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Outpatient Facility Coding Alert

NCCI Policy: Adhere to These NCCI Policies on Your Endoscopic Surgery Claims

Think twice before coding separately for access routes.

As a surgical coder, you're all too familiar with the importance of the National Correct Coding Initiative (NCCI) Policy Manual as a reference guide for coding operative reports with accuracy and precision. In recent issues of Outpatient Facility Coding Alert, we've outlined and unpacked various NCCI policies that impact your practice.

Covering those policies puts you in a better position to succeed, but the journey through the NCCI Policy Manual isn't over yet. In this issue, you'll be confronted with a few more rules, regulations, and instructions that every practicing endoscopic surgical coder should be familiar with.

Have a look at the following NCCI policies to put yourself in the best position for surgical coding success.

Identify Evaluation of Access Regions Surgeries

The first, and arguably most important, NCCI policy on endoscopic respiratory surgeries applies to the concept of "access regions":

- "When a diagnostic or surgical endoscopy of the respiratory system is performed, it is a standard of practice to evaluate the access regions. A separate HCPCS/ CPT® code shall not be reported for this evaluation of the access regions. For example, if an endoscopic anterior ethmoidectomy is performed, a diagnostic nasal endoscopy shall not be reported separately simply because the approach to the ethmoid sinus is transnasal. Similarly, fiberoptic bronchoscopy routinely includes an examination of the nasal cavity, pharynx, and larynx. A separateHCPCS/ CPT® code shall not be reported with the bronchoscopy HCPCS/ CPT® code for this latter examination whether it is limited ("cursory") or complete."

In the world of surgical endoscopy coding, this NCCI guideline should be at the forefront of your mind whenever you are working on an endoscopic operative note. Essentially, this NCCI policy is telling you to code the end result of the endoscopic service - not the physician's approach to the underlying procedure.

One of the more common miscoded scenarios is when a coder reports 31276 (Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed) with a modifier 59 (Distinct Procedural Service) in addition to 31253 (Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed) or 31255 (Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)). This is because the services in 31276 are necessary in order for the provider to gain access to perform an ethmoidectomy.

Note: In addition to 31253 and 31255, the parenthetical note under 31276 states not to report 31276 in addition to 31296 (Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)) and 31298 (... with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)) "when performed on the ipsilateral side." If the provider performs a separate nasal endoscopy with frontal sinus exploration on the side contralateral to the ethmoidectomy, for example, you may bill both services with a modifier 59 appended to 31276.

"A similar example can be made with diagnostic endoscopies," says **Barbara J. Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CENTC, CPCO, AAPC Fellow**, of CRN Healthcare in Tinton Falls, New Jersey. "A diagnostic endoscopy such as 31235 [Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)] can be coded on the contralateral side from 31257 [Nasal/sinus endoscopy, surgical with ethmoidectomy; total

(anterior and posterior), including sphenoidotomy]. However, it is not the case with 31231 [Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)], since this code can be unilateral or bilateral," Cobuzzi explains.

Know What Qualifies as Scout Endoscopic Exploration

Next up, have a look at these two related NCCI guidelines instructing you on how to address endoscopic surgeries that precede nonendoscopic surgeries:

- "If the findings of a diagnostic endoscopy lead to the decision to perform a non-endoscopic surgical procedure at the same patient encounter, the diagnostic endoscopy may be reported separately.
- "However, if a 'scout' endoscopic procedure to evaluate the surgical field (e.g., confirmation of anatomic structures, assess extent of disease, confirmation of adequacy of surgical procedure such as tracheostomy) is performed at the same patient encounter as an open surgical procedure, the endoscopic procedure is not separately reportable."

The key here is identifying the difference between a scout versus non-scout endoscopic procedure. While it might seem like an ambiguous distinction, you will want to refer back to the provider's initial intent when performing the endoscopy.

For example, if the provider performs a routine endoscopic service that precedes a planned open surgical operation, you should not bill separately for the endoscopic service. However, if the provider performs an exploratory diagnostic endoscopy and determines from there that an open surgical procedure is necessary, you may consider billing the initial endoscopic service separately.

"The key here is determining what the surgeon knew when scheduling the surgery," says Cobuzzi. If, for instance, the physician was aware of diseased tissue from a biopsy or endoscopy prior to the date of service for the » surgery in question, then the scope performed is a scout endoscopy and is nonbillable.

"But, if the surgeon has no knowledge as to the morphology and/or presence of diseased tissue prior to the surgery, the diagnostic or biopsy endoscopy is separately billable on the day of the open surgery," explains Cobuzzi.

By the same token, the NCCI Policy Manual provides one further guideline for services involving an endoscopic and open surgical procedure at the same encounter:

- "If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure."

You should report a routine endoscopic service following an open procedure the same way as you would a preliminary scout endoscopic service. If the follow-up endoscopy is related to the underlying surgical procedure, you should not consider the endoscopy separately billable.

To download the 2019 NCCI Policy Manual, go to:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.