CPT 31541 – Can it Be Billed Bilaterally?

Question:

One of my physicians wants to code 31541 bilaterally; so far it has been denied each time. Can you tell me if this is allowed or am I wasting my time? Also I would like to attend one of AAOHNS/KZA seminars, are they for office staff as well as physicians?

Answer:

Absolutely – office staff may attend the coding course such as the one your physician attended. It would be great if you could go as well. Practices find it extremely helpful when the physician and billing staff attend together.

It isn’t surprising that payors are denying payment for 31541-50 (modifier 50 for bilateral procedure). CPT 31541 states: Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope. Because the code says vocal cords, meaning both vocal cords, 31541 should not be billed with modifier 50.

Intraoperative Monitoring

Question:

When performing a thyroidectomy or parathyroidectomy, and a physician’s assistant is assisting, can the PA bill for the nerve monitoring codes, 95867, 95868, +95940?
Answer:

No, neither the surgeon or an assistant surgeon or even a co-surgeon may bill for intraoperative nerve monitoring.

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**VEMP**

**Question:**

Our audiologist is doing this new test called VEMP? The equipment vendor gave me a big long list of codes to bill for this test including the ENG, EMG and other diagnostic testing codes. It just doesn’t seem right. What is your advice?

**Answer:**

We agree that billing ENG and EMG codes isn’t accurate for the VEMP test. Actually, the March 2011 CPT Assistant that is published by the American Medical Association states that there is no code for vestibular evoked myogenic potential (VEMP) testing. Therefore, an unlisted code (92700) is used to report this service.

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**Nasal Endoscopy**

**Question:**

I did a nasal endoscopy (31231) and adenoidectomy (42830) on a young child. The insurance company denied the nasal endoscopy but paid on the adenoidectomy. I wouldn’t think these two codes are bundled. What do you think?
To answer your question, we requested the operative report from you to see what the documentation says. Your note lists “adenoid hypertrophy” as a pre- and post-operative diagnosis. The body of the operative report states: “The nasal endoscope was placed down into the posterior nasopharynx and there was a large adenoid pad. There was clear mucoid fluid around the bilateral nasal cavities.” Then the operative report describes the adenoidectomy procedure.

It appears that the nasal endoscopy was a diagnostic procedure to confirm the pre-operative diagnosis of adenoid hypertrophy. The diagnostic nasal endoscopy procedure was followed by a more definitive surgical procedure (adenoidectomy). Therefore, only the definitive procedure – the adenoidectomy – is reported. It would not be appropriate to bill for the nasal endoscopy (31231) in this scenario.

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**A Letter From a Private Payor About My E & M Coding. Should I Be Concerned?**

**Question:**

I received a letter from a private payor saying I report a higher percentage of 99204, 99205, 99244 and 99245 services than my peers. The letter advised me to review the E & M requirements for these codes. Should I be concerned?

**Answer:**

Yes you should! This is essentially a warning letter that your
payor is trending your E&M services and has identified you as an outlier with these levels of service in comparison to your peers. You may choose to contact your healthcare attorney to determine next steps. This may include an internal or external review of E&M services that were reported with these E&M codes or perhaps some one-on-one E&M Coding and Documentation education. You should also run a CPT frequency report (may be called a productivity report in your system) and benchmark yourself and your group, if appropriate, to state and national benchmark data. This data is available from the Medicare website or KZA can assist you with our E & M Analyzer.

The Analyzer, provides you with a comprehensive assessment of your E & M coding patterns as compared to your peers and where you might be at risk. Click here to find more information about the E&M Analyzer. Now is the time to act as your payor has already identified they are paying attention.

**Skin Lesion Removal and Closure**

**Question:**

I have a question on lesion removal and closure coding. If two lesions the same size, same diagnosis (e.g., malignant) and same area (e.g., neck) are removed, is the code used twice or are the sizes added together for one code? I have the same question for a repair- same site (per code description), same type of closure (e.g., intermediate) – do we add the lengths together or use the same code twice?

