

## Coding for Balloon Sinus Dilation 2010

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The AAO-HNS submitted three new code requests this past fall to the AMA for Category I CPT codes for the use of stand-alone balloon sinus dilation technology during endoscopic sinus surgery. The AMA has accepted these new code proposals and has recommended work and practice expense relative value units (RVUs) to CMS for the new codes. These codes are scheduled to be introduced in CPT 2011. In the meantime CPT Assistant has published in its January 2010 edition a basic guideline for proper coding when balloon dilation technology is used alone and in conjunction with current traditional instrumentation. The purpose of this article is to further discuss coding recommendations to be used by our members during the rest of 2010.

The primary goal of endoscopic sinus surgery is relieving obstruction and re-establishing sinus ventilation and drainage. This is a generally accepted surgical principle that applies to all of the paranasal sinuses regardless of what instrumentation is utilized. With the introduction of balloon dilation technology there is a recognized difference in the physician work involved between traditional endoscopic sinus surgery with tissue removal (bone, mucosa, polyps, tumor, and/or scar) and endoscopic sinus surgery when the balloon, or any device, is employed as a dilation tool only and no tissue is removed.

When a balloon is used to dilate a sinus ostium under endoscopic visualization as a stand-alone procedure and no tissue is removed, the correct code to use is 31299, "Unlisted procedure, accessory sinuses". This will be the correct coding for the service until the new codes are introduced in 2011, and apply to dilation of the frontal, maxillary, and/or sphenoid sinus. Balloon dilation of the maxillary ostium performed via the canine fossa approach is also reported with 31299, including cases in which tissue is removed from within the antrum. It is critical to accurately document all elements of the procedure.

This does not apply to endoscopic surgery of the ethmoid sinus as there is no current balloon technology for use in the ethmoid sinus. If ethmoidectomy is performed in conjunction with balloon dilation of the frontal, maxillary, and/or sphenoid (no tissue being removed), the appropriate ethmoid code should be reported in addition to 31299: 31254 Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior), or 31255 Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior). Removal of ethmoid tissue as part of ethmoidectomy does not constitute tissue removal from the frontal, maxillary, and/or sphenoid sinuses if the balloon is used for dilation of these sinus ostia alone.

The majority of endoscopic frontal sinus procedures focus on relieving obstruction in the frontal recess, the inferior aspect of the frontal sinus outflow tract, while others focus on enlarging the ostium. The goal of frontal sinus surgery, as with the other paranasal sinuses, is to relieve obstruction and re-establish ventilation and drainage.

CPT code 31276-Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from the frontal sinus describes the work performed as follows: Obstructing frontal recess cells, polyps, or scar tissue and intersinus septae from the dome of the ethmoid and skull base are delicately removed. It may also include removal of osteitic bone between the frontal sinus and a supraorbital ethmoid cell. The skull base is at significant risk for perforation resulting in CSF leak or intracranial bleeding. The following examples satisfy the criteria for reporting this code such that at the completion of a Draf I/IIA-B/III procedure, one can visualize the frontal sinus for exploration and proceed with removal of tissue from the frontal sinus, if performed:

- A Draf I frontal sinusotomy would include removing the posterior wall of the Agger nasi, the superior attachment of the bulla lamella of the ethmoid bulla, and/or Type I and II frontal cells. This removes tissue obstructing the frontal sinus and is not part of the typical ethmoidectomy.
- A Draf IIA frontal sinusotomy would include removal of a Type III frontal cell reaching into the frontal sinus.
- A Draf IIB/III (endoscopic modified Lothrop) frontal sinusotomy not only reaches the ostium but enlarges it with punches, drills, etc.

There are instances when the balloon is used to establish a pathway, through the frontal recess to the frontal sinus followed by tissue removal (mucosa, polyps, scar, tumor and/or bony partitions) with traditional instrumentation such as forceps and/or the microdebrider. In this instance, the balloon is used as an adjunct to traditional instrumentation. When the result is a frontal sinusotomy and tissue has been removed, the appropriate code is 31276 and the dilation is not separately reported.

Similar rationale would apply to surgery involving the maxillary and sphenoid sinuses. If the balloon is used to dilate the sinus ostium and subsequently tissue is removed relative to that sinus, the appropriate maxillary sinus and/or sphenoid sinus codes is/are utilized. For example, if an endoscopic balloon dilation of the maxillary sinus is performed with a 6 mm balloon and the uncinate process is fractured and subsequently removed and/or peri-ostial polypoid mucosa is excised to create a sinuostomy, the appropriate code that describes the work performed is 31256 (Nasal/sinus endoscopy, surgical; with maxillary antrostomy). If 31256 is performed and mucosa is subsequently removed from the interior of the maxillary sinus, 31267-Nasal/sinus endoscopy, surgical; with removal of tissue from the maxillary sinus is utilized.

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Similarly, if the sphenoid sinus ostium is dilated with a balloon under endoscopic visualization and subsequently a portion of the superior turbinate, bone and/or peri-ostial polypoid mucosa is removed from the sphenoid recess to further re-establish ventilation and drainage from the sphenoid sinus, 31287- Nasal/sinus endoscopy, surgical, with sphenoidotomy describes the work performed. Once the sphenoidotomy has been performed and if tissue is removed from the interior of the sphenoid sinus, 31288- Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus is reported.

As 31299 is an unlisted CPT code, it cannot be appended with modifier -50 to show the carrier that the procedure was bilateral; likewise when you dilate more than one sinus ostium, you must still report 31299 only once.

As an example, if you performed two frontal, one maxillary, and two sphenoid sinus dilations, you would only report 31299 once. In order for the carrier to understand what was done surgically, a full and detailed explanation of the surgery needs to be documented in the accompanying letter of explanation appeal that should be sent to the carrier with a copy of the operative report. Both documents (as well as any communications needed to precertify the procedure) should explain in detail for each site what was done with respect to the unlisted procedure, namely balloon dilation 31299 on one or more sinuses, unilateral or bilateral.

A common question is how one bills or anticipates reimbursement when an unlisted code is submitted? Generally it is up to the operating surgeon to request and the local carrier to determine, based on the procedural work, what reimbursement is warranted. The physician should estimate a charge based on a procedure of similar time, work, and intensity, and bill that to the payer. In the case of multi-sinus dilations, this is the sum of each component of 31299, i.e., the full price of each discrete sinus ostium dilated, added together. Reimbursement is generally payer specific and depends on the policies of that specific payer.

When claims are submitted with an unlisted code, there is a significant amount of paperwork and documentation that needs to be submitted with the operative report in order for the payer to understand exactly what was surgically performed. These claims must be submitted via paper and will be subject to medical review. It is always recommended that a letter from the operating surgeon be included with the paper claim submission that includes a detailed explanation as described above. It is expected that much of the potential confusion will be resolved when the new CPT code set for sinus ostial dilation is published in CPT 2011.

If members continue to have problems with respect to coding and reimbursement for these procedures, please contact the American Academy of Otolaryngology- Head and Neck Surgery's Health Policy Department at [healthpolicy@entnet.org](mailto:healthpolicy@entnet.org).

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This statement was developed by a task force that consisted of representatives from the Academy's Physician Payment Policy workgroup (3P), Rhinology and Paranasal Sinus Committee, the American Rhinologic Society (\*), and an expert early adopter of the technology:

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(\*) The participation of a representative from the American Rhinologic Society leadership does not imply formal endorsement of this policy by the Society.