Check Nerve, Time, Equipment Before Reporting Monitoring Combo

Your monitoring claim will be incomplete if you forget to look for these details.

Recognize Passive, Active Monitoring

When choosing the test code, go beyond cranial to look for the specific nerve monitored.

VIIth nerve: Facial nerve monitoring, such as may be necessary for parotids, mastoids, and acoustics, falls under 95867 (Needle electromyography; cranial nerve supplied muscle[s], unilateral). In facial nerve monitoring, an instrument sounds an alarm when a muscle innervated by the seventh (VIIth) nerve is activated. This is known as passive monitoring and does not require ongoing active attention or decision making unless the alarm sounds.

Payment: More often than not, third party payers will not pay for passive intraoperative monitoring. But the probability of reimbursement improves if there is medical necessity for someone apart from the surgeon to be actively engaged in intraoperative monitoring and exercising ongoing clinical judgment.

VIIIth nerve: The code combination +95940 (Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes [List separately in addition to code for primary procedure]) or +95941 (Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour [List separately in addition to code for primary procedure]) with 92585 (Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive) requires ongoing attention and decision making relative to whether a waveform is present and stable from the eighth (VIIIth) cranial nerve or auditory nerve, such as with posterior fossa, acoustic neuroma, or skull base surgeries. If the waveform shows changes, the person providing the monitoring has to determine whether those changes are due to OR conditions or an actual change in the nerves status.

Unit of 95940/95941 = Minutes/Hour of Monitoring

Pay attention to the documented monitoring time: The 95940 would be the minute code for intraoperative monitoring with the number of units billed whereas 95941 would be the hourly code. The documentation in the medical chart should list the start-time and the end-time for the active monitoring to support the number of units billed to the third party payer.

Add 26 Unless ENT Owns Machine

You'll be overbilling 95985 and 95940/95941 if the hospital owns the monitoring equipment and if you don't add modifier 26 (Professional component). If the clinician performs only the interpretation and does not own the equipment, modifier 26 must be appended to the code used for the study performed, according to the AAO-HNS.

Exception: If the otolaryngologist or the audiologist owns the equipment and brings it to the operating suite, it is customary for the audiologist to bill the global fee for both 95940/95941 and 92585.

Note: For more on 95940/95941 performed by an audiologist, see the Audiology chapter of the Ear Procedures Section.

Which Modifier for Multiple I&D?

It’s not uncommon for ENTs to perform 10060 multiple times within the global period of the original procedure you reported with 10060. Keep these quick tips in mind to determine if you can report the procedure again with modifier 58.

Watch for same cyst: Assuming the ENT is performing the multiple incision and drainages (10060, Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; simple or single) in the office to drain the same cyst that keeps refilling, modifier 58 (Staged or related procedure or
service by the same physician or other qualified health care professional during the postoperative period) is appropriate. The modifier can be applied even when the doctor only anticipated the possibility of surgery instead of planning it.

**OR instead:** When an I&D requires a return trip to the operating room, you would instead use modifier 78 (Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period).

**Count the days:** Each time you report 10060-58, a new 10-day global period starts. You would include all related care, such as the typical follow-up office visit, during this time in 10060. Enter the bundled E/M as 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an E/M service was performed during a postoperative period for a reason[s] related to the original procedure) at a $0 charge.

Use 11900 for Injection, Not Drug

**Question:** May I bill for Kenalog in addition to 11900? If so, how do I calculate the fee? I have the vials cost, but the procedure required drawing only half of the vial.

**Answer:** In the office (place-of-service code 11), you may report the medication and the injection (11900, Injection, intralesional; up to and including 7 lesions).

When your ENT office purchases the Kenalog, you would code the medication with J3301 (Injection, triamcinolone acetonide, not otherwise specified, per 10 mg). To bill for half of a 10-mg vial (Kenalog-10), use 0.5 units, which equates to billing for 5 mg of Kenalog. If your staff drew half of a Kenalog-40 vial, use J3301 x 2 (for 20 mg).

