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CODING & BILLING

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Coding Endoscopic Sinus Surgery

Here are the keys to more compliant, accurate and better-paying coding.

Coding endoscopic sinus surgery can be a real challenge — especially in an outpatient setting — and especially because CMS keeps changing the rules. Clear and concise documentation is the key to ensuring proper reimbursement and reducing the risk of non-compliance. Even then, it takes a talented coder to translate the documentation and assign accurate medical coding.

Take note

Don't code from the list of operations, as it doesn't tell the whole story. Instead, refer to your treasured set of coding books, bundling resources and the actual documentation. Documenting endoscopic sinus surgery is all about the facts — the who, what, when, where and why. Here's what should be included in the operative note:

- the side(s) (unilateral or bilateral) on which the procedure(s) was performed;
- the procedure(s) done (noting which sinuses) and how (scope, open or sub mucosal);
- unique qualities;
- extenuating circumstances, such as heavy bleeding, repeat sinus surgery, diabetes and obesity; and
- if there was any tissue removal — CPT codes differ depending on whether there was tissue removal from the maxillary or sphenoid sinus.

Procedural scope

Many types of procedures fall under the category of endoscopic sinus surgery. Break the op report apart to ensure all billable codes are captured, modified correctly and appropriately sequenced. You should also read the body of the operative notes to make sure that what's described in "procedure performed" is described in the text as well.

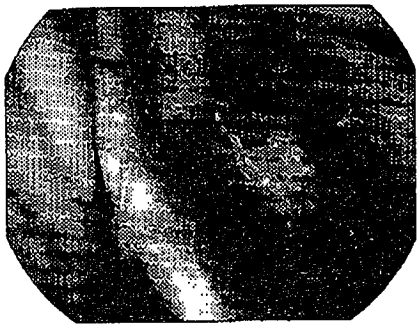
Starting with the procedure that has the most value, select the primary diagnosis and procedure codes based on the sinuses involved. The diagnosis code will support the "why" and the procedure codes will support the "what." Sequencing of multiple procedures is critical, especially if both unilateral and bilateral procedures are performed, as lower-paying procedures could "trump" higher-paying procedures if performed bilaterally.

Although not bundled in CCI, ethmoidectomy and sphenoidotomy codes (31254, 31255, 31287, 31288) are considered access to CSF (cerebrospinal fluid) leak and orbit decompression procedures, since the scope must go thorough the ethmoids and sphenoids to accomplish these procedures. For Medicare, you can code 31240 at the same time you code 31254 or 31255. CCI edits support the fact that this set of codes requires additional expertise and effort over and above ethmoid surgery. Private payors, however, may bundle 31240 into endoscopic sinus surgery codes and not pay for it separately.

Endoscopic Sinus Surgery Codes

CPT Code	Description
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
31293	Nasal/Sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression
31290	Nasal/sinus endoscopy, surgical with repair of cerebrospinal fluid leak, ethmoid region
31291	Nasal/sinus endoscopy, surgical with repair of cerebrospinal fluid leak, sphenoid region
31294	Nasal/sinus endoscopy, surgical; with optic nerve decompression
31299	Unlisted procedure, accessory sinuses

For frontal sinusotomy, the documentation should describe ostitic bone removal between the frontal sinus and the supraorbital ethmoid cell. The note should include any work performed inside the frontal sinus ostium for enlargement or other reasons. A frontal sinusotomy can be done on a partially developed frontal sinus if it needs to be enlarged for drainage. If the surgeon only explores the frontal sinus while performing an ethmoidectomy, bill only 31255.



The diagnosis code will support the "why" and the procedure codes will support the "what."

To bill 31276, the surgeon must perform a sinusotomy (opening the frontal sinus, for example). Entering the "frontal recess" isn't entering the frontal sinus. The frontal recess leads up from the ethmoids to the frontal sinuses. Note that 31276 includes endoscopic exam of obstructing frontal recess cells, polyps or scar tissue (including partially developed frontal sinuses), delicate removal of intersinus septi from the dome of the ethmoid and skull base, and (may include) removal of ostitic bone between the frontal sinus and a supraorbital ethmoid cell.

