Sinus Surgery in ASC Includes Stereotactic Guidance

You cannot report add-on codes +61781-+61783 (Stereotactic computer-assisted (navigational) procedure ...) with a sinus surgery done in your ambulatory surgical center. The code has a payment indicator of N1 (Packaged service/item; no separate payment made). This means no separate payment can be claimed for this service even if your physician uses the guidance during a sinus surgery under the ASC setup.

Maxillary Cyst Removal Coding Simplified

Sometimes a code's wording can leave just enough gray area to throw a coder off.

For instance, take 31267 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus). The phrase “removal of tissue” sounds like a debridement.

But what if your physician removes a polyp or cyst from the maxillary sinus? There's no code that says "polyp removal" or "cystectomy" for that sinus. Can you still call on 31267, or would you have to rely on a lesser code like 31256 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy)?

If the surgeon removed a maxillary cyst but did not mention that he removed diseased mucosa would you code 31256 or 31267?

Let's take a look at the op note that raised the above question.

The patient presented with a long history of chronic sinusitis “that is typically refractory to medical management. His primary symptoms are nasal obstruction, significant pressure, and frequent infections,” the op note says. The patient has heavy nasal polyps bilaterally and a deviated septum, the doctor notes.

Procedure: The physician started on the patient's left side. The middle turbinate was removed on its anterior inferior half. Polyps were removed laterally and medially to the middle turbinate.

The bulla ethmoidalis was opened up with a curette and polyps were removed in to the anterior ethmoid up in to the nasofrontal recess. The ground lamella was penetrated and the anterior wall of the sphenoid was identified. Septations of the ethmoid were broken up with the curette and polyps were removed from the sphenoid anteriorly following the roof of the sinuses. The natural maxillary antrostomy was identified. Polyps were removed superiorly and inferiorly with the Concept shaver and forceps. There was mucopurulence aspirated from the left maxillary sinus with suction. There was fairly heavy mucosal oozing. This was cauterized to obtain control.

Then the physician worked on the patient's right side. The septum was so far deviated that the instruments could not be placed in to the nose. A right-sided hemitransfixion incision was made and the submucoperichondrial flap was elevated. Just posterior to the caudal cartilage there was perpendicular plate of the ethmoid and vomer which was deviated over towards the right. This was removed.

The physician found out just how bad the polyps were. They had pretty much replaced the middle turbinate. This was removed medially and lateral to the middle turbinate and portions of the polypoid changes of the middle turbinate were also removed with the Concept shaver. The anterior wall of the sphenoid was identified.

Following from posterior to anterior a curet and Concept shaver was used to remove the polyps and the ethmoid septations up in to the nasofrontal recess. The natural maxillary antrostomy was identified and widened. A superior and inferior uncinectomy was performed.

Breaking down the Op Note
So what's going on here? First, let's look at the patient's diagnoses. The physician found four conditions that support medical necessity for the procedures:

- 473.0 — Chronic sinusitis; maxillary
- 473.2 — Chronic sinusitis; ethmoid
- 471.8 — Other polyp of sinus; maxillary
- 470 — Deviated nasal septum

And here are the codes you'd report for this case:

- 30520 (Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft) supported by 470.
- 31255-50 (Nasal/sinus endoscopy, surgical; with ethmoidectomy, total [anterior and posterior]). You'd append modifier 50 (Bilateral procedure) to indicate the ENT worked on both ethmoid sinuses. Diagnosis code 473.2 supports this procedure.
- 31267-LT (Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus). You'd append Modifier LT (Left side) to help distinguish it from the next procedure, and support it with dx codes 473.0 and 471.8.
- 31256-59-RT (Nasal/sinus endoscopy, surgical, with maxillary antrostomy). Modifiers 59 (Distinct procedural service) and RT (Right side) tell the payer this was a separate procedure on a separate site from the 31267. Dx code 473.0 supports this procedure.

Understand Maxillary Surgery

The maxillary sinuses are right behind your cheekbones.

In adults, these are the sinuses where an infection usually occurs. Your maxillary sinuses drain into your nose about one-half inch below the corners of your eyes. This area of your nose is called the osteomeatal complex.

When this part of your nose is blocked, the maxillary sinuses no longer drain properly and infection can develop. Often, the sinus opening itself becomes blocked, too. The procedure to clear the sinus opening is called a maxillary antrostomy. In an antrostomy, the physician makes an opening (-ostomy) into an antrum — a cavity or chamber — so it can drain. The procedure to clear the osteomeatal complex is called an uncinectomy. Usually, both are performed together.

When your ENT performs these procedures endoscopically, you use 31256 or 31267. Though 31267 doesn't specifically refer to polyps, cysts, or other lesions, if the surgeon removes them — or any tissue — from the maxillary sinus, you’ll code with 31267.

