Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Keep This Laryngoscopy Primer on Hand for Distinguishing Three Types

Highlight these key words to know what you should report when.

If you're not certain what laryngoscopy code to report, you could be setting yourself up for a disaster. If you confuse a relatively simple procedure (such as an indirect laryngoscopy, where the ENT does not use a scope) with a far more complicated surgery because both codes use the word "laryngoscopy" in their descriptors, then you could face a denial or worse, suspicions of fraud.

CPT® lists 29 distinct laryngoscopy codes. Don't rely only on "laryngoscopy" written at the top of the operative note. You must check your otolaryngologist's documentation carefully to know what laryngoscopy procedure to bill.

Identify Laryngoscopy Code Groups

The 29 codes can be divided into the following three groups:

- indirect laryngoscopy
- direct laryngoscopy
- flexible laryngoscopy

Each of these groups, further, consists of four or more codes that differ by function, including but not limited to the following criteria:

- diagnostic
- with biopsy
- with removal of foreign body
- with removal of lesion

The reimbursement rates for these procedures vary greatly. For example, a diagnostic indirect laryngoscopy (31505, Laryngoscopy, indirect; diagnostic [separate procedure]) has an assigned value of 2.56 relative value units (RVUs). A direct scope with arytenoidectomy (31561, Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope or telescope), the most extensive of the laryngoscopy procedures, has an assigned value of 10.21 RVUs.

This range of codes and corresponding payment rates means you need to know how the three main laryngoscopy categories differ from each other. Further, coders need to know how to recognize key words in the otolaryngologist's operative report that point not only to the correct category but also to the specific procedure performed.

Identify Indirect Laryngoscopies With These Terms

Indirect laryngoscopy is the simplest of the three laryngoscopy categories. Consequently, the five procedures in this category do not involve a scope and offer the least reimbursement. Rather, they are used when the otolaryngologist examines the patient using mirrors to visualize the larynx, either for diagnostic purposes or as a guide for biopsy, lesion or foreign body removal, or vocal cord injection.

The simplest of these codes (diagnostic) often is used during a routine examination and should not be billed separately, experts say. A mirror examination of the larynx is part of the standard otolaryngology E/M bulleted examination. The only time you can bill for a simple diagnostic indirect or mirror exam (31505) is if the physician performs this without an accompanying E/M service.

Other services performed via indirect laryngoscopy are:

- 31510 □ Laryngoscopy, indirect; with biopsy
- 31511 □ Laryngoscopy, indirect; with removal of foreign body
- 31512 □ Laryngoscopy, indirect; with removal of lesion
- 31513 □ Laryngoscopy, indirect; with vocal cord injection

Although these diagnostic procedures should not be reported if performed during the same session as a surgical endoscopy, they may be reported if an open surgical procedure is performed. In addition, 31511 may be billed separately if the procedure is performed during critical care of a patient.

Key words: When an indirect laryngoscopy has been performed, coders should look for the following key words: indirect and mirror.

An indirect laryngoscopy should be coded 31505. Additional words such as biopsy, removal of foreign body or lesion, and vocal cord injection should direct the coder to choose either 31510, 31511, 31512 or 31513, as appropriate.

Fixate on these Flexible Laryngoscopy Descriptors

The second category of laryngoscopy codes describe when a flexible fiberoptic scope is inserted through the patient's nose or mouth to examine the interior of the larynx. The flexible laryngoscope is unique in that it usually does not require sedation or general anesthesia to use and the physician only uses topical anesthetics in the office. These procedures offer specific information in the functional and anatomic assessment of the upper airway, according to a policy statement by the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), and typically are performed in the otolaryngologist's office.

The following codes should be used when a flexible laryngoscope is used for a biopsy or to remove a foreign body or lesion:

- 31575 laryngoscopy, flexible fiberoptic; diagnostic
- 31576 ... with biopsy
- 31577 ... with removal of foreign body
- 31578 ... with removal of lesion

Note: Code 31579 (Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy) typically is performed via flexible scope. In this procedure, the otolaryngologist shines a strobe light at the vocal cords to measure their function.

