Debridement of Ear Canal

February 6, 2014

Question:

We billed 11000 (Debridement of extensive eczematous or infected skin; up to 10% of body surface) for debridement of an ear canal with a diagnosis code of otitis externa (380.23). The payor denied 11000 and say there was no “medical necessity” documented. I don’t get it. Please help.

Answer:

The denial occurred because 11000 is an integumentary system, or skin, code and not appropriate to use for a procedure performed in the ear canal. The ear canal debridement is included in your E&M code and you may also report 92504 if binocular microscopy was used for the procedure.

Stand-by Services

January 23, 2014

Question:

What is the right code and way to document a stand by tracheostomy? Here’s a clinical scenario… 70 y/o woman comes in to the ER with tongue swelling, she has respiratory distress needs intubation. I get called in to stand by while the anesthesiologist performs an intubation. I will need to perform a tracheostomy if the intubation fails. No trach needed. I just watched the anesthesiologist intubate the patient. No intervention from my part. What code should I use
for this procedure? What is the reimbursement?

Answer:

The standby code is 99360 Physician standby service, requiring prolonged physician attendance, each 30 minutes (e.g., operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG). You may bill 1 unit of this code for each 30 minutes of standby. Unfortunately, Medicare does not reimburse this code but some of your other payors might.

In-Office Audiology Diagnostic Testing On An Inpatient

January 9, 2014

Question:

We were asked to do an audiogram on a Medicare inpatient. The hospital does not have a booth so the patient was transported by wheelchair to our private practice office for testing. What place of service code should we use – inpatient or office?

Answer:

Good question. Medicare released new information about this in October 2012 and said you must use the place-of-service code that reflects the patient’s inpatient status. Therefore, you will use POS 21 (inpatient hospital). Here is the direction from the MedLearn Matters #7631 dated October 11, 2012 which was effective April 1, 2013:
“Special Considerations for Services Furnished to Registered Inpatients When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, will, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter.”

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**Intraoperative Monitoring**

**Question:**

OK, so I now realize that I should not be billing for intraoperative monitoring based on the CPT changes for 2013. The consultants at KZA have been saying this for years and I’m now on board with you. My question is: Can I at least bill the codes 95867 or 95868 for the surgeon at the time of the surgical procedure? My doctor wants to get paid something for placing the needles.

**Answer:**

No, placing the needles is part of the procedure set up and not separately reported. It is not accurate to call it an EMG (95867, 95868).
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.

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**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.