Chapter3 4. Coding

Jay Meisner, MD, FACS

- **Brief History:** The fourth edition of *Current Procedural Terminology* (CPT, 2011 modification)[1] was developed by the American Medical Association (AMA) and was published for first use in 1966. Its initial purpose was unrelated to reimbursement; it was developed as a type of medical shorthand for documenting and recording procedures. In 1983, the Health Care Financial Administration (HCFA) mandated that CPT be used as a standardized method for Medicare billing. This was extended to include Medicaid billing in 1986. Major insurers soon began to mandate its use, and would reject any medical claims not using CPT coding.[2]
- **Purpose of CPT coding:** Today, CPT coding is a standardized means by which a medical provider most accurately describes procedures performed. It may be used as a tool for documentation alone, as with purely aesthetic procedures. More commonly, it must be used as a communication tool to health insurers to accurately document procedures performed and to obtain appropriate reimbursement.
- The **International classifi ation of diseases**[3] (ICD) originated in seventeenth-century England, and its current ninth revision (ICD-9) is used to describe medical diagnoses. Using the most specifi c ICD-9 code(s) matching the specifi c CPT code(s) of the procedures (to be) performed is the best way to communicate what was done, and for what reason. Insurers will deny payment for viable claims if the ICD-9 code does not match the CPT code.
    - *Cosmetic vs. reconstructive surgery*: In 1989, the AMA adopted the following definitions of cosmetic and reconstructive surgery, which is reiterated in the American Society of Plastic Surgeons (ASPS) Recommended Insurance Coverage Criteria for Third-Party Payers. *Cosmetic* surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. *Reconstructive* surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.[4]
    - The treating physician must carefully assess the potential patient to determine whether the proposed procedure is purely elective and aesthetic, purely reconstructive, or a combination of cosmetic and reconstructive procedures.
    - *Combined cosmetic and reconstructive procedures*: When rhinoplasty has both cosmetic and functional components, it is always important to preauthorize the procedures in writing, to be sure to distinguish which components are reconstructive (both preoperatively and in a single operative dictation), and to not bill the carrier for the cosmetic components.[5] It is worthwhile to quote the AMA definitions above in the preauthorization request. Similarly, it is recommended that the cosmetic and reconstructive portions are clearly itemized for the patient in writing. The patient should understand the cost of the cosmetic component as well as any deductibles, coinsurances, and balances above and beyond the usual and customary reimbursement for the reconstructive portion.
- **Elective aesthetic rhinoplasty:** CPT coding for elective, purely aesthetic rhinoplasty may be used for documentation of the type and extent of the procedure for the physician's medical records. Practices may use and analyze this documentation for practice management, procedure trends, combined procedure analysis, and marketing. Although not mandated, the use of aesthetic rhinoplasty codes in combination with functional CPT codes may serve to fully document which portions of a combined procedure are aesthetic and non-reimbursable and which portions are functional and reimbursable.
    - When ICD-9 coding is necessary, V50.1 (plastic surgery for unacceptable cosmetic appearance) may be used.
    - CPT codes may be used to document the various types and extent of aesthetic rhinoplasty. Primary rhinoplasty implies no prior nasal surgery. Secondary rhinoplasty implies prior nasal surgery by the treating surgeon or by another surgeon.
- **Reconstructive rhinoplasty and related procedures:** It is imperative that any and all proposed reconstructive

