Nasal Septal Graft Bundling

June 12, 2014

Question:

My physician did a septoplasty and also harvested a graft from the septum for repair of nasal vestibular stenosis. I billed CPT 30465 (nasal vestibular stenosis repair), 30520 (septoplasty) and 20912 for the septal graft. Insurance denied the graft code as bundled. I tried to appeal this and was denied. Shouldn’t this be paid because the physician did the work of harvesting the graft in addition to the septoplasty?

Answer:

We appreciate your question! Although your physician did do the work of harvesting a septal graft, any grafts taken from the same surgical field are not separately billable. A separate incision is required to bill a graft harvest in addition to a primary procedure for most codes. Some codes actually include harvesting the graft in the work of performing the primary procedure, so depending on where the graft is harvested from and primary procedure performed you may or may not be able to bill separately for the graft harvest. For instance, if your physician was performing a nasal valve reconstruction and needed a septal graft but did not do a septoplasty, the graft harvest would be separately reportable because a separate incision was made to harvest the graft from the nasal septum.
Sub-Specialty
Otolaryngologists

May 29, 2014

Question:

I am new to credentialing at my clinic. We have 3 ENT doctors and a new physician joining the practice in the next few months. The new physician is a Pediatric Otolaryngologist. I am starting the initial paperwork, but can’t find a specialty code for Pediatric Otolaryngology. Should I credential him under Pediatrics? Also, since he is a different specialty, can I bill new patient codes for any of our patients that have been seen in the practice by another physician who isn’t a pediatric otolaryngologist? The other otolaryngologists in our group refer the pediatric patients to the new physician.

Answer:

Thanks for your questions. Unfortunately, payors do not recognize the subspecialties of Otolaryngology. Even though your new doctor is a pediatric otolaryngologist, he is considered an Otolaryngologist like the rest of the physicians in your practice.

Because there is not a separate distinction for subspecialties in Otolaryngology, all physicians in the same tax ID are considered part of the same group. If a patient was evaluated by a physician of the same specialty (otolaryngology) in the same group within the last three years and is now being evaluated by your new pediatric otolaryngology physician, the service would be billed using an established visit code (9921x).
Removal Of Nasal Pack

May 15, 2014

Question:

A patient came to the office after being seen in the emergency room with a nasal pack in place. I removed the nasal pack, but can’t figure out how to bill for taking it out. The nasal control codes only seem to be for placement.

Answer:

There isn’t a code for just removal of a nasal pack. The codes for controlling nasal hemorrhage include the necessary removal of the packs that are placed. Since there isn’t a code for removal only, you will need to report this service with either an Evaluation and Management code (e/m) or CPT 31231 if you performed a nasal endoscopy to further evaluate the nose during the visit. Depending on what occurred during the patient encounter, either of these options might be appropriate to bill for removal of nasal packs.

*ICD-9-CM = 784.7 Epistaxis*

*ICD-10-CM = R04.0 Epistaxis*

---

Suture Removal

May 1, 2014

Question:
We had a patient come into our office to have their sutures removed from a facial laceration repaired by someone else. The patient was hurt while on vacation and couldn’t have the sutures removed while away. The problem is the patient is still in the global period from the repair performed by another physician. How can I report this work? Or is it not billable since the patient came into our office during the other physician’s global period?

Answer:

Billing for suture removal depends on several factors. Technically, suture removal is included in the intermediate and complex repair codes (but not in the simple repair codes so you can always bill for suture removal). Ideally, the physician who placed the sutures would have reported the intermediate or complex repair code with modifier 54 (surgical care only) so you would report the same surgical CPT code with modifier 55 (postoperative management only). But we know this rarely happens!

There isn’t a CPT code for suture removal in the office setting. There are codes to report removal of sutures under anesthesia (other than local) for either the same surgeon (CPT 15850) or other surgeon (15851). Therefore, your work is captured through whatever Evaluation and Management (e/m) code you will report.

Remember to document appropriately to support the e/m code reported. The three key components for an e/m service are history, exam and medical decision making. A new patient e/m code requires 3 of 3 key components meet the same level and an established patient e/m code requires 2 of 3 key components meet the same level. *See CPT Evaluation and Management Services Guidelines for official rules and guidelines for reporting office and other outpatient services.

ICD-9-CM = V58.32 Encounter for removal of sutures with code
for the injury.

ICD-10-CM = Z48.02 Encounter for removal of sutures with code for the injury.

**Medication Refills**

April 17, 2014

**Question:**

The physician I work for will often send patients home with two different samples of medication to try to see which works best for them. When the patient calls back to tell the physician which medication has worked, the physician writes the prescription and sends it into the pharmacy. He has been billing a 99211 for this on the day he calls the prescription in for them. Is this correct?

**Answer:**

No, you may not bill an E&M code for writing a prescription without a face-to-face visit. The activity of writing a prescription related to a condition that was evaluated in the office is included in the Evaluation and Management (e/m) code the physician submitted the day he/she saw the patient in the office regardless of when the prescription is written. Per CPT instructions, pre- and post- non-face-to-face work associated with an encounter was included in the calculation of the total work of typical services. So the e/m reported for the face-to-face encounter you had with the patient includes any work associated with the visit that is done prior to or after the patient is seen and should not be reported as a separate service.
Also, CPT 99211 requires a face-to-face visit. Because this communication took place over the phone, it would not be appropriate to charge 99211. There are non-face-to-face codes for telephone services, but these are typically not covered by third-party payors and would be a patient-pay service. Be aware these telephone services codes also have guidelines about when they can be billed. If the phone call results in a decision to see the patient or was a result of an e/m service that was reported in the previous 7 days or during the postoperative period the phone call is included in the work of that e/m or procedure and is not separately reported.

Cerumen Removal 2014

April 3, 2014

Question:

I noticed that I am getting denials from Medicare when I use modifier 50, bilateral procedure on 69210. I thought we were allowed to bill with modifier 50 as of January 1, 2014. What should I do?

Answer:

This has been an ongoing issue since the code 69210 was revised effective January 1, 2014. Some payors are indeed recognizing modifier 50 on 69210 while others, including Medicare, are not. For Medicare, just report 69210 without any modifiers. Do not bill 69210-RT and 69210-LT thinking you’ll be paid for bilateral procedures – your claim will still be denied. Also, we’ve heard of practices billing 69210 on two separate claims in an attempt to get both services paid – don’t do this.
For more information, please click here to see the webinar that Kim Pollock gave a few weeks ago: Resolving Cerumen Coding Chaos – we think you’ll find it very helpful.

---

**Excision of a Skin Lesion**

March 6, 2014

**Question:**

When coding for excision of a skin lesion (114xx, 116xx), do I use the size on the pathology report to determine the correct CPT code?

**Answer:**

The most accurate measurement, according to CPT, is when the lesion has not yet been excised and is still on the patient. The specimen reduces in size when it is in formalin. So reporting a CPT code with the size listed on the pathology report may result in a lower CPT code being billed and a loss of revenue.

---

**Postop Mastoid Debridement**

February 20, 2014

**Question:**

My doctor did a mastoidectomy on a patient. Can we bill for the mastoid debridement using 69220 when the patient comes
back to the office for a postop debridement?

Answer:

The mastoidectomy codes (e.g., 69641-69646) have a 90-day postoperative global period and include all postoperative care related to the mastoidectomy procedure. Therefore, the postop office debridement is not separately reported.

---

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.