If your ENT provides the injection in a facility, the facility bills for the Kenalog. In these cases, the outpatient hospital (POS 22) or ambulatory surgical center (POS 24) has purchased the medication and therefore charges for the supply.

**Get Comfortable With Staged Modifier When ENT Anticipates 2nd Surgery**

Modifiers 58 and 78 may seem to be referring to the same situation. But there is a clear distinction between the two.

**Protocol:** Choose the correct modifier based on these guidelines:

- Modifier 58: warrants some level of planning or anticipation
- Modifier 78: reserve for procedures that are unplanned and not foreseen in advance.

**Check for Scheduled Language**

When your otolaryngologist performs a procedure that is staged or related to the global postoperative period of another procedure, you may use modifier 58 (Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period). Identifying a staged surgery that the surgeon planned has always been straightforward.

**Example:** An otolaryngologist places a transtracheal oxygen (O₂) therapy tube. On day 1, the otolaryngologist performs a tracheostomy (31610, Tracheostomy, fenestration procedure with skin flaps). On day 2, during the second step of the procedure, the physician moves the O₂ cannula of the long-term O₂-use patient from the nose to the trachea (31730, Transtracheal [percutaneous] introduction of needle wire dilator/stent or indwelling tube for oxygen therapy).

**You code:** Because the tracheostomy code (31610) used on day 1 has a 90-day global period, code 31730 with modifier 58 to let payers know you planned the tube placement at the time of initial service.

Look for these documentation clues that signal modifier 58’s applicability. During any global period, if the treating physician uses language that indicates that further procedures are scheduled during the global period as a related procedure, modifier 58 applies.

**Extend 58 to Anticipated Procedure**

Whether you should count second surgeries that are unplanned in the surgeons mind but still staged has been more contentious.
Per CPT®, a staged procedure refers to a procedure that is planned or anticipated (staged).

**The difference:** Prospective means expected or likely, and anticipated means to look forward to. The AMA may have made this change to try to more plainly state the reasoning preceding a staged procedure, some coders say.

**Impact:** Modifier 58 applies to staged or related procedures that were planned or anticipated at the time of the original surgery, not just ones that your doctor planned in advance. Many coders were already using modifier 58 when the doctor only anticipated the possibility of surgery instead of planning it. The change made those coders more comfortable with that usage.

Anticipated surgeries — ones that are unplanned but obviously staged — involve a lesser procedure that results in a more complicated one. Part of the reason behind 58 is to encourage surgeons to practice conservative care leading to more extensive care.

For instance, an otolaryngologist does a lobectomy (60220, Total thyroid lobectomy, unilateral; with or without isthmusectomy), hoping that the procedure will remove the patient’s cancer. The pathology report shows that the lobectomy did not remove the entire malignancy. During 60220’s 90-day global period, the surgeon performs a completion thyroidectomy (60260, Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid).

In this case, you would use 58 on the completion thyroidectomy: 60260-58. Although the surgeon didn’t say that he would do a total thyroidectomy, he anticipated that a more extensive procedure might be necessary. Therefore, the second procedure, which involves more work than the original procedure, is staged.

**Use 78 for Unplanned OR/PR Procedure**

For treatment of an unanticipated clinical condition that requires a return to the operating room (OR), you should use modifier 78 instead. CPT® stresses that the modifier is for an unplanned procedure following initial procedure in the modifier’s revised guidance. The modifier’s definition also adds unplanned, procedure room, and by the same physician to read: *Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period.*

Modifier 78 means an unexpected, unplanned return to the OR (or procedure room) by the same physician. In the above O2 tube placement scenario, 31730 is not done in an OR and is planned at the time of the initial procedure. Therefore, modifier 78 would be inappropriate.

**Instead:** Turn to modifier 78 when a complication prompts a surgeon to take a patient back to the operating room. Medicare will only pay for a surgical complication that requires a return to the operating room, meaning it qualifies for modifier 78.

**Learn From This Example**

During the 90-day Medicare global period for 42826 (Tonsillectomy, primary or secondary; age 12 or over), a 68-year-old Medicare beneficiary has severe post-tonsillectomy hemorrhaging. The otolaryngologist is unable to control the bleeding and treats the patient in the operating room.

