

	Reimbursement Policy Manual		Policy #:	RPM009
Policy Title:	Postoperative Sinus Endoscopy and/or Debridement Procedures			
Section:	Surgery	Subsection:	None	
Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:				
Companies:	<input checked="" type="checkbox"/> All Companies: Moda Partners, Inc. and its subsidiaries & affiliates <input type="checkbox"/> Moda Health Plan <input type="checkbox"/> Moda Assurance Company <input type="checkbox"/> Summit Health Plan <input type="checkbox"/> Eastern Oregon Coordinated Care Organization (EOCCO) <input type="checkbox"/> OHSU Health IDS			
Types of Business:	<input checked="" type="checkbox"/> All Types <input type="checkbox"/> Commercial Group <input type="checkbox"/> Commercial Individual <input type="checkbox"/> Commercial Marketplace/Exchange <input type="checkbox"/> Commercial Self-funded <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Short Term <input type="checkbox"/> Other: _____			
States:	<input checked="" type="checkbox"/> All States <input type="checkbox"/> Alaska <input type="checkbox"/> Idaho <input type="checkbox"/> Oregon <input type="checkbox"/> Texas <input type="checkbox"/> Washington			
Claim forms:	<input checked="" type="checkbox"/> CMS1500 <input type="checkbox"/> CMS1450/UB (or the electronic equivalent or successor forms)			
Date:	<input checked="" type="checkbox"/> All dates <input type="checkbox"/> Specific date(s): _____ <input type="checkbox"/> Date of Service; For Facilities: <input type="checkbox"/> n/a <input type="checkbox"/> Facility admission <input type="checkbox"/> Facility discharge <input type="checkbox"/> Date of processing			
Provider Contract Status:	<input checked="" type="checkbox"/> Contracted directly, any/all networks <input checked="" type="checkbox"/> Contracted with a secondary network <input checked="" type="checkbox"/> Out of Network			
Originally Effective:	10/1/2009	Initially Published:	7/6/2011	
Last Updated:	7/10/2024	Last Reviewed:	7/10/2024	
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No				
Last Update Effective Date for Texas:		7/10/2024		

Reimbursement Guidelines

A. Summary Policy Statement:

Postoperative sinus endoscopies (31231) and postoperative sinus debridements (31237, S2342) are eligible for separate reimbursement in a limited set of circumstances:

1. For dates of service 1/1/2020 and following:
 - a. When Medical Necessity Criteria requirements are met ((see “Post-operative Sinus Endoscopy and/or Debridement Procedures,” Moda Health Medical Necessity Criteria) and,
 - b. One of the following applies:
 - i. When all the procedure codes performed at the original surgical session have zero follow-up global days.
 - ii. When any one of the original surgical procedures carry a global period of 10- or 90-days, and the postoperative sinus endoscopy/debridement is not submitted with modifier 79 (unrelated) appended.

2. For dates of service 12/31/2019 and prior:
 - a. When all the procedure codes performed at the original surgical session have zero follow-up global days.
 - b. When any one of the original surgical procedures carry a global period of 10- or 90-days, and the postoperative sinus endoscopy/debridement is submitted as a staged or a related procedure.

B. Global Surgery Package

1. Postoperative sinus endoscopies (31231) and postoperative sinus debridements (31237, S2342) are always considered to be related to all the nasal and sinus procedure codes performed at the original surgical session.
2. The longest global period for any procedure code from the original date of surgery applies to the entire surgical session and all subsequent services until the global period is complete.
3. Services may not be “unrelated” to the procedure code creating the postoperative global period and also “related” to another procedure code performed by the same physician during that same original surgical session.
4. Correct modifier coding is necessary. Either the failure to use a needed modifier when appropriate or the incorrect use of a modifier when not appropriate may result in denial of the subsequent surgery.

C. Reporting Postoperative Sinus Endoscopies and/or Debridements

1. When all the procedure codes performed at the original surgical session have zero follow-up global days, then postoperative sinus endoscopies and/or debridements should be reported without appending modifiers 58, 78, or 79.
2. When any one of the original nasal or sinus surgical procedures carry a global period, postoperative sinus endoscopies and/or debridements are always considered related to the original nasal/sinus surgical procedures.
 - a. Postoperative sinus endoscopies (31231) and/or debridements (31237, S2342) may be submitted as a staged procedure (modifier 58 attached).
 - i. The staged relationship needs to be supported in the medical record with documentation of the anticipated need for probable endoscopy and/or debridement procedures.
 - ii. If modifier 58 is not appended to the office surgery code, then the endoscopy/debridement procedure code will be denied as included in the surgical global payment for the original nasal or sinus surgical procedure(s), per RPM011, section I.2.
 - b. Postoperative sinus endoscopies (31231) and/or debridements (31237, S2342) which require a return to the operating room may be submitted as a related procedure with modifier 78 attached.
 - i. Modifier 78 may not be submitted with POS 11.

