Chapter 12: Scope Procedures

Know All Your New Sinus Endoscopy Procedures Choices

You have three codes in the CPT® manual for sinus endoscopy procedures that are meant to report endoscopic dilation of sinus ostia. Here is what the codes describe:

31295 – Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg. balloon dilation), transnasal or via canine fossa.

31296 – …with dilation of frontal sinus ostium (eg. balloon dilation)

31297 – … with dilation of sphenoid sinus ostium (eg. balloon dilation)

Stop on Higher-Paying Scope Code Minus Laryngeal Exam Indication

You can net significant extra dollars in diagnostic scope pay if you can spot the words that should keep you with 31231 or 92511 instead of 31575.

With ENTs billing Part B carriers for more than 500,000 scopes with 31575, you can't afford to miss capturing higher-paying codes when the physician performed and documented the medically necessary service. An otolaryngologist can actually make more money per hour on in-office procedures than in surgery. The office setting is much less bureaucratic and thus allows for a more efficient patient flow than a hospital.

The numbers should be on your side if you grasp these scope fundamentals.

Maximize Your Endoscopic Reimbursement by Avoiding These Pitfalls

For functional endoscopic sinus surgeries (FESS) documentation, global periods, and modifiers, you need to be extra vigilant if you want to recoup the highest possible ethical reimbursement the first time you submit your claim.

Dodge these three pitfalls to ensure Zero Denial

Pitfall 1: You Don't Verify Endoscopic Procedure

Otolaryngologists use FESS (31237-31288) as a sinus surgical method. The term “functional” distinguishes this type of endoscopic surgery from non-endoscopic, more conventional sinus surgery procedures. The main purpose of FESS is to restore normal drainage of the sinuses.

Warning: Before you apply nasal/sinus endoscopy codes (31231-31294), make sure your otolaryngologist performed and documented endoscopic procedures. Auditors reported encountering a few cases in which physicians performed sinus procedures via Caldwell-Luc antrotomies or frontal sinusotomies and not via endoscopy (or at least the otolaryngologist did not document via endoscope). Despite this lack of detail, the coders still used endoscopy codes.

Do this: Reserve the FESS codes for cases in which the operating room (OR) supports via endoscopy. The Caldwell-Luc (31020-31032) and frontal sinusotomy (31070) require documentation that specifies through the nose or a trephine (hole).

Pitfall 2: You Assume Multi-Day Global Periods

When your ENT sees a FESS patient postoperatively in the office, reporting services can get tricky. For FESS (31237-31288 except 31239), there is no postoperative period. Keeping that in mind, here's how to report these visits: If your physician sees the patient for an office visit postoperatively for FESS with no other surgeries performed, you should report that visit (99212-99215, Office or other outpatient visit for the evaluation and management of an established patient ...) with no modifier. The same rule applies if you have to bill any other procedure, such as debridement (31237, Nasal/sinus
endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure) performed on the patient after his FESS.

Although Medicare indicates a zero-day global period for most FESS procedures, codes with zero-day global periods still include a very small E/M component. When your otolaryngologist documents that an E/M service is significant and separately identifiable from the minor E/M included in debridement (31237), you can apply modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of a procedure or other service) to the E/M code.

If the initial surgery codes, such as a septoplasty (30520, Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft), create an existing global period and the ENT debrides the sinus during that period, append modifier 79 (Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period) to 31237. The debridement is for the sinus, which is totally unrelated to the septoplasty work that is done on the septum and turbinates.

Pitfall 3: Your Codes Aren’t Listed by Highest RVU

If you’re not looking at your relative value units (RVUs), you could be allowing payers to reimburse your practice less than your practice ethically deserves. You should always list the code with the most RVUs first.

When coding for endoscopic sinus surgery, you should start with the procedure that has the most value.

Discover When You Can Report E/M + Flexible Scope Visits

In an office visit, a patient must fail the mirror exam, which is part of your E/M exam, before you can charge separately for flexible laryngoscopy. Just as important is your physician’s report as to why the patient needs a flexible scope. If you don’t have this information, you won’t be able to report the service.

