Codify
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Outpatient Facility Coding Alert

ENT Spotlight: Consider These Factors to Find Success with Tonsillectomy Claims

Pay attention to whether post-op bleeding is payable.

Tonsillectomy and adenoidectomy cases might be common in your facility, but that doesn't mean the billing is always straightforward. Multiple factors come into play when you're considering how to code your surgeon's work, so keep our experts' advice in mind the next time you tackle a claim.

Start by Verifying the Patient's Age

The first distinction between tonsillectomy and adenoidectomy codes is based on two age groups: under 12 years, or age 12 and over. Your choices are 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: Earlier in 2015, Medicare's Correct Coding Initiative (CCI) edits reinforced the importance of paying attention to the patient's age. Newly announced bundled codes for tonsillectomy and adenoidectomy included 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, COC, CPC-P, CPC-I, CPCO,** vice president Stark Coding & Consulting, LLC., in Shrewsbury, N.J. "She can't be both, so the descriptors will never coexist."

Know the Difference Between '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 or grew back subsequent to 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 reimbursement $15.40 to be exact (42830 pays $216.04 and 42835 pays $200.64 when performed in either a facility or non-facility setting , based on the 2016 national unadjusted conversion factor of 35.8279).

Pay Attention to Combination Codes

The combination adenoidectomy/tonsillectomy codes (42820-42821) present an additional coding pitfall you'll need to avoid: If the surgeon performs both procedures during the same surgical encounter, you must submit 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," explains **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.

Potential snag: 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.

Also: Steer clear of appending modifier 50 (Bilateral procedure) to these codes.

"Modifier 50 does not apply to tonsillectomy and adenoidectomy codes (42820-42836), because the codes assume bilateral surgery," Bucknam says.

However, 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 post-adenoidal 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.

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. You should report 42820 for the tonsillectomy/adenoidectomy and 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. It is unrelated because the post operative procedure is being performed for the post-operative bleed, (J95.830, Postprocedural hemorrhage and hematoma of a respiratory system organ or structure following a respiratory system procedure) not for the reason the T&A was performed originally, for example, J35.3 (Hypertrophy of tonsils with hypertrophy of adenoids). The payer should recognize and reimburse for both codes.

Caveat: Because Medicare does not follow the AMA 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 into the surgical global period," 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.