When coding and billing a total ethmoidectomy, you must document the entrance and work on both the anterior and posterior ethmoid sinuses in the body of the operative note. If only the anterior ethmoids were done, the operative note should indicate a partial ethmoidectomy. If neither the posterior nor anterior were indicated, code for a partial (31254).

Note that endoscopic sinus surgery procedure codes have zero follow-up days in the Medicare fee schedule. However, additional procedures performed with FESS may alter the global period (septoplasty or turbinectomy, for example).

Turbinates

When billing for turbinate resection, make sure you use the diagnosis for turbinate hypertrophy (478.0) and nasal obstruction (478.1), as you must demonstrate the medical necessity of these procedures.

Report 30130 (Excision inferior turbinate, partial or complete, any method) for the partial or complete excision of the inferior turbinate. For this code, the entire inferior turbinate, mucosa and turbinate are excised. Bill this code bilaterally if both inferior turbinates are resected. If FESS surgery wasn't performed, and a middle turbinectomy was done, bill 30999 unlisted procedure, nose.

Report 30140 (Submucous resection inferior turbinate, partial or complete, any method) for the sub mucous resection of the inferior turbinates. This means that the physician entered the mucosa, excised the inferior turbinate bone and slipped it out of the mucosa and left the mucosa behind. Bill bilaterally if both inferior turbinates are resected.

Excising or doing a sub mucous resection of the middle turbinates is considered access to the sinuses and, therefore, incidental to FESS surgery and not billable. Watch out for procedures that are automatically included in any surgical endoscopic procedures by convention or bundling, including:

- 31231. Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
- 30115. Excision nasal polyp(s), extensive
- 30117. Excision or destruction (e.g., laser), intranasal lesion; internal approach
- 30999. Unlisted Nasal Procedure for excision of middle turbinates
- 31238. Nasal sinus endoscopy, surgical; with control of nasal hemorrhage

Navigational assistance

CPT code +61795 (Stereotactic computer assisted volumetric [navigational] procedure, intracranial, extracranial or spinal) is an add-on code. If the procedure is performed in an ASC, Medicare will only reimburse the physician, not the ASC. (Check if private payors may have a different rule for this code.)

Medicare doesn't bundle CPT 61795 into FESS codes for physician services, so list 61795 separately in addition to the primary procedure FESS code. Don't report 61795 alone, don't attach a modifier to it and, as always, make sure medical necessity is documented.

Balloon sinuplasty

The Relieva Sinus Balloon Catheter technology is often used during endoscopic sinus surgery to gently open blocked sinuses. Outpatient facilities may have a hard time getting paid for balloon sinuplasty (C1726 Catheter, balloon dilatation, non-vascular), as many carriers consider it experimental. If you meet with resistance, refer to the AAO-HNS Position on Coding for Sinus Balloon Catheterization at **www.entnet.org/practice/policysinusballoon catheterization.cfm**. Bill balloon sinuplasty using endoscopic sinus codes when assisted with endoscopic sinus surgery in the frontal and sphenoid sinuses.

To successfully bill for balloon sinuplasty, documentation must support the following criteria:

- sinus endoscope must be used to position the balloon before and during cannulation of the ostium;
- confirming dilation with the balloon; and
- bone and mucosa must be moved in such a

How Would You Code This Case?

The pre-op diagnosis indicates prior nasal fracture, nasal polyps, acute and chronic sinusitis, concha bullosa, failure of antibiotics, failure of topical steroids, and failure of topical antihistamines as well as systemic antihistamines.

Reading the operative report, you see that the physician performed an anterior and posterior ethmoidectomy, a sphenoid sinusotomy without removal of any tissue, a maxillary antrostomy with removal of tissue on the left and no tissue removed on the right, a frontal sinusotomy, a submucous resection of inferior turbinates, a nasal polypectomy without any documentation of any substantial increased service and the open reduction of a nasal fracture with internal fixation. All of these procedures were performed bilaterally. The physician used stereotactic guidance throughout this surgery due to the complexity of the surgery — in particular the work in the frontal and sphenoid sinuses. General endotracheal anesthesia was used, and there was less than 50 cc's of blood loss. There were no complications.

