines for the prolonged services codes.

Modifer 33 (Preventive Services)

This modifier has been effective since January 1, 2011, but was not included in CPT until the 2012 version. The Patient Protection and Affordable Care Act (PPACA) requires all healthcare insurance plans to begin covering preventive services and immunizations without any cost-sharing. Modifier 33 allows providers to identify for insurance payers that the service was preventive under applicable laws and patient cost sharing does not apply. In other words, co-pays or deductibles are not collected for services covered under this law.

The U.S. Preventive Services Task Force (USPSTF) A and B preventive service recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecons.htm, accessed November 16, 2011) applicable to otolaryngology include:

- Hearing loss screening in newborns,
- Tobacco use counseling and interventions: non-pregnant adults, and
- Tobacco use counseling: pregnant women.

For more information about modifier 33, refer to the CPT Assistant, December 2010.

Summary

It is important for otolaryngologists and their support staff to stay abreast of CPT changes. We recommend annual attendance at an Coding and Reimbursement Workshops. The 2012 course dates and locations are listed in the table below. Please visit http://karenzupko.com/workshops/otolarngology/index.html for more information.

Reference


Kim Pollock and Mary LeGrand are senior consultants at KarenZupko & Associates, Inc. (www.karenzupko.com), a physician practice management and training consulting company based in Chicago, IL. Both are instructors for the AAO-HNSF Coding and Reimbursement Workshops and long-time affiliate members of the Academy.

Note These 2012 Course Dates

January 20-21 Southlake (Dallas), TX
February 17-18 Las Vegas, NV
March 9-10 Orlando, FL
April 2-7-28 Chicago, IL
August 17-18 Nashville, TN
September 21-22 Baltimore, MD
October 26-27 Costa Mesa, CA
November 16-17 Chicago, IL
Kim Pollock, RN, MBA, and Mary LeGrand, RN, MA

There are several Current Procedural Terminology (CPT) code changes for 2012 applicable to otolaryngologists. This article provides a high-level overview of CPT code changes and is not meant to be an all-inclusive discussion.

Integumentary System
Skin, Subcutaneous, and Accessory Structures

The guidelines were revised to direct users to append modifier 59 (distinct procedural service) with either code 11042 or 11044, as appropriate, and the instruction to append modifier 59 to the add-on codes was deleted.

Repair (Closure)
Refer to the CPT codebook for specific guideline changes related to wound repairs. A significant change is the instruction to use modifier 59 when more than one code classification of wounds is reported. CPT states “list the more complicated repair as the primary procedure and the less complicated as the secondary procedure, using modifier 59” rather than modifier 51 (multiple procedures) as was historically used.

Skin Replacement Surgery
Significant changes were made to this subsection of the CPT codebook. The changes include deletion of 24 codes, revision of six codes, and the creation of eight new codes (15271-15278). The old codes (e.g., 15330) were intended to be used for skin replacement, though there was much confusion about this among physicians and coders.

The new codes are defined by the anatomic location, the surface area size in square centimeters (the first 25 or 100 sq. cm), and then an associated add-on code for each additional 25 sq. cm or 100 sq. cm as appropriate for the anatomic location and wound surface area size. Refer to the CPT codebook for a comprehensive listing.

These new codes apply to non-autologous human skin (dermal or epidermal, cellular or acellular) grafts (e.g., homograft, allograft), non-human skin substitute grafts (i.e., xenograft), and biologics that form a sheet scaffolding for skin graft. The graft is anchored using the surgeon’s fixation of choice, however CPT codes 15271-15278 do not apply to products that are non-graft wound dressings, such as gel, ointments, foam, or liquid.

While otolaryngologists may not commonly perform the above-noted skin replacement procedures, they will use a new code that resulted from these code changes. CPT 2012 introduced a new biological implant add-on code.
+15777, Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (e.g., breast, trunk) (List separately in addition to code for primary procedure).

Many otolaryngologists will likely use this code to provide soft tissue reinforcement to a defect (e.g., parotid, temporal) prior to skin closure.