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rhinoplasty and related procedures be preauthorized by the involved health insurance carrier *in writing* prior to performing such procedures. CPT codes for rhinoplasty do not and cannot directly indicate whether the procedure is cosmetic or reconstructive. Most rhinoplasty CPT codes may be construed as cosmetic in nature, so complete documentation of the reconstructive nature of the proposed procedures must be conveyed to the carrier and acknowledged as reimbursable. Both primary and secondary rhinoplasty codes not only describe procedures performed electively for correction of primary nasal deformities and post-rhinoplasty deformities, respectively, but they may be used to report treatment of an array of functional and/or reconstructive nasal problems. In the event that any of the above procedures are performed for functional reasons, appropriate pre-procedure authorization as well as post-procedure documentation of the extent and nature of the procedure performed must accompany any insurance billing.
  - The following ICD-9 codes, which are not meant to be fully inclusive, may be used to describe the most common functional problems in reconstructive rhinoplasty (Table 34-1):
- **CPT Coding of reconstructive rhinoplasty procedures:** The following is a listing of the most common reconstructive rhinoplasty codes. It is imperative to match the diagnosis code(s) with the CPT code(s) and to document all procedures performed in detail in the operative report. There is no distinction made as to the surgical approach, whether open or endonasal (Table 34-2).
- The following graft codes may be used in addition to the primary procedure codes (Table 34-3):
- **Coding of traumatic nasal fractures and their sequelae:** Acute traumatic nasal fractures (closed, ICD-9 802.0 or open, ICD-9 802.1) are often treated by closed reduction with or without stabilization (CPT 21315 or 21320). The results of closed reduction, however, may not be optimal and may require a secondary procedure to restore the nose to the pre-injury state. If the fracture is healed, it is no longer an acute fracture and using 21315 or 21320 again is not indicated. The use of a primary rhinoplasty code is appropriate, yet if only osteotomies are performed, there is no appropriate primary rhinoplasty CPT code. Therefore, CPT 30410-52 may be used, indicating the bony work was performed without the cartilage work. Of course, appropriate detailed documentation is required.[6]
- **The use of CPT modifiers:** CPT modifiers may be used to denote services above and beyond the usual magnitude of the procedure (-22) or diminished services (-52). These modifiers serve to increase or diminish services not sufficiently described by the particular CPT code.
  - The postoperative period, when any additional procedures are considered incidental to the primary procedure, is usually 90 days. Staged procedures performed within this postoperative period may be identified using the -58 modifier. An unplanned return to the operating room during the postoperative period must be billed with the -78 modifier. An unrelated procedure (eg, removal of a skin cancer during the postoperative period for a submucous resection) must be billed with a -79 modifier.
  - Bilateral procedures are denoted by the -50 modifier. Some carriers prefer the use of –LT and –RT.
  - Although the -51 modifier may be used to denote multiple procedures (using -51 for any procedures after the first), omitting it rarely has any effect on claims processing.
- **Unbundling of procedures:** When a single CPT code exists that describes a combination of procedures, it is not appropriate to separately bill each part of the procedure with an individual code. In many cases, the CPT manual makes note of codes not usable with certain other codes. This unbundling of procedure codes is usually picked up at the initial claims processing level, when sophisticated claims processing algorithms deny codes, which are documented as being a part of another procedure. This may occur even in the face of a fully preauthorized listing of CPT codes. For example, CPT 30420 (complete rhinoplasty with major septal repair) includes CPT 30520 (septoplasty or submucous resection).
  - It is recommended that any and all proposed procedure codes be carefully reviewed for inclusive components prior to preauthorization or billing. Of course, if there is a denial of a code that is felt to not be bundled into another code, the claim should be appealed with a detailed explanation.
- **Criteria for insurance coverage for reconstructive rhinoplasty and related procedures:** Many third-party payers (health insurers) have specific criteria that need to be met prior to approving proposed reconstructive

Table 34-1

ICD-9	Description
095.5	Saddle nose deformity
470.0	Deviated nasal septum, acquired
478.0	Nasal turbinate hypertrophy
478.1	Nasal airway obstruction
709.2	Scar
733.81	Malunion of nasal/septal fracture
748.1	Congenital nasal deformity
754.0	Congenital nasal/septal deformity
905.0	Late effect of fracture of skull or facial bones

Table 34-2

CPT	Procedure (Reconstructive Rhinoplasty)	Comments
30400	Primary rhinoplasty: lateral and alar cartilages and/or tip	May be used for congenital, traumatic, or extirpative soft tissue deformities. This codes rhinoplasty without bony work.
30410	Primary rhinoplasty: lateral and alar cartilages, tip, bony pyramid	May be used to code correction of soft tissue deformities with osteotomies. It may also code osteotomy only without a tip or cartilage procedure, using the -52 modifier. This codes rhinoplasty with osteotomies. It may also code osteotomy only without a tip or cartilage procedure, adding the -52 modifier.
30420	Primary rhinoplasty: lateral and alar cartilages, tip, bony pyramid, including major septal repair	Use this code when performing reconstructive rhinoplasty in conjunction with septal work. Use 30520 for isolated septal work. Septal repair may be done for nonfunctional reasons such as non-obstructive deformity or caudal dislocation.
30430	Secondary rhinoplasty: minor revision, nasal tip	Be sure to document the indications for functional tip revision. Note that the secondary codes are somewhat different from the primary codes.
30435	Secondary rhinoplasty: bony work with osteotomies	This code is best used for correction of secondary bony deformities.
30450	Secondary rhinoplasty: nasal tip and osteotomies	
30520	Septoplasty or submucous resection	Use this code alone or in addition to a secondary reconstructive rhinoplasty code. There is no CPT code for isolated septal work during a secondary rhinoplasty. This code may also be used for primary nonfunctional septoplasty.
30130	Excision inferior turbinate, partial or complete, any method	Note that turbinate codes are by default bilateral.
30140	Submucous resection inferior turbinate, partial or complete, any method	Use -52 modifier for "reduction" of turbinates (eg, needle cautery)
30460	Cleft lip rhinoplasty including columellar lengthening; tip work only	Columellar lengthening is included in 30460 and 30462.
30462	Cleft lip rhinoplasty; tip, septum, osteotomies	This code contains all soft tissue and bony components. May use -52 modifier if only bony work is done. May be used in addition to the cleft lip nose repair codes 30460 or 30462.
30465	Repair vestibular stenosis (spreader grafting, lateral nasal wall reconstruction)	Be sure to add the appropriate code for the graft used (below).

rhinoplasty procedures. These criteria may usually be found at the carrier's website or by request. By obtaining a specific insurer's criteria, steps toward preauthorization may be optimized.

