



**AMERICAN ACADEMY OF
OTOLARYNGOLOGY—
HEAD AND NECK SURGERY**

September 30, 2011

Greg McKinney, MD, MBA
Part B Medicare Medical Director
Cahaba GBA
P.O. Box 13384
Birmingham, AL 35202-3384

Re: Once in a Lifetime Procedures – Specified procedures that can only be performed once in a lifetime per beneficiary

Dear Dr. McKinney,

The American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) represents approximately 10,000 physicians in the United States who diagnose and treat disorders of the ears, nose, throat, and related structures of the head and neck. The medical ailments treated by this specialty are the most common that afflict all Americans, old and young, including hearing loss, balance disorders, chronic ear infections, rhinological disorders, snoring and sleep disorders, swallowing disorders, facial and cranial nerve disorders, and head and neck cancer.

We would like to express concerns over some procedures, which although uncommon, Cahaba GBA views as only occurring once in a lifetime. The procedures were documented in the January 2007 issue of the *Cahaba GBA Medicare Newline*. This *Newline* article has also been cited on the issue list of CGI, the Recovery Audit contractor (RAC) for Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin. After discovering Cahaba's list of once in a lifetime procedures, the Academy contacted Marie Casey, Deputy Director of Audit Division at the Centers for Medicare and Medicaid Services (CMS) to determine how we could request the removal of some procedures from the list. Ms. Casey informed us that because each Medicare Administrative Contractor had discretion to assemble its respective 'once in a lifetime' list, CMS does not have any jurisdiction on editing any once in a lifetime lists. As a result, we are following up with you and providing information to support the removal of some procedures primarily performed by otolaryngologist – head and neck surgeons from your 'once in a lifetime' list.

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If the aforementioned ‘once in a lifetime’ list of codes from the *Cahaba GBA Medicare Newline* is still current, we would like to identify some of those procedure codes which are relevant to otolaryngology-head and neck surgery, which we believe ***should be removed***. The CPT codes and rationales for removal are as follows:

31400 - Arytenoidectomy or arytenoidopexy, external approach

Arytenoidectomy is usually performed as a unilateral procedure to lateralize one vocal cord in a fashion that improves airway without undue compromise of voice. Typically, the associated diagnosis is bilateral vocal cord paralysis or arytenoid fixation resulting in airway obstruction. The contralateral side might need to be performed at a later time and should be reported for this date of service with this same code. Arytenoidopexy (surgical fixation of the arytenoid cartilages or muscles) is performed for unilateral vocal cord paralysis to position and help close the glottis during phonation and swallowing. It may require revision when this positioning is suboptimal due to scarring or other factors. Arytenoidopexy may be occasionally performed on the opposite side from the original procedure.

41150 – Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection

41153 - Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection

41155 - Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)

Although uncommon, 41150, 41153, and 41155 could be performed at a later time on the contralateral side from that which underwent a primary procedure, typically resection for malignancy. The code descriptors for this triplet of codes do not require total or complete glossectomy.

42825 - Tonsillectomy, primary or secondary; younger than age 12

42826 - Tonsillectomy, primary or secondary; age 12 or over

42835 - Adenoidectomy, secondary; younger than age 12

42836 - Adenoidectomy, secondary; age 12 or over

Although uncommon, with this group of tonsillectomy and adenoidectomy codes, revision or secondary excisions might be medically necessary at a future time. If



subcapsular tonsillectomy were performed, regrowth might occur requiring secondary tonsillectomy. Unilateral tonsillectomy is occasionally performed, most commonly for biopsy purposes when there is clinical suspicion of malignancy. If, at a different time, the other tonsil required excision, it would be reported with a secondary tonsillectomy code. Adenoid tissue will sometimes regrow requiring secondary resection and necessitating use of the appropriate secondary code for adenoidectomy a second time in the patient's lifetime.

62842 – Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure

42844 closure with local flap (eg, tongue, buccal)

42845 closure with other flap

Each of this triplet of codes is unilateral and reported typically for resection of unilateral malignancies of the tonsillar fossa and adjacent tissue. Although uncommon, if a similar resection were required on the contralateral side at some future date, the appropriate code would be reported for that procedure.

60220 - Total thyroid lobectomy, unilateral; with or without isthmusectomy

Thyroid lobectomy is, by definition, a unilateral procedure and this code may be reported with or without inclusion of the thyroid isthmus. One may frequently excise only one lobe of the thyroid, often for a benign mass or tumor. However, at a future time for the same, or another, clinical condition, the remaining lobe might require resection. This service would be separately reported with the same code, 60220. However, if the second procedure did result in complete removal of all thyroid tissue, 60260 *Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid* would be the correct code.

Our major concern with your decision to include these particular codes on your 'once in a lifetime' list is that the Medicare Recovery Audit Contractors (RACs), which have added these procedures to their list of issues to investigate, may erroneously view reimbursement for these legitimate and medically necessary procedures as overpayments. As we have previously mentioned above, there are certain instances when it is medically necessary to perform the indicated procedures on your "once in a lifetime" list more than once. We request that you address such instances in your "once in a lifetime" list. The immediate negative



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impact of RACs auditing these procedures is that it may, by dissuading physicians from providing high quality appropriate care to Medicare beneficiaries, limit their access to treatment. We request that you re-evaluate the procedures on your 'once in a lifetime' list and incorporate our rationales into your review.

We thank you for your consideration. Should questions remain unanswered, we would appreciate an opportunity to have you discuss your 'once in a lifetime' list with our Physician Payment Policy workgroup or during your next Contractor Advisory Committee (CAC) meeting. The ENT CAC for your region is Matthew L. Jerles MD; (478) 743-1963. If further information is needed, please contact Joe Cody, Health Policy Analyst at (703) 535-3729 or via e-mail at JCody@entnet.org to schedule a conference call.

Sincerely,

David R. Nielsen MD

David R. Nielsen, MD
Executive Vice President and CEO

cc: Richard Waguespack, MD
Michael Setzen, MD