**Bottom line:** CMS clearly advises you to include the mirror exam (or regular fiberoptic scope) in the E/M, and states that the flexible laryngoscopy is separately billable only if the patient is a child or has undergone a failed mirror exam.

**Example:** A patient comes into your otolaryngologist’s office for an exam complaining that he feels he has something in his throat. The ENT carries out the exam and thinks that the patient needs a flexible laryngoscopy.

**What happens:** A flexible laryngoscopy employs a thin, flexible endoscope that an otolaryngologist can manipulate to examine areas not normally seen by traditional examination techniques. It is done under direct visualization. Although the image quality is not as good as that obtained by rigid laryngoscopy, most patients undergo flexible laryngoscopy without much difficulty.

In this case, you can bill the E/M service, such as 99213-25 (Office visit for the evaluation and management of an established patient ... Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) with the scope (31575, Laryngoscopy, flexible fiberoptic; diagnostic).

**Why:** The physician does a diagnostic procedure to assist the patient in what might be causing his complaint and what course of treatment to take. That could be a significant amount you could add to your bottom line (To get the exact picture see the RVUs the code has and the current conversion factor).

**Keep in mind:** Some insurance companies require you to use modifier 25, but if the diagnostic procedure does not have a global period, you don’t need to append it. Per CPT®, you do not have to have a separate diagnosis for the E/M and procedure.

Avoid These 2 Documentation Pitfalls

**Pitfall 1:** Flexible laryngoscopy is an exam of the larynx. If the physician’s documentation gives you an examination of only the nasopharynx, do not go for 31575. Instead, choose 92511 (Nasopharyngoscopy with endoscope [separate procedure]). Otolaryngologists generally agree that you have to pass through the nasopharynx, the pharynx, and supraglottis/hypopharynx to get in position to examine the laryngeal area.

**Pitfall 2:** A typical source of confusion is when physicians choose to perform a nasal scope insertion for a laryngoscopy because inserting the scope through the patient’s nose is easier than making the patient hold his mouth open for a long
time. In this case, the phrase "nasal scope insertion" in your physician's documentation can give you a wrong reading; you incorrectly might assume that he performed a nasopharyngoscopy instead of a laryngoscopy.

**Check for 31575 Medical Necessity**

Trace how far a flexible scope goes to see if you’re in 31231, 92511, or 31575 territory.

Use 31231 for a scope of the nasal cavity. Code 92511 reflects viewing up until the nasopharynx. Code 31575 is for a medically necessary scope that examines all the way down to the larynx.

**Example:** An ENT used topical lidocaine for anesthesia and performed flexible fiberoptic laryngoscopy via the right nostril. The procedure note indicates, “The nasopharynx, vallecula, epiglottis, sinuses, and vocal cords were all visualized.”

Because the scope goes all the way into the larynx, 31575 might be correct based on anatomy. You should use 31575 instead of 92511 only if the note shows that examining this far was medically necessary. In other words, you must have a chief complaint and a history of a laryngeal problem.

If, however, the ENT examines only the nasopharynx, such as for eustachian tube dysfunction or a mass in the nasopharynx, you would code 92511.

**Spot ‘Rigid’ or ‘Flexible’**

To choose between 31525 (Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn) and 31575 (Laryngoscopy, flexible fiberoptic; diagnostic), look at the type of scope and location. Code 31525 is for rigid laryngoscope, and 31575 is for flexible laryngoscope.

**Clinical lowdown:** Physicians may use a rigid scope, which is a straight metal instrument that goes through the mouth into the throat, for surgical procedures, such as removing foreign objects, collecting tissue (biopsy), removing polyps, or performing laser surgery. A rigid scope also aids in diagnosing cancer of the voice box (larynx). Physicians perform the procedure in the operating room under sedation.

In contrast, a flexible scope allows better diagnostic views, is tolerated better by patients, and can be performed in the office. It is a pencil-thin, flexible fiber optic scope that goes in through the nose and then down the throat.