- The most common indications for nasal reconstructive surgery include impaired nasal respiratory function (including decreased or altered airway flow), anatomic abnormalities caused by birth defects or disease, or structural deformities due to trauma. Congenital deformities, such as cleft lip nasal deformity or developmental anomalies may be covered even if there is no functional deficit; often the carrier denies the preauthorization request if no true functional deficit exists. It requires diligence and persistence, and on occasion a peer-to-peer discussion with a medical director, to convince the carrier that the patient has a congenital deformity requiring correction in order to approximate a normal appearance.[2]

- **Methods of documentation for preauthorization:** The treating surgeon should accurately document the patient's pertinent medical history, past surgical history, social history, and detailed physical examination findings. A written referral from the referring provider

Table 34-3

CPT	Procedure (Additional or Ancillary Procedures)	Comments
15760	Graft, composite	
20912	Septal cartilage graft to nose	May not be used with 30420, 30462 or 30520, as these are primary septal codes.
20926	Tissue grafts, other (paratenon, fat, dermis)	
21210	Bone graft to nose (includes obtaining graft)	
21230	Rib cartilage graft to nose (includes obtaining graft)	
21235	Ear cartilage graft to nose (includes obtaining graft)	

may help to strengthen the indications for surgery. Reports from other treating physicians as well as any prior operative reports or photographs should be obtained. Preoperative photographs, as indicated, should be clearly labeled with the patient's name, the surgeon's name, and the date taken.

- ◦ Any and all functional abnormalities and/or nasal defects should be documented, not limited to: visible or palpable deformities, visible degree of septal deviation, degree of turbinate hypertrophy, difficulty breathing at rest and with exercise, effect of external nasal repositioning on airflow (Cottle maneuver).
- ◦ For congenital anomalies or traumatic injuries, it is important to document the significance of how it deviates from the norm, and in some cases how it impacts the individual psychosocially.
- ◦ Diagnostic studies may be performed as clinically indicated, including facial X-rays, CT or MRI scans, nasal endoscopy, and/or nasal airflow studies.
- ◦ When submitting a written preauthorization request, include as much pertinent documentation as possible, trying to meet all of the specific carrier's criteria. It is worthwhile requesting that a board-certified plastic surgeon review the preauthorization request.
- ◦ Some practices send preauthorization requests via traceable mail carrier. It is recommended the carrier be called to confirm receipt and to follow up the request in timely fashion.
- ◦ Obtaining preauthorization *in writing* is strongly recommended prior to performing surgery.

- **Handling preauthorization denials:** Denials for preauthorization should be received in writing. Many carriers do not give detailed explanations, and often the request is reviewed by a clerk or nurse. Unless the carrier specifically excludes the proposed procedure(s), it is worthwhile to appeal their decision in writing and, if possible, with a peer-to-peer discussion with the individual who denied the request. Denial by a nonphysician should be followed by an immediate request that a physician (preferably a board-certified plastic surgeon) review the request.
  - ◦ Despite clear indications and documentation, many preauthorization requests are denied. The surgeon and staff should follow all appeal procedures in the hope that escalating the exposure to higher ranking carrier's representatives and medical directors will lead to preauthorization of indicated procedures.
  - ◦ Persistent denials for these types of procedures may require involvement of the local Medical Society's insurance advocate. If the coverage is not a self-funded plan, an external appeal with the state's Department of Insurance may be possible.
  - ◦ Finally, it may be advantageous to involve the patient in the process. Depending on the nature of the anomaly or deformity, a personal appeal by the patient to the carrier may have positive results.
- **Billing of reconstructive rhinoplasty procedure:** A carefully itemized billing should include the following:
  - ◦ Standard HCFA billing form with appropriate CPT codes and modifiers
  - ◦ Matching ICD-9 diagnosis codes
  - ◦ Appropriate modifiers
  - ◦ Preauthorization reference number
  - ◦ A copy of the written preauthorization
  - ◦ The operative report, which should clearly make note of the patient's history, symptoms, physical findings, prior surgery, and specific indications for surgery. "All proposed procedures have been preauthorized in writing by the carrier" may be added.
- **Medicare billing:** There are several situations that distinguish the billing of procedures for Medicare beneficiaries. There is no preauthorization necessary or possible with Medicare. Documentation or operative reports may not be sent in with Medicare billings. As most rhinoplasty codes may represent either aesthetic or reconstructive procedures, documentation is paramount. Many functional rhinoplasty procedures are summarily denied and must be appealed. In the case of a Medicare patient who will undergo either a purely elective nasal procedure, or where a portion is considered cosmetic, it is imperative that patient understand and sign a Medicare Advance Beneficiary Notice of Non-Coverage.[7] This informs the patient that part or all of their surgery will not be covered by Medicare.

REFERENCES

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