Removal of Tube in Office

Question:
How do I code for the removal of ventilation tubes when performed in the office setting?

Answer:
There is no separate CPT code for this activity so it is part of your E&M service. It is not appropriate to report 69200 (Removal foreign body from external auditory canal; without general anesthesia) or 69424 (Ventilating tube removal requiring general anesthesia).

Endoscopic Zenker’s Diverticulum

Question:
How do I code for removal of a Zenker’s diverticulum when the procedure was performed endoscopically? Can I still use 43130 (Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach)?

Answer:
There is no code for the endoscopic removal of the Zenker’s diverticulum as 43130 describes an open procedure. You will need to use an unlisted procedure code such as 43499 (Unlisted procedure, esophagus).
**E&M Visit with Allergy Injection**

**Question:**

Can I bill for both the 99211 and “95117 – Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections” – codes when the patient comes for their weekly allergy injection?

**Answer:**

If the purpose of the visit is to provide the allergy injection then report only the code for the allergy injection (e.g., 95115, 95117). If you provide a significantly, separately identifiable E&M service then you may separately report that with 9921x and append modifier 25 to the E&M code. Be sure you have good documentation of the separate E&M service and can support the medical necessity of this additional charge.

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**Ear Exam Under Anesthesia**

**Question:**

Our surgeon performed an evaluation of the external ear canal on a pediatric patient because the child would not allow the surgeon to evaluate the ears thoroughly in the office. We cannot find a CPT code for this service. Do we use an unlisted code?
The correct way to report this service, assuming a more definitive procedure was not performed is CPT code 92502-52. CPT code 92502, (Otolaryngologic examination under general anesthesia) describes a complete ENT exam, thus modifier 52 (reduced services) is appropriate to indicate an entire otolaryngologic examination was not performed.

Wound Cultures

Question:

Our surgeon recently took a patient to the OR for an I&D of a neck abscess. The documentation in the operative note indicates a culture was taken. The only CPT codes I can find are in the pathology section. Is this work reportable by the surgeon?

Answer:

Thanks for your question and one that is not uncommon. The work associated with obtaining the culture is included in the more extensive surgical procedure for the I&D.

Written Physician Order for Audiologic Evaluations?

Question:
Does Medicare require a written physician order for audiologic evaluations, even if the audiologist is employed by our otolaryngology practice?

Answer:

Yes. Medicare requires the following in order to file under the NPI of the audiologist for diagnostic audiology procedures, as specified in the Medicare Benefit Policy Manual, Chapter 15:

a. The order must be “for the purpose of obtaining information necessary for the physician’s diagnostic medical evaluation or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem.”

b. “The reason for the test should be documented either on the order, on the audiological evaluation report, or in the patient’s medical record.”

c. “Documentation should indicate that the test was ordered, that the reason for the test results in coverage, and that the test was furnished to the patient by a qualified individual.”

d. Orders may be a “written document, signed by the physician, hand-delivered, mailed or faxed; a telephone call or e-mail placed by the treating physician” to the audiologist.

Chapter 15 adds that both the referring physician (who could be an offsite physician, e.g., a primary care physician or neurologist) and the audiologist must have telephone referrals documented in their respective charts.

Make sure your EMR makes documentation easy!
Medicare Supervision Requirements for Audiologic Diagnostic Testing

Question:

We would like to maximize the time the audiologist sees patients in the office when the otolaryngologist is in surgery. Is the physician required to be in the office for the supervision of any diagnostic testing when the audiologist is here alone and performing diagnostic hearing tests on Medicare patients?

Answer:

No. Per Medicare supervisions requirements (CMS MM6447), when performed by an audiologist, the direct supervision requirement is not applicable to diagnostic audiology procedures. The audiologist may see any patient, but remember, the physician referral for a medically necessary reason for Medicare beneficiaries is required.

CPT and Diagnosis Codes for a Skin Lesion

Question:

A patient was sent to us by another provider who had a biopsy proven pathology report showing a basal cell carcinoma. We removed additional margins and the pathology report came back benign for us. We are confused about whether we should report
the CPT and diagnosis codes for a malignant or benign lesion since we did not do the original biopsy.

**Answer:**

This is a very good question! Because you have a previous positive pathology report, even though it is from a different physician, then you may report your procedure using the excision of malignant lesion CPT code (e.g., 116xx) and a malignant skin neoplasm diagnosis code.

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**Selective Debridement of the Skin – How is it coded?**

**Question:**

The debridement codes for skin, 11040 and 11041 are no longer in the CPT book. Does that mean debridement of the skin is no longer billable?

**Answer:**

The selective debridement codes were revised in 2011. CPT 11040 and 11041, previously used for debridement of partial and full thickness skin respectively, have been deleted. To report selective debridement of the skin, use 97597 and 97598.

New descriptions of the other debridement codes advise reporting 11042 for debridement of subcutaneous tissue, 11043 for muscle and/or fascia, and 11044 for bone. Also new in 2011, these codes are reported by size of debridement and have add-on codes for additional square centimeters debrided. Refer to the CPT Manual for a complete description of the appropriate use of these new/revised codes.
Coding Multiple Z-Plasties

Question:

When billing for multiple Z-plasties, is the billing done by the number of Z-plasties or the total sq cm having added together each of the Z-plasty areas in sq cm?

Answer:

The coding for a Z-plasty (140xx codes) is done based on the total sq cm of the primary and secondary defect size and not necessarily the number of Z-plasties done. So you will report one code for each defect. If there are two separate defects closed with two separate advancement flaps report one 140xx code for each defect – or two codes.