A growing number of otolaryngologists now use flexible laryngoscopy, also known as nasal pharyngeal laryngoscopy (NPL), in place of the mirror exam because it offers a much better look at the upper airway. As a result, however, more carriers are including 31575 as part of any accompanying E/M service, much like the mirror exam. So, in order to be paid for the flexible laryngoscopy, the physician's note must demonstrate the medical necessity of the flexible laryngoscope and why it is needed over the traditional indirect mirror exam.

Place of service also should be checked in the operative report. If the procedure occurred in the office or at the bedside, it was either an indirect or flexible laryngoscopy.

Factor In Flexible Laryngoscopy and Sinus Endoscopy

Because the flexible laryngoscope typically is passed through the nose, the sinus area can be examined before the scope enters the larynx. In other words, a nasal/sinus endoscopy as well as a flexible laryngoscopy may be performed. In these circumstances, however, both procedures cannot be billed.

The Correct Coding Initiative (CCI) still lists 31575 as a column 1 code and 31231 (Nasal endoscopy, diagnostic, unilateral or bilateral [separate procedure]) as a column 2 code an edit that was a throw back from before 2004, when 31575 had higher RVUs than 31231. However, currently 31231 has higher RVUs at 6.43 while 31575 has 3.47 RVUs.

If the physician documents both the nasal scope and laryngeal scope as medically necessary (because the patient has sinus problems but also has indications for gastro-esophageal reflux disease [GERD]), then you should consider reporting the procedure with the higher RVU (31231).

In addition, you may convert 31231 to 31576 (6.84 RVUs) if a biopsy is taken or 31578 (8.54 RVUs) if a lesion is removed. Again, CCI has implemented bundling rules with these codes.

Key words: The following key words help coders recognize when a flexible laryngoscopy has been performed: flexible, fiberoptic and NPL.

A flexible laryngoscopy should be coded 31575. Additional words such as biopsy, removal of foreign body or removal of lesion should direct the coder to use either 31576, 31577 or 31578, as appropriate.

Beware Confusing 31231 With Another NPL Code

The nasal endoscopy (31231) includes looking at the anterior portion of the nose and often requires multiple passes to examine the meatus, turbinates and openings to the sinus cavities.

You also have a different code, not in the 3xxxx series, that is often also referred to as an NPL. This code also utilizes a flexible endoscope just like the flexible laryngoscopy. That code is 92511 (Nasopharyngoscopy with endoscope [separate procedure]). However, 92511 only includes looking at the eustachian tubes, adenoids, and choanae (where the pharynx and the nasal passages meet, at the end of the hard palate) all of which are located in the nasopharynx.

Then, the flexible laryngoscopy (31575) takes over, examining from the nasopharynx to the larynx.

So, if there is medical necessity to only examine the nasopharynx to look at the openings of the eustachian tubes in the nasopharynx for a patient that has eustachian tube dysfunction (381.81), the correct CPT code would be 92511 and not 31575. The reason is that the physician has no medical necessity to examine all the way to the larynx. The diagnosis only supports examination to and including the nasopharynx, which would be 92511. It so happens that since 2004, 92511 has higher RVUs than 31575 at 4.23.

Determine When to Code a Direct Laryngoscopy

Although flexible laryngoscopy is useful for diagnostic purposes, more complex scoping procedures often need to be performed using direct laryngoscopy, which almost always takes place in the operating room (OR).

The flexible laryngoscopy might identify a problem that requires better instrumentation to obtain a more complete picture. For example, an otolaryngologist examining a patient with swallowing difficulties (787.2x, Dysphagia) might perform a flexible laryngoscopy that determines there is a problem. But due to difficulties in performing a biopsy

because of the location of the problem, the patient is scheduled for the OR to have a direct laryngoscopy. An operating microscope might also be used.