**Solution:** You should use modifier 78 on the bleed control code 42962 (Control oropharyngeal hemorrhage, primary or secondary [e.g., post-tonsillectomy]; with secondary surgical intervention): 42962-78. Because the tonsillectomy complication required the surgeon to return to the OR for surgical intervention, modifier 78 is appropriate. The modifier breaks the carrier’s global period edit for 42826.

**3 Do’s for Correct Application of Modifier 59**

You can get paid for separate side FESS and separate session epistaxis — and stay off payers’ audit radar, by correctly using one of the most misused modifiers: 59 (Distinct procedural service).

**1: Reserve 59 for Breaking 'Different' Bundle**

The right combination of an otolaryngological procedure and a modifier can make or break your claim. Through modifiers, payers know what transpired in the operative process without having to read every operative report.
Modifier 59 indicates that a distinct procedure has been performed during the same date. This modifier encompasses treatment for multiple primary, unrelated problems and may represent a different surgery, a different site, a different lesion, a different injury, or a different area of injury.

**Example 1:** If the otolaryngologist performs a total ethmoidectomy (31255, Nasal/sinus endoscopy, surgical; with ethmoidectomy, total [anterior and posterior]) on the right side and also a partial ethmoidectomy (31254, Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial [anterior]) on the left, you would report the service as 31255 and 31254-59. Although total ethmoidectomy (31255) usually includes partial ethmoidectomy (31254), modifier 59 allows you to unbundle them when the physician does the total and then the partial on two different sites.

**Example 2:** The otolaryngologist performs a diagnostic nasal endoscopy (31231, Nasal endoscopy, diagnostic, unilateral or bilateral [separate procedure]) in the office and later in the day sees the patient in the emergency room for complex epistaxis control (30903, Control nasal hemorrhage, anterior, complex [extensive cautery and/or packing] any method). You may append 59 to 30903 since you are reporting two different encounters for two procedures that are normally bundled together.

**2: Check CCI Edits for 59 Support**

You should use caution when using modifier 59 and check if another modifier isn't more appropriate. Usually dubbed as a "modifier of a last resort," modifier 59's descriptor indicates that you should only use it "if no more descriptive modifier is available, and the use of modifier59 best explains the circumstances." Anatomical (such as RT, Right side) or bilateral (50) modifiers, for instance, may be more appropriate to use than 59.

**How to:** Report the code without the modifier on the first line. On subsequent lines, report the code with modifier 59 and the unit of service is equal to one.

**Why:** You have to prove within the operative report that the otolaryngologist did a distinct procedure.

Reporting 59 on subsequent lines with a unit of one is the best way to explain this to the payer. Just like any modifier, the risks in using or overusing modifier 59 come into play when you use it incorrectly. You need to verify if procedures performed are bundled together in respect to Correct Coding Initiative (CCI) edits. In not doing so and just appending modifier 59 to codes may put your practice to the risk of being 'red flagged' for a possible audit.

**Wrong way:** Appending modifier 59 to a diagnostic laryngoscopy (31575, Laryngoscopy, flexible fiberoptic; diagnostic) when the physician is also performing a nasal endoscopy (31231) is a big no-no. Even though these procedures include different sites and different scopes, the two codes are intentionally bundled with these facts in mind. The only way you could unbundle these two codes with modifier 59 would be if the scope and bleed control occurred in different encounters during the same day.

**3: Beware 51 Reduces Pay, 59 Might Not**

Don't confuse modifier 59 with modifier 51 (Multiple procedures), which is used to identify secondary procedures or services provided along with the primary procedure. Modifier 51 is an indicator to payers that multiple procedures were done during one operative session. Indicate which procedure is primary, since many payers allow for 100 percent of allowable for only the primary procedure and drop payment for subsequent procedures to 50, or even 25 percent.

Meanwhile, modifier 59 is more of a "bundling/unbundling" modifier, which is typically used to indicate that procedures normally considered 'components' of one another (therefore not separately reimbursable) are in certain cases to be looked at 'individually.'

