Maxillary “Enterostomies”

October 18, 2018

Question:
I’m trying to find a code – can you help me please? I see this a lot – the note says “bilateral maxillary enterostomies” were performed. What is the code?

Answer:
Oh good grief! This is a transcription error. Please instruct the transcriptionist to use the term “antrostomy” instead.

*This response is based on the best information available as of 10/18/18.

Nurse Visit Code for SLIT

October 4, 2018

Question:
What do you think about a practice charging a nurse visit (99211) when a patient comes in for SLIT?

Answer:
What is the nurse doing separately to support 99211? If the intent of the services is to provide the vial of sublingual immunotherapy (SLIT) and instruct the patient how to take the medication, then no. CPT is very clear that picking up a prescription does not substantiate 99211.

*This response is based on the best information available as
Question:
My doctor wants me to bill 69990 (use of the operating microscope) with 69436 when she uses the microscope in the operating room to place tympanostomy tubes. What do you think?

Answer:
We do not advocate this practice. Why? Because the microscope is not being used for microdissection or microsurgery as the code states. Rather, it is being used for magnification and illumination during tympanostomy tube placement. A CPT Assistant from February 2018 actually supports this advice we’ve been giving for years.

*This response is based on the best information available as of 09/20/18.
Post-Tonsillectomy Bleed

September 6, 2018

Question:
I am being told that treating a post-tonsillectomy bleed in the ED with local anesthesia and silver nitrate will not be paid. Is it true that the only code that would be reimbursed is bringing the patient back to the OR?

Answer:
Medicare says that the tonsillectomy’s 90-day postoperative period includes treatment of any complications (e.g., bleed) unless the patient is taken to the operating room. So if this is a patient covered by Medicare, or Medicare payor, then the ED service would not be billed. You’ll have to check your non-Medicare plans to determine their postoperative global period policy and whether services provided in the ED related to the surgical procedure are separately payable.

*This response is based on the best information available as of 09/06/18.*

Allergy Injections

August 23, 2018

Question:
We are giving 5 allergy immunotherapy injections to a patient. Do we bill 95117 x 5 units?

Answer:
CPT 95117 is reported once per day, with 1 unit, when 2 or more injections are given. Do not report more than 1 in the units box on the claim form.

*This response is based on the best information available as of 08/23/18.

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**Modifier 50 with 30930?**

August 9, 2018

**Question:**
Can I bill 30930 with a modifier 50? My physician and I are confused if it’s appropriate or not. We’ve heard conflicting information.

**Answer:**
No. A CPT Assistant from November 2017 overturned advice they published in July 2016. The advice in the CPT Assistant, July 2016 stated modifier 50 (bilateral procedures) was acceptable on 30930 [Fracture, nasal inferior turbinate(s)]. However, that advice was corrected in an Erratum published in the November 2017 CPT Assistant. Bottom line is that the code says “turbinate(s)” which implies plural and modifier 50 should not be appended.

*This response is based on the best information available as of 08/09/18.*
Removal of Mandibular Implant

July 26, 2018

**Question:**
We are removing old plates from the right and left mandible. It is ok to use 20680 x 2?

**Answer:**
There was just a CPT Assistant about this in January 2018. CPT 20680 (Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)) may be reported twice for removal of implants from noncontiguous sites on the same bone, such as the mandible, if separate incisions are made. However, use 20680 only once if one incision is made to remove bilateral implants from the same bone such as the maxilla.

*This response is based on the best information available as of 07/26/18.*

Multiple Procedure Payment Formula

July 12, 2018

**Question:**
What is Medicare’s multiple procedure payment formula? When I do more than one procedure, I know Medicare reduces payment
for some but I can’t remember by how much.

Answer:
It used to be 100%, 50%, 25%, 25%, etc but many years ago the formula changed to the physician’s advantage and now is 100%, 50% for subsequent stand-alone procedures. Remember, add-on codes (+) and codes exempt from modifier 51 (⦸) are always paid at 100% of the allowable.

*This response is based on the best information available as of 07/12/18.

Complex Closure with a Soft Tissue Tumor Code

June 28, 2018

Question:
Can I also bill for the complex repair when I’ve also excised a soft tissue tumor like a lipoma in the 21552-21555 series of codes?

Answer:
Actually CPT says these soft tissue tumor codes include the simple or intermediate repair and a complex repair may be separately reported. That said, Medicare and many other payors will not reimburse the code because they consider it to be a primary closure.

*This response is based on the best information available as of 06/28/18.
Debridement Prior to Skin Grafting

June 14, 2018

Question:
I’m taking a patient to the OR for debridement of a dehiscent surgical wound and will skin graft it for closure. I’m looking at getting 11042 (debridement) and the skin graft codes precertified. Is this right?

Answer:
Not exactly. You’re right about the skin graft code(s). However, we do not recommend the 11042 – 11047 codes. These codes are used for wound debridement but only when you are debriding an open wound with no intention of closing it; you expect the wound to heal by secondary intention. In your example, you will be closing the wound. Therefore, the more accurate code is a surgical preparation code (15002 – 15005) for excision (note the term is not debridement) of the open wound to prepare a viable wound surface for grafting.

*This response is based on the best information available as of 06/14/18.*