Endoscopic Concha Bullosa Resection with Other Sinus Procedures

Question:
I did endoscopic sinus surgery (maxillary antrostomies and anterior ethmoidectomies) as well as endoscopic bilateral resection of concha bullosa. I told my biller to submit the following codes for me: 31254-50, 31256-50, 31240-50. My biller says the concha bullosa resection code is “bundled” into the other codes and she won’t submit the codes. I say it is a separate procedure and should be billed. What do you think?

Answer:
We agree with you. The work of an endoscopic concha bullosa resection (31240) is not included in the endoscopic maxillary sinus or ethmoid sinus surgery codes (31256, 31267, 31254, 31255) and may be separately reported. There is no CCI edit that bundles 31240 into the other codes. However, some payors may have their own software that does bundle 31240 so you may need to append modifier 59 to 31240 to show this procedure was distinctly separate from other procedures performed at the same operative session.

How Do I Calculate The Size
Question:

I am inquiring how to calculate the size of a wound to determine which adjacent tissue transfer code should be reported. The surgeon excised a dematofibrosarcoma protuberans of the chest that resulted in a primary and secondary defect documented as a 16.5 x 7. The secondary defect was closed primarily. My surgeon says the size of the defect is 115.5 sq cm and I am saying the wound size is 23.5 sq cm. Who is right?

Answer:

Your surgeon is right. To report adjacent tissue transfers, the wound size is based on square centimeters (sq cm). To determine the total size of the wound defect, the defect size is determined by first multiplying the length times the width of the primary and secondary defects and adding both of them to determine the total defect size when the secondary defect is closed primarily as noted. Report 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. Please note, some payors may not require the modifier 59 on the second add-on code.
Maxillary Sinus Lavage (31000)

**Question:**

My doctors want to bill 31000 for a maxillary sinus lavage every time they do an endoscopic procedure on the maxillary sinus such as 31256 (endoscopic maxillary antrostomy), 31267 (endoscopic maxillary antrostomy with tissue removal from within the sinus) and 31295 (endoscopic balloon dilation of the maxillary sinus). The lavage is bundled with 31256 and 31267 when I look at Medicare’s Correct Coding Initiative edits but I can bypass the edit using modifier 59 (distinct procedural service). Is it appropriate for us to append modifier 59 to 31000 in these instances? CPT 31000 is not bundled with the balloon dilation code, 31295, so it must be ok to bill both codes.

**Answer:**

It is not appropriate to append modifier 59 to 31000 just to get the procedure paid. You must meet the criteria for use of modifier 59 in order to use the modifier appropriately and bypass the CCI edits. In these three examples, it is not accurate to separately report 31000 with or without a 59 modifier. The lavage is a lower-valued procedure performed at the same operative session on the same structure (maxillary sinus) and, therefore, would be included in the primary procedure codes of 31256, 31267 or 31295. Do not separately report 31000 for maxillary sinus lavage.
**Thyroidectomy with Central Neck Dissection**

**Question:**

How do I code a thyroidectomy for malignancy with bilateral central neck dissections? I see 60252 for *Thyroidectomy, total or subtotal for malignancy; with limited neck dissection* but not bilateral central neck dissections.

**Answer:**

Actually the central neck is not considered to be a structure that has laterality to it – central is middle. So if you are doing both side of the middle, then it is still a central neck dissection. CPT 60252 considers a central neck dissection to be included in 60252 and the code includes removing all the nodes around the thyroid; therefore, modifier 50 (bilateral procedure) does not apply.

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**Direct Laryngoscopy with Multiple Biopsies**

**Question:**

I did 31535 *Laryngoscopy, direct, operative, with biopsy* but took multiple biopsies through the laryngoscope of the hypopharynx and base of tongue looking for an unknown primary malignancy. Can I report 31535 more than once to account for the multiple biopsies? Can I bill 42802 (*Biopsy; hypopharynx*) with the direct laryngoscopy? Lastly, what if I did a separate nasopharyngeal biopsy at the same time also looking for an
unknown primary malignancy – can I bill separately for the nasopharyngeal biopsy?