When the physician performs a direct laryngoscopy, the otolaryngologist is able to see the throat through the scope, which goes into the mouth and down the larynx of the sedated patient.

This laryngoscopy category is the largest group and involves the most complex procedures. In addition, there are separate codes depending on whether microlaryngoscopy (i.e., direct laryngoscopy with operating microscope or telescope) is performed. For example, a diagnostic direct laryngoscopy has a different code (31525) than a diagnostic direct laryngoscopy performed with an operating microscope (31526).

Other services that may be part of a direct laryngoscopy and performed with or without a microscope include:

- 31530 – Laryngoscopy, direct, operative, with foreign body removal
- 31531 – Laryngoscopy, direct, operative, with foreign body removal; with operating microscope or telescope
- 31535 – Laryngoscopy, direct, operative, with biopsy
- 31536 – Laryngoscopy, direct, operative, with biopsy; with operating microscope or telescope
- 31540 – Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis
- 31541 – Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope
- 31560 – Laryngoscopy, direct, operative, with arytenoidectomy
- 31561 – Laryngoscopy, direct, operative, with arytenoidectomy, with operating microscope or telescope
- 31570 – Laryngoscopy, direct, with injection into vocal cord(s), therapeutic
- 31571 – Laryngoscopy, direct, with injection into vocal cord(s), therapeutic, with operating microscope or telescope

The highest-paying code, 31561, has a value of 10.21 RVUs and involves the removal of the arytenoid cartilage, which plays a role in the functioning of the vocal cords.

Note: Microlaryngoscopy procedures pay slightly more than their non-microscope equivalents. For example, removal of foreign body via microlaryngoscopy (31531) is valued at 6.33 RVUs, slightly more than 31530 (5.88 RVUs).

The following codes are for services performed via a direct laryngoscopy have their own codes:

- 31515 – Laryngoscopy, direct, with or without tracheoscopy; for aspiration
- 31520 – Laryngoscopy, direct, with or without tracheoscopy; diagnostic, newborn
- 31527 – Laryngoscopy, direct, with or without tracheoscopy; with insertion of obturator
- 31528 – Laryngoscopy, direct, with or without tracheoscopy; with dilatation, initial
- 31529 – Laryngoscopy, direct, with or without tracheoscopy; with dilatation, subsequent

Note: The most commonly performed direct laryngoscopies are 31535, 31536 and 31541.

If a procedure began as an indirect or flexible laryngoscopy and had to be converted to a direct scope, you should only report the direct scope. If the physician performs a significant separately identifiable E/M with a laryngoscope on the same day, you should append modifier 25. This will indicate that the E/M was not the small E/M that belongs with a minor procedure. That means the physician must document that the medical necessity for the scope and the separate nature of the scope from the E/M service. The documentation must show the scope was not planned or that the E/M service was

what led to the physician's decision to perform the scope. Some private carriers ask providers to use modifier 57 (Decision for surgery) when billing E/M with the direct laryngoscopy, even though all laryngoscopy procedures have 0 global days.

Direct laryngoscopies usually take place in the OR, whereas flexible and indirect laryngoscopies usually are performed in the otolaryngologist's office or at the patient's bedside. In addition, only direct laryngoscopy codes include the use of the operating microscope. Therefore, if the procedure took place in the OR and the operative note also reports that an operating microscope was used, the coder can determine that in all likelihood, a direct microlaryngoscopy was performed.

Key words: The following key words help coders recognize when a direct laryngoscopy was performed: operating room or OR, operating microscope, microscope, microlaryngoscopy , telescope and direct.

If the procedure was performed for more than diagnostic purposes, the following key words may offer clues as to what procedure was performed: aspiration, newborn, obturator, dilatation, foreign body removal, biopsy, excision of tumor, stripping of vocal cords, epiglottis, arytenoidectomy, and vocal cord injection.