**Vital:** Always attach modifier 59 to the column 2 code, which is usually the lesser valued of the two services, or to the code — regardless of value — that would otherwise be denied or is a component of another, more comprehensive code.

**Tissue Transfer Coding Tips**

Understanding and applying the new skin repair code bundles is going to help you keep denials, lost reimbursements, and fraud charges at bay.

**Excision, Radical Resection, and Ablation Procedures**
Descriptors with tumor size quantifiers you need to alert for otolaryngology codes and if you're going to correctly bill these procedures, then you need to alert your physicians to specify these excision or radical resection dimensions in their documentation.

Expanding your excision, radial resection, and ablation options means that you're less likely to make coding mistakes. Examine these otolaryngology CPT® codes.

When your otolaryngologist treats a patient with a really deep facial tumor, you have four tumor excision codes to choose from. They are:

- **21011** — Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm
- **21012** — ... 2 cm or greater
- **21013** — Excision, tumor, soft tissue of face and scalp, subfascial (e.g., subgaleal, intramuscular); less than 2 cm
- **21014** — ... 2 cm or greater.

Note: The codes are for much deeper, more complex lesions — hence referencing tumors. The excision codes also include procedures that are size-specific:

- **21552** — Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater
- **21554** — Excision, tumor, soft tissue of neck or anterior thorax, subfascial [e.g., intramuscular]; 5 cm or greater
- **21555** — Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm
- **21556** — Excision, tumor, soft tissue of neck or anterior thorax, subfascial [e.g., intramuscular]; less than 5 cm

Notice how the descriptors don't say 'malignant,' which means you're not compelled to have a malignant neoplasm when your note specifies 'tumor.'

In theory, the size of a tumor should fairly well reflect the depth and difficulty in terms of work that has to be done to remove the tumors. Payment received should be reflective of that work — more money for more work.

**Size Matters for Radical Resection Too**

The codes for radical resection of soft tissue also focus on size. For instance, the descriptor for 21015 states (emphasis added) "Radical resection of tumor (e.g., sarcoma), soft tissue of face or scalp; less than 2 cm so as the descriptor for 21016 (... 2 cm or greater).

**Example:** Your otolaryngologist performs a radical resection of a tumor present on the patient's face. He documents, "The tumor measures approximately 3 cm in size." In this instance, you would report new code 21016.

**Bonus:** The trend for size delineation doesn't stop there. Sometimes scar excisions are so severe that a physician must use an adjacent tissue transfer to close the wound. Although your otolaryngologist may not deal with 30 sq. cm or greater sizes very often, you should note that codes 14301 (Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm) and add-on code +14302 (Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof [List separately in addition to code for primary procedure]) are meant for such instances.

**Continue Leaving Consultation Codes Out of Medicare's Way**

Medicare stopped recognizing consultation codes, but don't tear out those pages altogether yet. They are still part of your E&M codes. You can still submit these codes to non-Medicare payers who don't follow Medicare's lead.

Since CPT® 2014 and the fee schedule still include the codes, you can submit them to private payers. Private payers might also begin to follow suit, however. It may take some more time (depending on how long the AMA keeps the codes in the CPT® manual) for private payers to also stop paying on consultation codes, but the possibility exists.

There has been much confusion about consultations in general. Coders often get caught between the transfer of care and a true consultation.

**Turn Back to Standard E/M Codes Instead**
Instead of reporting consultation codes, you would report new or established patient office visit or hospital care (E/M) codes for these services.

**Example:** A Medicare patient presents to your otolaryngologist with recurrent sinusitis that her primary care physician (PCP) has medically treated for multiple courses. The PCP sent the patient to your otolaryngologist for his opinion. Therefore, the otolaryngologist evaluates the patient, does a nasal endoscopy, and recommends functional endoscopic sinus surgery for the patient. You simply need to report a regular office visit E/M code (99201-99215).

**Small bonus:** To make up for the elimination of the consultation codes, CMS has made provision for more than one initial hospital visit or initial nursing home visit. CMS added a modifier AI (Primary physician of record) for the admitting physician to use with the initial hospital visit to indicate that the visit belongs to the admitting physician. 

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