Repair of Nasal Vestibular Stenosis

January 14, 2016

Question:
I am trying to come up with the right CPT codes for a repair of nasal vestibular stenosis so we can get it pre-certified. Can you help?

Answer:
Yes, you are wise to determine the correct codes for pre-certification, otherwise the surgery might not be paid if you billed different codes. Look at 30465 – Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction). You may also report a separate code if you harvest graft material through a separate incision. For example, you may report 20912 (Cartilage graft; nasal septum) if you harvest septal cartilage graft when you have not performed a septoplasty at the same operative session. If you did a septoplasty (30520) and repair of nasal vestibular stenosis (30465) then you may not report 20912 for the septal cartilage graft harvested/obtained from the septoplasty.

*This response is based on the best information available as of 01/14/16.*

Cerumen Removal

December 17, 2015

Question:
I was in attendance at the “top ten coding issues” talk that
you gave in Dallas at the AAOHNS annual meeting. Great talk, Kim! We spoke regarding CPT 69210 after the session. I just want to confirm that use of magnification is not necessary for this code. My associates insist that 69210 requires using the operative microscope. I realize that simple lavage doesn’t qualify, but I use illumination and instruments and or suction. What is correct?

Answer:
Thank you for your kind words! You’re the second person this week to ask me the same question. Note the language for the code 69210 says, “Removal impacted cerumen requiring instrumentation, unilateral.” It does not say “requiring instrumentation and microscope.” The CPT vignette says that magnification is used but does not specify that a microscope must be used; therefore, use of an otoscope is acceptable for 69210 and a microscope is not required. That said, it is never appropriate to report 69990 with 69210 because 69990 is meant for microsurgical techniques/microdissection. Be sure you document the specific type of instrumentation used (e.g., curette, forcep, suction) for the cerumen impaction removal.

*This response is based on the best information available as of 12/17/15.

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Endoscopic Skull Base Surgery

12/03/15

Question:
We are thinking about starting an endoscopic skull base surgery program and doing skull base procedures via an expanded endonasal/endoscopic approach. I’ve looked in the CPT
book for codes and it looks like CPT 61580-61619 are just what I’m looking for. Is this correct?

Answer:

That’s great that you’re starting a new program! And, we can help. There is one CPT code for an endoscopic skull base procedure – 62165, Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach. However, other procedures that you’ll do such as an endoscopic resection of a clival chordoma are not accurately coded using 61580-61619, as these existing codes are for open procedures. We wrote an article for the AAO-HNS Bulletin about this a few years ago that I think you’ll find helpful. Here are the links:

Sample Prior Authorization, Cover Letter, or Appeal Letter for the Otolaryngologist’s Use of an Unlisted CPT Code for Endoscopic/Endonasal Skull Base Surgery

Coding and Reimbursement Strategies: Using an Unlisted Code for Endoscopic Skull Base Surgery

*This response is based on the best information available as of 12/03/15.

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Cerumen Removal….Again

November 5, 2015

Question:

I just wanted to verify the guidelines for billing cerumen removal (69210). Before, it needed to state that the cerumen was “impacted” to be able to bill CPT 69210. I was just told
that guideline has changed and that anything that goes in the body (I’m thinking like a curette to remove cerumen), even if it is not impacted, is now billable. Is this correct?

Answer:

That is incorrect information – the guideline has not changed in that regard. The cerumen must be impacted to report 69210 (Removal impacted cerumen requiring instrumentation, unilateral). What did change a few years ago is the added requirement that instrumentation must be used to remove the impacted cerumen. So, there must be documentation of using a curette, forceps, suction, etc. in the procedure note. Click here for one hour webinar on Resolving the Cerumen Coding Chaos!

*This response is based on the best information available as of 11/05/15.

Bilateral Diagnosis Coding and Bilateral CPT Coding for Otitis Media

October 8, 2015

Question:

If I use one of the new ICD-10-CM codes for otitis media, do I still need to use the CPT modifier 50 for bilateral procedures when I bill for tympanostomy tube placement (69436)?

Answer:
Good question! Changing diagnosis coding systems from ICD-9-CM to ICD-10-CM does not change anything about CPT coding. The CPT coding system does not change at all with our change to ICD-10-CM for diagnosis coding. So, yes, you will still use modifier 50 or RT/LT or whatever modifiers you were using prior to October 1 to accurately report the bilateral procedure.

*This response is based on the best information available as of 10/08/15.*

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**ICD-10-CM for Otitis Media**

September 24, 2015

**Question:**

I am hoping that ICD-10-CM has codes for recurrent acute otitis media since this is one of the most common reasons why we put in tympanostomy tubes. Did this happen?

**Answer:**

Yes – someone must have heard you! Many of the otitis media codes now specify acute, acute recurrent, and chronic. Laterality is also a prominent issue with the ear codes. For example, serous otitis media has the following specific codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H65.01</td>
<td>Acute serous otitis media (ASOM), right ear</td>
</tr>
<tr>
<td>H65.02</td>
<td>ASOM, left ear</td>
</tr>
<tr>
<td>H65.03</td>
<td>ASOM, bilateral ears</td>
</tr>
<tr>
<td>H65.04</td>
<td>Acute recurrent serous otitis media (ARSOM), right ear</td>
</tr>
<tr>
<td>H65.05</td>
<td>ARSOM, left ear</td>
</tr>
<tr>
<td>H65.06</td>
<td>ARSOM, bilateral ears</td>
</tr>
<tr>
<td>H65.21</td>
<td>Chronic serous otitis media (CSOM), right ear</td>
</tr>
</tbody>
</table>
I noticed that the ICD-10 codes for many ear conditions are specific for right, left and bilateral. But what if I am billing for a bilateral procedure, such as tympanostomy tubes? Should I use the right and left codes, or should I use the bilateral code?

Answer:

Good question! If a bilateral code exists and the disorder is documented as bilateral, then the bilateral code should be used. You would not use the individual right and left codes just because you are billing bilateral procedures even if you are line-item billing the procedure (i.e., 69436 and 69436-50).

*This response is based on the best information available as of 09/10/15.
Holding Claims for Path Reports

August 13, 2015

Question:

Do you advise that we hold our claims for excision of skin lesion procedures until after the pathology report is received? That seems to delay our charges and I want to get them billed quickly!

Answer:

Yes, you need to hold the claim for the excision of skin lesion codes (114xx for benign skin lesions, 116xx for malignant skin lesions) if you do not have a previous pathology report showing a malignancy. Why? Because the CPT codes for the procedures require the lesion pathology be identified. If you have a biopsy report for the lesion showing a malignancy, then you can go ahead and bill the excision procedure using the malignant CPT (116xx) and diagnosis codes.

Lipoma Removal

July 30, 2015

Question:

I removed a huge lipoma from a patient and it seems like the benign skin lesion removal codes just don’t describe what I’m doing. Is there another code I can use?

Answer:
Yes! The “soft tissue tumor” codes were introduced into CPT in 2010 and better describe the procedure you are performing. These codes are located in the Musculoskeletal System section of CPT (e.g., 21555, 21556) rather than in the Integumentary System section of CPT (114xx for excision of benign skin lesions, 116xx for excision of malignant skin lesions).

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**Diagnosis Code**

*July 16, 2015*

**Question:**

I do a lot of reconstruction procedures after the Mohs surgeon has removed the skin cancer. I am not removing cancer so it doesn’t seem right to use a cancer diagnosis code. But what diagnosis code should I use?

**Answer:**

We recommend using an “open wound” diagnosis code since the purpose of your procedure is to close an open wound. You can use the cancer diagnosis code as a secondary diagnosis code.