Billing and Coding ENT Procedures

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What do otolaryngologists and ASC coders for ENTs need to understand about coding rules in order to optimize fair reimburse-ment? Consider the following tips.

Keep your eye on the contract you have with each payor

Many payors write contracts in which they limit the number of multiple procedures that will be reimbursed. When engaging in contract negotiations, be aware of how common multiple procedures are at your facility, and be willing to push the payor to expand the number of multiples beyond three or four. Persistence can pay off.

And speaking of multiple procedures, know your right from left

Laterality continues to be a misunderstood coding issue among ENT practices. Endoscopy codes presented in CPT are unilateral. Even codes that seem potentially bilateral, like 30930 Fracture nasal inferior turbinate(s), therapeutic are unilateral. When performing ENT procedures bilaterally, report modifiers RT and LT for most payors, although some may prefer modifier 50.

Match the ASC billing to the physician billing

Frequently, ENT surgeons provide codes to their billers incorrectly. The Centers for Medicare and Medicaid Services (CMS) and other payors are going to compare facility codes against physician codes to ensure everyone is telling the same story, and when there's a difference, payment will be delayed until the problem is resolved. Ensuring the physicians are billing correctly is one sure way to protect the ASCs accounts receivable.

Keep your diagnostic story straight, too

Sometimes, the physician will schedule a case that is clearly therapeutic in nature, but the operative notes suggest some cosmetic work was done as well, particularly in nasal reconstruction. To ensure your facility is fully paid for its services, work with physicians on how to create documentation that clearly identifies therapeutic vs. cosmetic procedures, so that the payors are satisfied and the patient can be informed if he's going to be billed for a portion of the care.

Know the payors' place of service rules

Payors differ in their rules regarding which procedures qualify for performance in an ASC. Create a cheat sheet of which payors exclude complicated head-and-neck surgeries, so place of service doesn't create payment problems for you. For example, CPT code 61795 is an add-on code reporting stereotactic computer-assisted volumetric guidance common to some complex endoscopic sinus surgeries. Medicare will not pay the ASC for this code. If performed in your facility, the physician will get paid, but not the ASC. A savvy ASC administrator negotiates payment for 61795 into private contracts, but will not get payment from Medicare.

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