**Example:** An otolaryngologist documents a "direct laryngoscopy used to view the vocal cords by using a fiberoptic scope without taking a biopsy." In this case, you should code the procedure with 31575. Link the diagnostic code to the chief complaint, such as halitosis (784.99, Other symptoms involving head and neck; Choking, sneezing, halitosis, mouth breathing).

**Replace 31575 for Abnormal Findings**

When your otolaryngologist finds a problem during a diagnostic scope, you should convert from the diagnostic scope code to a surgical flexible scope code. The surgical scope code includes the diagnostic scope, according to CPT® guidelines and multiple endoscopy payment rules.

Suppose during the above fiberoptic scope scenario the ENT found and biopsied a polyp on the vocal cords (478.4, Polyp of vocal cord or larynx). You should assign 31576 (... with biopsy), rather than 31575 for a diagnostic laryngeal scope.

Other procedures the ENT might perform with a flexible laryngoscope include removal of the following:

- foreign body (31577) with 933.1 (Foreign body in larynx)
- lesion (31578) linked to (478.4. Polyp of vocal cord or larynx).

Similarly, if during a nasal scope for obstruction, the ENT found and removed a polyp, you would report 31237 (Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement [separate procedure]) instead of the diagnostic nasal scope (31231).

**Clinch Extra $ in Diagnostic Pay With Scope Essentials**

You'll avoid undercoding or overcoding your ENT’s diagnostic scopes from the nasal cavity to the laryngopharynx if you hit
the codes' trifecta of extent, reason, and type.

**Overlooking Pertinent Modifiers can Hamper your Claim**

Transnasal endoscopies can be confusing. Knowing the right use of modifiers can help in getting your claims promptly processed. Here is a solution through a few questions and answers:

**Question 1:** Your otolaryngologist performs a TNE with examination of the entire esophagus to the gastroesophageal junction. How should you report this?

A. 43200  
B. 31575  
C. 92511

**Answer 1: A. Forgo Modifier with 43200 For Typical TNE**

You should report the service with 43200 (**Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) using no modifier**).

Physicians perform transnasal esophagoscopy (TNE) with examination of the entire esophagus to the gastroesophageal junction.

A typical TNE procedure involves visualizing the entire length of the esophagus to the gastroesophageal junction. It uses an ultrathin transnasal endoscope, with patients not usually sedated, which allows the physician to perform it in the office setting.

**Note:** The CPT® Moderate (Conscious) Sedation Guidelines states that “because the global period for codes 43200 is zero days, E/M services on the day before and the day after the procedure may be coded and reported without a modifier and without invoking global edits.”

**Question 2:** Your physician performs TNE but not to the gastroesophageal junction. What modifier should you report?

A. Modifier 22  
B. Modifier 51  
C. Modifier 52

**Answer 2: C. Append Modifier for Limited TNE**

Use 43200 with modifier 52 (Reduced services) when the procedure involves only a portion of the esophagus and does not extend to the gastroesophageal junction. You would report 43200-52 to imply that the usual work of the service was reduced to an extent and should not be paid at the full rate.

**Question 3:** A patient undergoes transnasal endoscopy for laryngopharyngeal reflux (LPR). How should you report this?

A. 43200  
B. 31575  
C. 92511

**Answer 3: B. Look Out for Medical Necessity, Anatomical Clues**

Report 31575 (**Laryngoscopy, flexible fiberoptic; diagnostic**) for a transnasal endoscopy done via the nose to view the larynx or other structures. For instance, you would use this code when an otolaryngologist performs a flexible fiberoptic laryngoscopy via the right nostril using topical lidocaine for anesthesia, and his procedure note indicates, "The nasopharynx, vallecula, epiglottis, sinuses and vocal cords were all visualized."