To meet the definition of 31267, the maxillary sinuses are opened up and tissue is removed. That can be polypoid tissue as well as mucoid tissue.

**Note:** If the surgeon removed diseased mucosa, that's tissue. If your ENT cleans out mucous, that's not tissue and would not qualify for 31267.

**Don't make this error:** Do not code the procedure described in this op note with 31237 (Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement [separate procedure]). As 31237 is listed as a separate procedure, you would call on it when that is the only procedure that was performed. In this case, the ENT performed an antrostomy as well as a polypectomy.

Coding Changes if FESS Switches to an Open Procedure

A patient presents for functional endoscopic sinus surgery (FESS) but has a much more extensive problem than you normally see for FESS: a large mass growing from the sinus actually goes into the mouth. Fortunately, you might be able to report a more extensive code than 31267 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus), depending on how your physician completed the procedure.

Actual coding always depends on the operative report, but the otolaryngologist may end up performing a Caldwell-Luc (CL). If during the endoscopic maxillary antrostomy, the surgeon uses the scope inside the maxillary sinus but cannot access and remove all the polyps and masses, the patient may require an open C-L antrostomy, entering the maxillary
tissues through the gum line — and changing your coding.

In this case, you would code the C-L with removal of tissue (31032, Sinusotomy, maxillary [antrotomy]; radical [Caldwell-Luc] with removal of antrochoanal polyps) and the appropriate functional endoscopic sinus surgery (FESS) ethmoidectomy (either 31254, Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial [anterior]; or 31255, ... with ethmoidectomy, total [anterior and posterior]). You may bill an endoscopic procedure performed on another sinus in addition to open maxillary antrostomy. The insurer may reduce payment for the ethmoidectomy 50 percent following Medicare multiple procedure rules.

**Watch for Global Period, Modifiers**

FESS procedures have zero global days, whereas open surgeries (such as C-L) have 90- days global period. The C-L procedure would include any subsequent related services, such as follow-up visits or debridements.

If the surgeon endoscopically begins the maxillary procedure and then during the surgery has to convert to an open procedure, you would bill only 31032. Medicare guidelines state that when an endoscopic procedure is converted to open, only the open procedure is billed.

Although CPT® states that you may bill both procedures with 52 (Reduced services) appended to the endoscopic procedure that was not completed, most private payers follow Medicare’s lead on this issue and will pay only for the open procedure. The operative report should clearly indicate why the endoscopic procedure was converted to open surgery.

**Tip:** If the completed, converted endoscopic procedure plus the open procedure consumed a lot of time and effort, consider appending modifier 22 (Increased procedural services) to 31032. Submit the claim electronically and then send the documentation with a cover letter explaining the increased work.

**Bust 2 Myths That Could Make You Leave Post- Op Scope Dollars on the Table**

Learn the documentation requirements for an E/M or scope following sinus surgery with septoplasty so you don't bundle separately reportable items into the global period.

**Review the Documentation**

Suppose that on Aug. 1, an otolaryngologist performed a septoplasty (30520) with 90 global days, as well as bilateral total ethmoidectomies (31255) and maxillectomy with tissue removal (31267), which have zero global days. See if you can tell what to break out and what to include in the following Aug. 14 office note:

**Vital signs:**

Height: 68 in.

Tobacco use: quit 10 years ago (PFSH-social)

Allergies reviewed: no changes (PFSH-history)

**Office note:**

**Chief complaint:** Patient returns to the office today in FU, status postnasal septoplasty, bilateral total ethmoidectomies and left maxillary sinusotomy with tissue removal.

**History of present illness:** Patient reports ongoing (HPI-duration) "sinus headaches" (HPI-associated signs and symptoms). She denies any purulent rhinorrhea (ROS-ENT) or fevers (ROS-constitutional). She does remind me that she has multiple types of headaches, including migraines, etc. (HPI-severity). She indicates that she is irrigating 2-3 times per day (HPI-modifying factors).

**Physical examination:** Anterior rhinoscopy reveals clear nose and midline septum (nose included in septoplasty's global package). Examined endoscopically patient's sinuses, including ethmoid sinuses bilaterally and left maxillary sinus (included in endoscopic exam). The patient's sinus surgery defects are healing nicely. There is no evidence of any infection, bleeding, etc. (findings included in endoscopy).
**Impression:** Satisfactory postoperative course.

**Recommendations:** Patient will continue to irrigate at least two times per day. We have asked her to return to see us on the three-month anniversary of surgery, sometime in late September.

**Procedure note:**

Procedure: Nasal/sinus endoscopy; bilateral ethmoid and left maxillary sinus endoscopy.

Anesthesia: Topical Lidocaine.

Findings: Included.

**Procedure:** Following adequate Lidocaine spray analgesia, inspected using the fiberoptic endoscope the patient’s nasal cavities bilaterally, ethmoid cavities bilaterally and left maxillary sinus. Note the above findings.