Action Steps:
- Use +15777 to accurately report biologics that are not skin replacement, but where the biologic is used for soft tissue reinforcement.
- Report +15777 in addition to a primary procedure code; do not report it as a stand-alone procedure code.
- Do not append modifier 51 to +15777 because it is an add-on code and modifier 51 is not applicable.
- Expect 100 percent of the allowable to be reimbursed because it is an add-on code and should not be reduced for multiple procedures (modifier 51).

Hemic and Lymphatic Systems
A revision to CPT +38746 in the Lymph Nodes and Lymphatic Channels subsection has implication for otolaryngologists. This add-on code has been revised to state Thoracic lymphadenectomy by thoracotomy, mediastinal, and regional lymphadenectomy (List separately in addition to code for primary procedure). Therefore, this code now requires the performance of a thoracotomy in order to be reported.

Additionally, +38792 was revised to state Injection procedure; radioactive tracer for identification of sentinel node to clarify that this code should be reported only for injection of a radioactive tracer for sentinel node identification.

Auditory System
CPT 69802
(Labyrinthotomy, with perfusion of vestibuloligic drug(s); with mastoidectomy) was deleted because this procedure has become obsolete.

Medicine: Special Otorhinolaryngologic Services
Audio/ogic Function Tests
CPT 2012 brings a new otoacoustic emission code (OAE) for automated analysis of OAEs, and the existing two codes have been revised. Below is a comparison of the 2011 and the 2012 CPT code descriptors.

2011

92587
2011
Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)

2011
Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, three to six frequencies) or transient evoked otoacoustic emission, with interpretation and report

92588
2011
Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)

2012
Comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report

92558
2011
Code did not exist

2012
Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis

The new code, 92558 (not to be confused with existing code, 92588), was developed to describe the automated testing of screening evoked otoacoustic emissions. Notice that the new code, 92558, has the # symbol prior to the code to show that this code is out of numerical sequence in the CPT codebook.

Medicare’s non-facility (physician office, place of service 11) relative value units (RVUs) for the existing codes, and the new code, are listed in the table below.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>’2011 RVU-NF’</th>
<th>’2012 RVU-NF</th>
</tr>
</thead>
<tbody>
<tr>
<td>92587</td>
<td>1.09</td>
<td>0.83</td>
</tr>
<tr>
<td>92588</td>
<td>1.95</td>
<td>1.26</td>
</tr>
<tr>
<td>92558</td>
<td>NA</td>
<td>0</td>
</tr>
</tbody>
</table>

Medicare considers the new code 92558 a “statutory exclusion” from the Medicare Physician Fee Schedule and will not reimburse for this service because it is a screening, automated analysis test. While this type of testing will likely not be performed on a Medicare patient, other payers may not reimburse due to Medicare’s policy. Check with your payers for their policies.

Evaluative and Therapeutic Services
CPT 92605 (Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour) was revised to include the time component in the descriptor. Additionally, a new add-on code, +92618 (Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient: each additional 30 minutes [List separately in addition to code for primary procedure]), was created to account for time spent face-to-face with the patient beyond one hour.

Finally, 92621 (Evaluation of central auditory function, with report; each additional 15 minutes [List separately in addition to code for primary procedure]) now includes the + symbol prior to the code to reflect the status of this code as an add-on code.

Medicine: Neurology and Neuromuscular Procedures
Sleep Medicine Testing
The guidelines for this subsection have been updated and should be reviewed by any otolaryngologist who performs sleep testing (attended or unattended). There were two new unattended sleep study codes, 95800-95801, in CPT 2011.

Summary
It is important for otolaryngologists and their support staff to stay abreast of CPT changes. We recommend annual attendance at an AAO-HNSF Coding and Reimbursement Workshops. The 2012 course dates and locations are listed in the table below. Please visit http://karenzupko.com/workshops/otorolaryngology/index.html for more information.

Kim Pollock and Mary LeGrand are senior consultants at KarenZupko & Associates, Inc. (www.karenzupko.com), a physician practice management and training consulting company based in Chicago, IL. Both are instructors for the AAO-HNSF Coding and Reimbursement Workshops and long-term affiliate members of the Academy.

Reference