**Key:** Assure your reimbursement when using 31575 by tracing how far a flexible scope goes. This code is for a medically necessary scope that examines all the way down to the larynx. If you do not have medical necessity for going all the way into the larynx, you might be stuck with 92511 (Nasopharyngoscopy with endoscope [separate procedure]). For instance, you would use this code when the otolaryngologist examines only the nasopharynx, such as for eustachian tube dysfunction or a mass in the nasopharynx.
**Code This Excision**

**Procedure:** Excision of left preauricular first branchial cleft sinus tract in a previously operated field.

**Pre-/postoperative diagnosis(es):** Recurrent left preauricular first branchial cleft sinus tract.

**Note:** This procedure qualifies for modifier 22 because it is a revision surgery in a previously operated field.

**Specimens sent to lab:** Overlying skin plus the deep sinus tract.

**Indications for surgery:** Recurrent left preauricular sinus tract.

**Findings in surgery:** Scarred preauricular areas from previous excision with no cutaneous fistula and no discernible sinus tract.

**Procedure:** An incision was made with the #11 scalpel blade around the area was most recently drained. This area was over the tragal cartilage region. A portion of the tragal cartilage was transected as the deep plane of the excision. Then, dissection was carried inferiorly and superiorly plus anteriorly to remove this portion of the pretragal scar and deep tissue. The depth of the dissection was the parotid gland. It was apparent that there was a large amount of scar tissue at the anterior excision site, and this was felt to also contain branchial cleft sinus tissue. Therefore, further excision of the scar was performed with the #11 and #15 scalpels, and a large portion of tissue removed down to and including a portion of the superficial aspect of the parotid gland. After removal of the specimen, a significant defect was present in the preauricular region. The closure of this area required undermining the facial skin inferior to the auricle and then anteriorly approximately one-third to 40 percent of the way to the corner of the mouth and lateral canthus of the eye. The tissue was then advanced and portion of the tissue rotated to allow a closure in a parotidectomy or fascial fashion in the preauricular area with a T-segment going anteriorly at the level of the tragus. Plicating 3-0 chromic sutures were used to reduce the space made vacant by excision of the deep tissue. This closure of the deep space was made possible by advancing the adipose tissue posteriorly and superiorly. Again, this tissue was held in place with 3-0 chromic suture.

**Check Cleft Type**

Identifying whether the cyst excision was in the neck or ear region avoids using a code from an incorrect CPT® anatomy section.

Make sure you don't lump branchial and preauricular cysts because each is from a different embryological source.

**Link Branchial to Neck's 42810-42815**

For branchial cysts, you'll be in the neck section. Branchial cleft cysts are congenital cysts that form during the embryonic development stage because of failure of the second branchial cleft to close in the later aspect of the neck.

There are four branchial or pharyngeal clefts that develop between the branchial arches in approximately the fourth week of the embryo's life.

Use 42810 (Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues) when the branchial cyst is superficial. If the provider dissects all the way to the tongue base or tonsillar pillars, report 42815 (Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx).

**Think Ear for Preauricular Cyst**

Preauricular cysts come from the six hillocks that form the external ear.

**Result:** You can't use 42810 or 42815 in the above operative report. That's because this is a preauricular sinus tract and 42815 is for the neck around the tonsil area.

Preauricular cysts connect to the outside with a sinus tract that opens into a pit, just anterior to the root of the helix. Cystic lesions near or around the external auditory canal are believed to represent first branchial cleft duplication anomalies. Tracts arising from or paralleling the external auditory canal can lead to a cystic cavity, which will become recurrently infected and often drain in or near the ear.
Spot 'TDC' or 'Hyoid' Before Using 60281

CPT® could throw you another curve with 60281 (Excision of thyroglossal duct cyst or sinus; recurrent) unless you can connect a third type of cyst with the corresponding anatomy. The operative report's cyst is not a thyroglossal duct cyst (TDC).

Explanation: Thyroglossal duct cysts are remnants of the embryonic thyroglossal duct that may occur anywhere from the base of the tongue to the thyroid gland. The majority, however, are found at the level of the thyrohyoid membrane, under the deep cervical fascia. They are in the midline or just off on the midline, and move up and down upon swallowing.

Occasionally, a sinus tract is present in the midline without a visible cyst. This midline sinus tract represents the remnant of the thyroglossal duct. It may open into the region of the hyoid or lower above the sternal notch.

Key words: Look for the "hyoid dissection" before using 60281. The physician may also call this a Sistrunk procedure, but still make sure that hyoid dissection occurs.

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