Use of Acellular Dermal Matrix for Soft Tissue Reinforcement

March 26, 2015

Question:

What code can I use when I place acellular dermal matrix in a parotid defect? I’ve looked at 15777 and it seems to describe what I’m doing. Is it OK to use this code?

Answer:

CPT 15777 is an add-on code and says: Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (e.g., breast, trunk) (List separately in addition to code for primary procedure). At first glance this code may seem appropriate to use, however, look closely and you’ll see the statement “e.g., breast, trunk.” This means the code only applies to use in the breast or trunk areas. If the code had indicated “e.g., breast, trunk” then the breast and trunk would be examples of the code use and we could report 15777 for placement into a parotid defect. But this is not the case; therefore, there is no code for placement of an acellular dermal matrix product in a head and neck defect (e.g., parotid, temporal bone area). You could use an unlisted code such as 17999 (Unlisted procedure, skin, mucous membrane and subcutaneous tissue) and compare it to 15777.
Question:

I did a direct laryngoscopy, bronchoscopy and esophagoscopy for tumor staging. Are all three codes billable?

Answer:

Yes, but make sure that you performed what CPT now says is included in the esophagoscopy. Effective 1/1/15, CPT added this guideline: “Esophagoscopy includes examination from the cricopharyngeus muscle (upper esophageal sphincter) to and including the gastroesophageal junction. It may also include examination of the proximal region of the stomach via retroflexion when performed.” This means you must look all the way down to the GE junction in order to separately report a code for the esophagoscopy. Be sure your documentation includes these anatomical landmarks as you’ll likely need to appeal with the operative note.

If you do not examine from the upper esophageal sphincter to the gastroesophageal junction, then you may not report a separate esophagoscopy code. Whatever examination you perform is included in the other CPT code(s) you bill.
**Question:**

I would like to know the codes I can bill for neural monitoring during a thyroidectomy, mastoidectomy, and parotidectomy cases.

**Answer:**

Intraoperative neural monitoring is included in the global surgical package for the surgical procedure code(s) billed by the surgeon; therefore, the surgeon would not bill for this service. Placing the needles for intraoperative nerve monitoring is also not separately reportable by the surgeon as this is considered part of the set up.

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**Measuring Square Centimeters**

February 5, 2015

**Question:**

I’m confused about how to determine the square centimeters for using the Adjacent Tissue Transfer codes (14000-14302). Can you explain it in terms that I will understand? I’m not a doctor.

**Answer:**

I will certainly try! The adjacent tissue transfer codes are used when there is a primary defect that results from the excision and there is a secondary defect that results from flap design to perform the reconstruction. You measure each of the two defects, calculating the area in square centimeters, separately. Then you add the two areas, in square centimeters, together to determine the code.
For example, you excise a 1 cm x 1 cm malignant lesion from the face and close it with a 1 cm x 2 cm advancement flap. The primary defect resulting from the excision is 1 cm x 1 cm = 1 sq cm. The secondary defect resulting from the flap design to perform the reconstruction is 1 cm x 2 cm = 2 sq cm. The primary defect, 1 sq cm, is added to the second defect, 2 sq cm which equals 3 sq cm. The key point for surgeons is to accurately document the areas of both primary and secondary defects. Hope this helps!

Ear Canal Debridement...Again

January 22, 2015

Question:

What CPT code would I use for a debridement of purulent debris from the ear canal, with or without placement of a wick in, such as when the patient has Swimmer’s ear? One of my colleagues told me he bills cerumen removal (69210) because there is always a little bit of cerumen mixed in the debris. I thought I’d better check on that.

Answer:

Good idea to check! CPT 69210 (Removal impacted cerumen requiring instrumentation, unilateral) requires the cerumen be impacted and the diagnosis should be 380.4 (Impacted cerumen). If the diagnosis is really Swimmer’s ear and there is “a little bit” of cerumen, then it doesn’t seem right to use 69210 with a diagnosis of 380.4. There is not a CPT code for ear canal debridement for Swimmer’s ear. This service is considered part of the E&M code you will report for that visit. However, if you used the microscope for the diagnosis
Weekend Rounds (Part 2)

January 8, 2015

Question:

Thanks for answering my question last time – I get it now that I would not charge for rounding on post-op patients of my call partners. What about non-surgical patients? Can I bill for making rounds?

Answer:

Yes, absolutely! As I said, you should treat the patient as if it were your own. So you would bill for subsequent hospital care (9923x) on patients previously seen by your call partner during that hospitalization.

Weekend Rounds

December 23, 2014

Question:

I have just a quick question regarding weekend rounding. I share weekend call with another practice that I am not affiliated with. Sometimes, when rounding, I check on 5-10 of their patients, some of which are their post-ops and some have
not had surgery. Since I am not part of their practice, is this something I can bill for? If so, should I bill a consult or a follow-up visit?

Answer:

Good question. You should not charge for rounding on their post-op patients and they shouldn’t charge for rounding on yours. You should treat the patients as if they were your own...and you would not bill for routine post-op care on your own patients.

UPPP & Tonsillectomy

December 11, 2014

Question:

Can you tell me if in fact the tonsillectomy code is bundled into the UPPP code? We are having an argument about that in our office and would appreciate it if you’d weigh in.

Answer:

That’s a very good question. From a CPT coding standpoint, the tonsillectomy code may be separately reported from the UPPP.

Here is a Q&A from the August 1997 CPT Assistant:

Question:

At the same surgical session, my physician performed a palatopharyngoplasty and a tonsillectomy. Can both of these services be reported, or is the tonsillectomy part of the palatopharyngoplasty?
**AMA Comment:**

From a CPT coding perspective, the tonsillectomy is a separate and distinct procedure. Therefore, if the physician performs a palato-pharyngoplasty and a tonsillectomy, both services would be reported. In this instance, the modifier -51 should be appended to the secondary or additional procedure to indicate that multiple procedures were performed on the same day or at the same surgical session by the same physician.”

While CPT may allow separate reporting of the tonsillectomy code, many payors, including Medicare, bundle payment of the tonsillectomy into the UPPP.

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**Billing an Injection Given by a Nurse**

**November 13, 2014**

**Question:**

Dr. A ordered a Rocephin injection on a patient but he was not in the office when the nurse gave the injection. We billed the injection under Dr. A’s name and NPI because it was his patient. Does Dr. A have to be in office for us to bill the injection or is it ok if Dr. B is in office supervising?

**Answer:**

Assuming all other guidelines are met, Medicare’s “incident to” billing guidelines would allow reporting the injection service under Dr. B’s name and NPI. Medicare’s guidelines require that the billing/supervising physician be in the office suite at the time the service is provided by the nurse.
Therefore, this service may not be billed under Dr. A because Dr. A was not in the office.

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**Videostroboscopy/Flexible Fiberoptic Laryngoscopy**

October 30, 2014

**Question:**

I recently purchased a videostroboscopy for my practice and was talking to the rep about how to bill for the service. The rep told me to bill 31575 for the flexible fiberoptic laryngoscopy and also 31579 for the videostroboscopy. I’ve billed both codes a couple of times but we can’t seem to get paid on both codes. Please help!

**Answer:**

Congratulations on the new service and expanding your practice! Unfortunately, you’ve been given inaccurate advice. It is not appropriate to report both 31575 and 31579 for the same service. CPT 31579 includes the flexible fiberoptic laryngoscopy (31575), so we suggest you write off the denials and do not report 31575 with 31579.