Compare how you'd code this case based on just this documentation with the below coding based on the full (undisclosed) documentation:

CPT CODE	DESCRIPTION	RVUs	ICD-9
21330	Open Reduction Nasal Fx with Fixation	14.91	802.1 Open nasal fracture
31276-RT	Frontal sinusotomy	13.97	473.1 Chronic Frontal sinusitis
31276-LT	Frontal sinusotomy	13.97	473.1 Chronic Frontal sinusitis
31255-RT	Total ethmoidectomy	11.08	473.2 Chronic Ethmoid sinusitis
31255-LT	Total ethmoidectomy	11.08	473.2 Chronic Ethmoid sinusitis
30140-RT	Submucous inferior turbinectomy	10.48	478.0 Hypertrophy of turbinates
30140-LT	Submucous inferior turbinectomy	10.48	478.0 Hypertrophy of turbinates
31267-LT	Maxillary Antrostomy w/Removal of tissue	8.75	473.0 Chronic maxillary sinusitis
31287-RT	Sphenoid sinusotomy without removal of tissue	6.37	473.3 Chronic sphenoid sinusitis
31287-LT	Sphenoid sinusotomy without removal of tissue	6.37	473.3 Chronic sphenoid sinusitis
31256-59-RT	Maxillary Antrostomy without removal of tissue	5.42	473.0 Chronic maxillary sinusitis

The polypectomy wasn't coded since it's considered incidental to the other FESS surgery. The stereotactic surgery wasn't coded since this is the facility coding. The physician would have coded 61795 for the stereotactic guidance as an add-on code at the end of the list. Also, a physician wouldn't have used the RT and LT, but used the -50 modifier. The placement of the bilateral codes on one or two lines for the physician would have depended on the payer. The -59 modifier was needed for the maxillary antrostomy without removal of tissue because 31256 is considered a component of 31267, maxillary antrostomy with removal of tissue. The -59 modifier delineates that the second procedure was performed on a separate side. Note that the codes are in RVU order, from top value to lowest value.

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way as to significantly enlarge the ostium.

If documentation doesn't support these requirements, save yourself the trouble and use an unlisted code instead.

Modifiers

Modifiers let you report unique qualities and extenuating circumstances. Here are a few modifiers you might use when coding endoscopic procedures.

• **Modifier 50.** Most sinus endoscopy CPT codes are unilateral unless otherwise stated. For Medicare, report endoscopic procedures listed as unilateral that are performed bilaterally with "modifier 50: bilateral." For example, if the physician performs a total ethmoidectomy on both sides, report 31255-50 on a single line for physician services.

Watch for procedures that have in their descriptions "unilateral or bilateral." You may not bill these procedures bilaterally, since the base codes include both unilateral and bilateral performance. For example, CPT code 31231 isn't eligible for modifier 50. Additionally, ASC coding doesn't recognize modifier 50. When performing ENT procedures bilaterally, report modifiers RT and LT for most payers for the facility services.

• **Modifier 22.** Use "modifier 22 increased service" in cases such as an extensive polypectomy (30115) performed with a FESS. Although it isn't considered bundled with FESS surgery, the physician debriding the nose of polyps is considered access to the sinuses and thus is considered integral to FESS. If an extensive polypectomy is done, and documented as an increased service, you can attach modifier 22 to the FESS procedure code. Just make sure the documentation supports the complexity. You might also use modifier 22 to bill for a revision FESS, since there is no code for increased work and there is complexity involved in a revision surgery. Use the primary endoscopic procedure code and append modifier 22. As always, documentation must support that the revision was over and above the standard ESS.

• **Modifier 78.** Control of bleeding is an integral component of endoscopic procedures, but isn't separately reportable. For example, CPT code 30903 (Control nasal hemorrhage, anterior, complex [extensive cautery and/or packing] any method) isn't separately reportable during a nasal/sinus endoscopic procedure. But if bleeding occurs in the post-op period [1 day for ASC] and requires a return to the OR for treatment, a HCPCS/CPT code for control of the bleeding may be reported with modifier 78. This indicates that the procedure was a complication of a prior procedure. Control of post-op bleeding not requiring a return to the OR isn't separately reportable. OSM

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