Answer:

CPT 31535 includes any number of biopsies obtained through the same surgical exposure as the direct laryngoscopy so it would not be appropriate to also report biopsies from the hypopharynx, vocal cords, arytenoids or the larynx areas. Any biopsies taken via the scope are included in 31536 not 42802 which does not define a biopsy via a laryngoscope. If a biopsy is not taken via the scope, then it may be separately reported using the appropriate biopsy code. Be sure to make this very clear in your operative note. You may separately report a code for the nasopharyngeal biopsy since that procedure is performed through a separate surgical exposure, the nose.

Modifier 25

Question:

Do we have to append modifier 25 to the E&M code if only an audiogram were also performed at that same visit? Or does modifier 25 not apply since the audiogram is a diagnostic test? What about when we do an in-office CT on the same day as an office visit – should we append modifier 25 modifier to the E&M code or is it not required because the CT is a diagnostic test?

Answer:

Good questions! The CPT descriptor for modifier 25 is: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service. CPT states: “It may be necessary to indicate
that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.” Recall, however, that there is no pre- or postoperative care associated with diagnostic testing such as audiograms or CT scans.

As you know, since 2008 Medicare has required audiologists to bill directly using the audiologist’s NPI as the billing provider. Therefore, it is not likely that you will have an E&M code and an audiogram on the same claim form to Medicare. So your question about appending modifier 25 to the E&M code is not applicable when the payor is Medicare.

Therefore, modifier 25 on the E&M code is not necessary when also reporting a diagnostic testing code such as an audiogram or CT scan. However, you might find that some payors require the use of modifier 25 but it is not a CPT coding requirement.

Nasal Fracture Repair vs. Rhinoplasty

Question:

I did an open treatment of a nasal fracture repair and septoplasty on a patient who was in a bar fight two years ago on spring break and had his nose broken. He now has nasal airway obstruction and deviated nasal septum as well as displaced nasal bones. I billed 21335 (Open treatment of nasal fracture; with concomitant open treatment of fractured septum) but the insurance company denied it. Did I do something wrong
or should I appeal it by sending in pictures?

**Answer:**

The nasal fracture treatment codes (e.g., 21310-21337) are to be used when you are treating an acute fracture, not an old or healed fracture. The rhinoplasty codes (e.g., 30420) are more appropriate when you are treating a healed fracture. You can try to appeal the denial but we suspect the insurance company will not pay for the procedure because they consider it to be “cosmetic.”

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**Endoscopic Zenker’s Diverticulectomy**

**Question:**

I can’t find a code for this procedure. I found 43130 (Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach) but it doesn’t say endoscopic so I’m not sure if I should use it.

**Answer:**

You are right to be cautious! CPT 43130 requires a skin incision so it should not be used for an endoscopic, or transoral, procedure. You should use an unlisted code, 43499 (Unlisted procedure, esophagus) for an endoscopic resection of a Zenker’s diverticulum.
**Botox of the Parotid Gland**

**Question:**

What is the code for injection of Botox the parotid for hyperhidrosis or to control excessive oral secretions?

**Answer:**

The code you are looking for is 64611 (Chemodenervation of parotid and submandibular salivary glands, bilateral). The code assumes you are doing at least four injections: right parotid, right submandibular, left parotid and left submandibular). Report 64611-52 (reduced services modifier) if you do less than four injections.

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**MSL with Lysis of Stenosis and Steroid Injection**

**Question:**

I am going to do a procedure on a patient with tracheolaryngeal stenosis – a microlaryngoscopy with lysis of the stenosis using a laser and excision of granulation tissue followed by a steroid injection. I gave my surgery scheduler two CPT codes to precertify: 31541 and 31571. She is telling me that I can’t bill these two codes together. Can you please help?

**Answer:**

Sure – be happy to. Let’s look at the code descriptions:

[table “8” not found /]
First, 31541 does not describe lysis of stenosis and/or excision of granulation tissue rather it describes excision of a tumor and/or stripping of vocal cords. Unfortunately, there is no CPT code for microsuspension laryngoscopy (MSL) with lysis of tracheolaryngeal stenosis. Therefore, you’ll have to use an unlisted code, 31599 (Unlisted procedure, larynx) for this procedure. You can use 31541 as your comparison code if you think the procedures are similar.

Then, yes, you may also report 31571 for the MSL with steroid injection assuming you clearly document the separate medical necessity for the procedure in the operative report (e.g., to prevent recurrence of granulation tissue).