Codify
BY AAPC

Outpatient Facility Coding Alert

ENT Refresher: Know Your Nasal Endoscopy Choices for Correct Coding

Catch the code right with your thorough knowledge!

Select the codes based on your in-depth knowledge of the code descriptors and the terminology associated with nasal procedures. This will not only help you to accurately select codes but a close eye on the code descriptors, will keep you from reporting redundant additional codes or help you catch the correct code for higher paying scope. It will also help you to be aware of the pitfalls which may lead to denials.

For example, 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.

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).

Steer clear: Coders who report FESS procedures often fall into several traps if they aren't careful. Watch for these four areas before submitting a FESS claim:

- Billing for removal that was performed but not included correctly in the operative report (upcoding).
- Incorrectly billing tissue removal when it is inappropriate (upcoding).
- Not coding the tissue removal when it is performed and described in the body of the operative report but not noted at the top (downcoding).
- Billing for endoscopy without tissue removal when it is performed and noted correctly in the operative report (downcoding).

The coder often believes that only the root procedure 31256 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy) or 31287 (Nasal/sinus endoscopy, surgical, with sphenoidotomy) is performed, when actually the otolaryngologist removed tissue.

In many cases, otolaryngologists do not note the removal of tissue at the top of the operative report, so coders have to read right down to the bottom of the procedure section of the op note to find out they removed sphenoid tissue, says **Cheryl Odquist, CPC,** an otolaryngology reimbursement specialist with California Health Management Billing, a medical management firm in San Diego, California.

To avoid such misunderstandings, Odquist recommends that otolaryngologists provide the CPT codes. The coder's function then should be to cross check to ensure the correct code is chosen. Failing that, she urges otolaryngologists to include exactly what the procedure involved in the body of the op note at the top under a heading such as "Procedures Performed."

Note: The operative report also must include the reason(s) for the removal of the tissue.

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Occasionally, the reverse occurs: The removal of tissue is noted at the top of the operative report but not in the description of the procedure, Odquist says. In the body of the op note, the otolaryngologist will state that he or she went into the ostium with the scope, and the sinuses were clear. But if the sinuses are clear, that means there was no tissue to be removed, she says.

Understand the Higher-Paying Scope

You can net significant extra dollars in diagnostic scope pay if you can spot the words that should keep you with 31231(Nasal endoscopy, diagnostic, unilateral or bilateral [separate procedure]) instead of 31575 (Laryngoscopy, flexible fiberoptic; diagnostic).

For example, for a larynx exam, you should report 31575 even if the provider inserts the scope via the nose for patient comfort. Choose the code based on the anatomic area examined, not the entry point.

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.

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

Document the Procedures Correctly in the Operative Note

Despite the intent of the physician, if the operative report contains no mention of tissue removal, then 31267 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus) or 31288 (Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus) cannot be billed. If the operative report simply states nasal endoscopy with antrostomy, even though tissue was removed to perform the procedure, all that can be billed is 31256 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy).

Although payment for either 31267 or 31288 may be forthcoming if these codes are billed without supporting documentation in the op note, doing so puts the otolaryngologist at risk for noncompliance if he or she is audited.

In short, the operative report must show that removal of tissue was a component of nasal/sinus endoscopies. In addition, the summary of the operation performed (at the top of the operative report) also should indicate nasal/sinus endoscopy with removal of tissue as the complete surgical description.

The difference in reimbursement between the two procedures is significant. Whereas 31256 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy) is assigned 5.71 relative value units (RVU) by the National Physician Fee Schedule Relative Value Guide, 31267 has 9.16 RVUs, based on based on the national conversion factor of 35.7547. The payment difference between 31287 with 6.69 RVUs and 31288 at 7.76 RVUs also is noteworthy. In other words, by documenting the procedures correctly, your otolaryngologists' reimbursement can be increased.

In addition, both 31267 and 31288 usually are secondary procedures accompanying ethmoid endoscopies (31254, Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial [anterior]; and 31255, ... with ethmoidectomy, total [anterior and posterior]). Because both ethmoidectomies are assigned more RVUs than the sphenoid tissue removal, 31288 should be listed after either 31254 or 31255 when billing for the procedures. Maxillary tissue removal would be listed ahead of 31254 but below 31255 on the CMS 1500 form. Be sure to check for NCCI (National Correct Coding Initiative) edits as well.

Note: If the surgeon performs any of these sinus endoscopies bilaterally, the sequence would change, depending on which procedures were bilateral and which were performed on one side only.

In other words, the order in which the procedures are listed on the claim form depends on what other procedures are performed, whether they are bilateral, and the total number of RVUs assigned to each. This would allow the otolaryngologist to maximize the payment for the procedures by listing those with the most RVUs first.

Be Careful About the Multi-Day Global Period

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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 (99211-99215, 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 performed on the patient after his FESS. You will use 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.

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