**Answer:**
We cover these exact questions in the AAOHNS/KZA coding courses. Report one CPT code for each lesion removed. Use modifier 59 on the second and subsequent same CPT codes. For example, removal of two malignant lesions of the neck each 1.2 cm in diameter are reported using 11642 and 11642-59. Be careful because some payors (including Cahaba Medicare) require the use of modifier 76 rather than 59 in the situation where more than one of the same CPT codes is billed on the same date of service.

For the repair codes, you will sum the repairs for similar types of repairs (e.g., intermediate, complex) in similar anatomic locations (per CPT code). Bottom line is lesion removal codes are never added together but the wound repair codes may be summed.

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**ER Discharge**

**Question:**

Our surgeon was called to the Emergency Room to see a patient in consultation. The patient was discharged from the Emergency Room. Can you tell us how to report this?

**Answer:**

The correct category of CPT code will be dependent on payor rules. According to the 2013 AMA CPT rules, the service is a consultation and the 99241-99245 codes are reported. Report the consultation code for all payors still recognizing this category of codes.

Medicare no longer reimburses consultation service, thus a CPT code from the Emergency Department (ED) Codes (99281-99825) will be reported when the patient is seen in consultation in
the Emergency Room and discharged to home.

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**Endoscopic Sinus Debridements: Reportable or Not?**

**Question:**

Is appropriate to bill 31237-79 at the 1 week post op for our sinus surgery patients? I can’t help but feel that service would be included in the septoplasty or the turbinate surgery performed at the same session. The physician and office manager it should be billed when performed during the global period, but I just can’t figure out why. Can you help me understand if the debridement services are or are not separately reportable during the global period?

**Answer:**

Thanks for your inquiry! The coding of sinus debridements and how to report is a frequently asked question. The endoscopic sinus surgery codes 31256, 31267, 31254, 31255, 31287, 31288, 31276 do not have a global period. Because there is no global period the debridement service (31237) is separately reportable after the surgery when medically necessary and supported by documentation. You are correct to question the use of the modifier 79 (unrelated surgical procedure) as the correct way to report this service. The septoplasty and turbinate surgery (30130, 30140) have 90 day global periods, thus the use of modifier 79 is required to indicate the debridement, performed at different anatomic locations is separately reportable. Remember, CPT code 31237 is a
unilateral procedure and may be reported with a modifier 50.

Calculating Size for Codes

Question:

I’m new to coding. My doctor and I have a disagreement on how to calculate the size for the adjacent tissue transfer codes (140xxx). The doctor says there was a 16.5 cm by 7 cm wound that he did an adjacent tissue transfer to close. I think I should use a code for a 23.5 square centimeter code because 16.5 plus 7 equals 23.5. My physician said we are to multiply the numbers so it would be 115.5 square centimeters. Who is right?

Answer:

Your physician is right. Area is measured in square centimeters and obtained by multiplying the length times the width of the wound. You will use CPT 14301 for the first 60 square centimeters (sq cm), add-on code 14302 for the next 30 sq cm and +14302-59 for the remaining 25.5 sq cm. Alternatively, you may report 14301 and 14302 x 2 units if you know that the payor will recognize more than 1 in the units box and reimburse the appropriate amount.

Intraoperative Angiography
During Microvascular Flap Surgery

Question:

I am doing this new thing during my microvascular free flap procedures where I do intraoperative fluorescent angiography (Spy) to evaluate tissue perfusion prior to closing the wound. I’m told I can bill CPT 15860 intravenous injection of agent (e.g., fluorescein) for this in addition to the microvascular free flap code. I’ve tried billing it the last couple of times but I can’t get the insurance company to pay for it. Please help.

Answer:

Anything you need to do to test the vascular flow in flap such as using a Doppler, tissue oximetry, or injecting fluorescein is included in the code for the primary procedure. Checking tissue perfusion and vascular flow is an inherent part of doing a microvascular free flap and not a separately billable procedure.