The Dilemma Surrounding Use of CPT 31276

Michael Setzen, MD, Chair of the Patient Advocacy Committee and Sanford M. Archer, MD, Member Patient Advocacy Committee

At our most recent Patient Advocacy Committee Meeting of the American Rhinologic Society in Washington DC, September 16th, 2007, it was brought to the attention of the Committee that there was confusion surrounding the use of CPT 31276.

CPT 31276 describes Nasal/sinus endoscopy, surgical, with frontal sinus exploration with or without removal of tissue from the frontal sinus.

The dilemma revolves around the uncertainty in applying 31276 and what the descriptor mandates is necessary in the surgical treatment for one to be able to use this code appropriately and fairly so that one can be reimbursed without denial.

Merrily entering into the frontal recess by inserting a probe or suction catheter into the frontal sinus does not allow the use of CPT 31276 and it is for this reason that the committee elected to clarify the use of the code more appropriately. It was the opinion of the committee that frontal sinus exploration requires the need to evaluate the nasal frontal recess with an endoscope and enlarge the opening passage into the frontal sinus with whatever modality one chooses be it a curette, a debrider, a balloon, or a curved suction.

Furthermore, one must visualize the interior of the frontal sinus chooses be it a curette, a debrider, a balloon, or a curved suction. There must be good documentation that the patient was, indeed, suffering from frontal sinus disease as documented on history, examination, or sinus CT.

One must continue to use common sense, good ethical judgment, and clear documentation when using this CPT code or any CPT code for that matter to avoid coding audits and potential penalties. The committee will continue to evaluate 31276 and will respond again in the near future.

Should you have any questions with respect to 31276 and should you have been denied reimbursement when this code was applied appropriately, please feel free to contact the ARS Patient Advocacy Committee or the AAO-HNS Health Policy department at healthpolicy@entnet.org.

(Correspondence was reviewed by Dr. Richard Wagenseil, Chair of the AAO-HNS CPT/RVU Committee, and Ms. Linda Ayers, MHCM, Senior Director of Strategic Alliances & Health Policy at the AAO-HNS).

Secretary’s Report

Brent Senior, MD

2007 has proven to be a very successful year for the ARS. The highest attendance level in several years at our Annual Meeting in Washington DC (309) was accompanied by an increase in membership of nearly 10% to over 1100. We have been particularly encouraged by the significant growth occurring in the resident and fellow categories, with a 33% increase in this category alone. While undoubtedly reflecting the high level of interest in the specialty among practitioners in general, these younger members bring new enthusiasm and excitement to the society. We hope to harness some of this in the newly minted Residents and Fellows program. Membership is free for residents, and we hope that after completion of their training they will convert to regular membership.

The requirements for Regular membership have been revised. Candidates for regular membership need to have graduated from an approved Otolaryngology residency program and eligible to sit for the Otolaryngology Board exam. Sponsorship from existing Members or Fellows of the ARS is no longer required. The resident membership requirements are that the applicant be an active resident in good standing in an approved Otolaryngology residency program. Membership is free for residents, and we hope that after completion of their training they will convert to regular membership.

The meeting was kicked off by an esteemed international panel, chaired by Dr. Jan Gospodar, featuring both otolaryngologists and neurosurgeons who discussed methodologies in minimally invasive trans-sphenoidal hypophysectomy. Common themes expressed by the group included detailed knowledge of parasellar anatomy and interactive cooperation between the otolaryngologist and neurosurgeon throughout the procedure. The group also illustrated how endoscopic technique is gradually expanding even beyond the pituitary to areas such as the posterior fossa, mamillothalamic and third ventricle.

In the afternoon, a keynote address was given by Dr. Gerald Healy, the first Otolaryngologist elected as President of the American College of Surgeons. His impassioned presentation, entitled What’s Happening: Are We Ready?, stressed our role as otolaryngologists in the American College of Surgeons. This is particularly timely, as the College has broken ground on a new facility in Washington, DC to support lobbying efforts for malpractice reform and patient advocacy. Dr. Healy also addressed the evolving role of electronic medical records and implications of pay-for-performance.

Overall, we as physicians also have to change our misconceptions on perception that doctors, rather than insurance companies, are responsible for skyrocketing healthcare costs. In addition to the array of traditional poster and oral presentations, the fall meeting also featured a novel medium where video presentations were displayed on laptop terminals situated adjacent to the poster area. These submissions captured a gamut of topics ranging from operative techniques in endoscopic skull base surgery, to bench models of mucociliary clearance as seen by high speed digital video and differential interference contrast microscopy. The format seemed ideal to convey these dynamic processes. Participants were able to listen to a narrative by headphone while viewing the streaming slides and video at the terminal.

The Society then co-sponsored a Unified Airway symposium in conjunction with the American Academy of Otolaryngic Allergy. The forum was held two days after the scientific program and featured a series of panels addressing airway physiology, the association between upper and lower airway disease, and strategies in systemic, medical, and allergy therapy. This forum underscored that chronic inflammatory disease of the airways has multifactorial etiologies that must be elucidated and treated in any individual patient.

The following awards were issued:

- Resident Research Awards - CORE
- In Vivo Laser Tissue Welding in the Rabbit Parasellar Sinus
- Benjamin S. Bleier, MD, University of Pennsylvania Medical Center
- Virtual Surgical Rehearsal for Pre-op Planning in Frontal Recess Sinus Surgery
- Sachin Parikh, MD, Stanford University School of Medicine
- New Investigators Award - CORE
- Regulatory T Cells in Chronic Rhinosinusitis
- Jayant Pinto, MD, The University of Chicago
- Congratulations to Drs. Bleier, Parikh, and Pinto for their exemplary efforts

Another stimulating program is anticipated for the Spring.

Credentialed Committee

John Delgadillo, MD

I would like first to take this opportunity to express my gratitude in being appointed to serve the American Rhinologic Society as Chair of the Credentialed Committee for the next three years. Looking forward, our goal is to make membership in the ARS as easy as possible so that we can increase our membership at every level.

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Fellow status is the highest category of membership in the ARS and requires that the member be practicing for at least three years and have performed 50 rhinologic cases over the preceding two years. Letters of recommendation from two Fellows of the ARS are required. International membership status is also available in the ARS. International membership has the same requirements as regular membership. International members are also eligible for Fellow status under the same guidelines as mentioned above.

The membership requirements for each category, along with membership dues, can be found on the ARS website.