Patient tolerated the procedure well. No complications.

**Stop Assuming E/M Is Never Legit**

**Question:** Should the doctor report an E/M service for this encounter?

The above office note has an expanded problem-focused history (HPI: 4-Extended; ROS: 2-Extended; PFSH: past, social 2-Complete) but no physical examination or medical decision making that stands separate from the scope’s minor included E/M. You’ll need more details to show that the decision for the procedure was secondary to the actual visit.

Although the patient mentioned headaches, the physician made no further documentation to support an E/M and gave no treatment. Because of this, the encounter looks like the patient returned to the office for a planned scope following sinus surgery. The E/M service does not represent an unrelated E/M service from the surgery that created the global.

**Sidestep Septoplasty Global Mishaps**

If endoscopy and office visit denials during a septoplasty’s global period plague you, a modifier could fix the condition. Check these two related questions from a common case.

**Code 1- or 2-Sided Look-See the Same**

**Question:** Do I need modifier 50 on the scope code?

Unlike all other sinus endoscopy codes, the code description for 31231 (Nasal endoscopy, diagnostic, unilateral or bilateral [separate procedure]) indicates “unilateral or bilateral.” Therefore, it wouldn't be appropriate to charge 31231 with modifier 50 (Bilateral procedure) because the code’s allowance already includes both sides.

**Designate Scope as Unrelated to Septoplasty**

**Question:** What modifier would you need on 31231 for sinuses during the septoplasty’s global period?

Modifier 79 (Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period) holds your answer. The septoplasty has the global period — 90 days — and the scope is related to the sinus headaches, not the septoplasty.

**Caution:** Don't assume you can automatically bill 31231-79 in every post-septo case. Medical necessity dictates whether or not to charge for the scope. If the ENT performed the scope just to check the healing status of the septoplasty, include the scope as part of 30520’s global package.

**Expect Challenge for 31231, E/M Pay**

**Question:** Will insurers pay for a postoperative look-see or unrelated E/M? Although there is no global period for the sinus surgeries (bilateral total ethmoidectomy, 31255-50; and maxillectomy with tissue removal, 31267), insurance companies always deny 31231 or an E/M code based on the septum global days. Show insurers the scope or E/M is unrelated to the global period employing these three tips:
1. Put modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during the global period) on the office visit code (99212-99215) to indicate the E/M is unrelated to the existing global period.

2. Link the documented non-septum diagnoses, such as headache (346.1x, Migraine without aura ...) and sinusitis (473.0, Chronic sinusitis; maxillary; and 473.2, Chronic sinusitis; ethmoidal) to 31231-79 to show the endoscopy is related to the headache and sinus surgeries.

3. Make sure the documentation that you are basing your E/M level on totally carves out any septum care of findings and relates only to the headaches.

And finally, be prepared to fight for payment. Even if you have a different diagnosis and a 24 modifier on the E/M code, you might still find yourself having to appeal.

Catch Often Missed Billable FESS Procedures Using 5 Tips

You don't have to be a super sleuth to unravel functional endoscopic sinus surgery (FESS) operative reports if you employ these insider tactics.

For optimal ENT coding, you've got to understand anatomic landmarks that the otolaryngologist might cite to know where in the sinuses the surgeon is working. The surgeon might note a landmark to indicate he's going into another sinus. To capture codeable procedures, try these best practices.

1. Ask for a Procedure Revealing Run-Thru

If your otolaryngologists are accessible to you, arm yourself with your notes, coding book, and anatomy book, and ask them to talk to you about the procedures they commonly perform. Have them walk you through how they dictate to see if there are opportunities for additional reimbursement.

Heads up: Did the surgeon go through the anterior ethmoid? If he came into this sinus for medically necessary reasons, then you should bill for the ethmoidectomy (31254, Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial [anterior]).

Beware: If you spot sphenoid (31287, Nasal/sinus endoscopy, surgical, with sphenoidectomy; 31288, ... with removal of tissue from sphenoid sinus; and/or 31291, Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region) in the operative report, ask the otolaryngologist how he got there. An ethmoidectomy could be billable if it was medically necessary. But if the surgeon used the sinus as the “freeway” on the way to the sphenoids, it is not a billable service.

2. Equate Stenosis With 30465

When you see “stenosis — nasal valve” in an operative report, a light should go off in your head. You should think, “I wonder if the surgeon did 30465 (Repair of nasal vestibular stenosis [e.g., spreader grafting, lateral nasal wall reconstruction]).”

If a patient's nasal valve angle has narrowed (stenosis) to less than 10 degrees to 15 degrees, he may not breathe right. Code 30465 describes the techniques the surgeon might use, such as spreader grafting or lateral nasal wall reconstruction. Osteotomy (cutting for realignment) of nasal bones is a buzz word in these types of cases.

In nasal valve repair, the ENT may create a graft that he puts up into the patient's nose, like shocks lifting up a car, to open up the angle.

Example: “Harvested nasal cartilage [from the patient's nasal septum] is often used as a spreader graft or as a nasal alar batten graft to repair a dysfunctional or collapsed internal nasal valve,” according to Coders' Desk Reference. In this case, you should separately use 20912 (Cartilage graft; nasal septum).

Don't miss: You need to use modifier 52 (Reduced services) on 30465 if a surgeon does not perform the repair bilaterally.

3. Point Out Concha Bullosa Is Payable
If you have never seen concha bullosa in an operative report, talk to your doctors. They may not dictate endoscopic concha bullosa resection (31240, Nasal/sinus endoscopy, surgical; with concha bullosa resection) because they don't know it's separately reportable. Or, they may not dictate it because they do not remove it endoscopically. It is always good to make sure.

There's no reimbursement for middle turbinates. Therefore, when the surgeon drops down there to remove a concha that impinges on the septum, he may similarly think the procedure is nonreportable. You do not want to miss out on those dollars. Read the operative report, not just the procedures list, or you could miss out on concha bullosa resection descriptions that could cut reimbursement your physician has earned.

4. Reorder, Back-Check Bilateral Claims

On multiple procedures claims, get in the habit of reporting procedures from highest to lowest valued. Although Medicare automatically places procedures in descending order to apply multiple procedures' payment reduction, other payers' systems are not as savvy. Third-party payers may apply reductions using the order you provide on the claim form. You may need to reorder claims involving bilateral procedures.

Why: A lower-paying bilateral procedure might trump a higher-paying procedure. For instance, if an otolaryngologist performs unilateral FESS (31254-31288) with septoplasty (30520, Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft), make sure you are putting the code with the higher RVU on the top. The code with a lower RVU might get higher RVUs if performed bilaterally.

Tip: If you've been using modifier 50 (Bilateral procedure), look at your payments to see if the insurer has been paying you unilaterally (at 100 percent) instead of bilaterally (at 150 percent). Audits frequently reveal documentation and coding that supports a bilateral procedure that the insurer has paid unilaterally.

The insurer may incorrectly process Medicare's preferred modifier 50 method of a one-line entry with modifier 50 (such as 31254-50). Private payers may want bilateral procedures on either two lines with modifier 50 on the second line (31254, 31254-50) or two lines with modifier RT and LT or no modifier with two units on a single line item (31254 x 2).

5. Go Beyond 473.9 With FESS

Finally, be skeptical when you have chronic sinusitis unspecified (473.9) as the only operative report ICD-9 code. If the patient's sinus condition is at the point where he requires FESS, the diagnosis should be specific.

Do this: Look in the operative report findings to get precise details about the real problem, such as removal of antral disease. Use the specific diagnosis that indicates the need for each sinus procedure. For instance, support maxillary antrostomy (31256, Nasal/ sinus endoscopy, surgical, with maxillary antrostomy) with chronic maxillary sinusitis (473.0) and total ethmoidectomy (31255, Nasal/sinus endoscopy, surgical; with ethmoidectomy, total [anterior and posterior]) with chronic ethmoid sinusitis (473.2), provided documentation includes these diagnoses.

If the physician does not include the diagnoses in the operative note, talk to him/her about documenting them. Explain to him/her that just documenting chronic sinusitis or pansinusitis is not sufficient for billing and reimbursement.

Spot Sinus Landmarks to Unravel Op Reports

Trace your otolaryngologist's work and capture functional endoscopic surgery (FESS) procedures and related nasal and concha bullosa work using this diagram.

If you can't keep track of where your surgeon is working, you could overlook separately codeable sinus procedures. To leave no dollars on the table, keep this anatomy sheet with CPT® and ICD-9 crosswalk handy.

Use 2 Diagnoses to Support 31575 With E/M

Question: A patient came in for chronic ethmoid sinusitis that wasn't resolving. The otolaryngologist changed the patient's prescription. Because the patient also complained of hoarseness, the physician performed a scope and found the patient had a paralyzed vocal cord. Should you report the E/M service in addition to the scope?
Answer: Absolutely, if the otolaryngologist's documentation supports both the service and the procedure. Ideally, he should write separate paragraphs for both with findings sections for each. The exam findings should indicate that the otolaryngologist was unable to visualize the larynx. He should include the larynx findings in the laryngoscopy section. This way he receives credit for the larynx findings once, not twice.

Although CPT® does not require separate diagnoses to report an E/M service with modifier 25 (Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service) in addition to a procedure, having two diagnoses helps show the insurer that the E/M service is significant and separate from the minor E/M included in the laryngoscopy (31575, Laryngoscopy, flexible fiberoptic; diagnostic).

- Published on 2015-01-01