- ii. Postoperative sinus endoscopies (31231) and/or debridements (31237, S2342) performed in the office (POS 11) or otherwise not requiring a return to the operating room need to be documented and submitted as staged procedures.
- c. Modifier 79 is not valid when attached to CPT codes 31231, 31237, S2342 for any sinus endoscopy and/or debridement performed within that global period. The use of modifier 79 in this circumstance to characterize 31231, 31237, or S2342 as “unrelated” to the procedure code with the global period is inaccurate, and an inappropriate use of modifier 79. The sinus endoscopy or debridement is related to the surgical session with the global period, regardless of which procedure code the surgeon deems the endoscopy/debridement to be related. (Moda Health^A) Postoperative sinus endoscopies and/or debridements are not eligible for separate reimbursement when modifier 79 is used. (AAO-HNS¹¹)

31231-79, 31237-79, or S2342-79 will be denied to provider responsibility as an invalid procedure code-modifier combination. Provider appeals will only be approved if the written documentation submitted for review shows that the original surgery creating the global period was performed on a body part other than the nasal or sinus structures.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
AMA	American Medical Association
CCI	Correct Coding Initiative (see “NCCI”)
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
FESS	Functional Endoscopic Sinus Surgery
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka “CCI”)
POS	Place of Service
RPM	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
UB	Uniform Bill

Definition of Terms

Term	Definition
Functional Endoscopic Sinus Surgery	A generic term for a group of endoscopic procedures used to manage severe or treatment-refractory sinus problems, including sinusitis and nasal polyps, recalcitrant infections, and other complaints. (TFD ¹²)

Procedure codes (CPT & HCPCS):

Code	Code Description
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
S2342	Nasal endoscopy for postoperative debridement following functional endoscopic sinus surgery, nasal and/or sinus cavity(s), unilateral or bilateral

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier 58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating/procedure room (eg. unanticipated clinical condition), see modifier 78.
Modifier 78	Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of the operating/procedure room, it may be reported by adding the modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76).
Modifier 79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79. (For repeat procedures on the same day, see modifier 76).

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

“B. Prepayment Edits to Detect Separate Billing of Services Included in the Global Package

In addition to the correct coding edits, A/B MACs (B) must be capable of detecting certain other services included in the payment for a major or minor surgery or for an endoscopy. On a prepayment basis, A/B MACs (B) identify the services that meet the following conditions:

...

- Services that were furnished within the prescribed global period of the surgical procedure;
- Services that are billed without modifier “-78,” “-79,” “-24,” “25,” or “-57” or are billed with modifier “-24” but without the required documentation; and
- Services that are billed with the same provider or group number as the surgical procedure or endoscopy. Also, edit for any visits billed separately during the postoperative period without modifier “-24” by a physician who billed for the postoperative care only with modifier “-55.”

(CMS²)

“5. Return Trips to the Operating Room During the Postoperative Period

When treatment for complications requires a return trip to the operating room, physicians must bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unspecified procedure code in the correct series, i.e., 47999 or 64999. The procedure code for the original surgery is not used except when the identical procedure is repeated.

In addition to the CPT code, physicians use CPT modifier “-78” for these return trips (return to the operating room for a related procedure during a postoperative period.) The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first procedure and requires the use of the operating room, this circumstance may be reported by adding the modifier “-78” to the related procedure.

NOTE: The CPT definition for this modifier does not limit its use to treatment for complications.

6. Staged or Related Procedures

Modifier “-58” was established to facilitate billing of staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.

The physician may need to indicate that the performance of a procedure or service during the postoperative period was:

- a. Planned prospectively or at the time of the original procedure;
- b. More extensive than the original procedure; or
- c. For therapy following a diagnostic surgical procedure.

These circumstances may be reported by adding modifier “-58” to the staged procedure. A new postoperative period begins when the next procedure in the series is billed.” (CMS²)

Cross References

- A. [“Modifiers 58, 78, and 79 – Staged, Related, and Unrelated Procedures,”](#) Moda Health Reimbursement Policy number RPM 010.
- B. [“Global Surgery Package for Professional Claims,”](#) Moda Health Reimbursement Policy number RPM 011.

- C. [“Post-operative Sinus Endoscopy and/or Debridement Procedures,”](#) Moda Health Medical Necessity Criteria.

References & Resources

1. AMA. “Coding Clarification: Modifiers 58 and 78”, *CPT Assistant*, February 2008, page 3.
2. CMS Manual System, Medicare Claims Processing Manual (Pub. 100-4), Chapter 12, § 40.2 – 40.4.
3. CMS National Correct Coding Initiative Policy Manual, Chapter 1 General Correct Coding Policies, § C.
4. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. American Medical Association, 2004.
5. “Modifiers Used with Surgical Procedures”, *CPT Assistant*, Fall 1992, page 15.
6. “Coding Commentary: Modifiers -21, -25, -57, -58”, *CPT Assistant*, Winter 1993, page 26.
7. “Modifiers, Modifiers, Modifiers: A Comprehensive Review”, *CPT Assistant*, May 1997, page 1, 4.
8. “Coding Communication: More on Modifiers”, *CPT Assistant*, September 1997, page 4.
9. “Coding Commentary: Global Surgical Package”, *CPT Assistant*, Fall 1992, page 10.
10. “Coding Communication: Global Surgical Package”, *CPT Assistant*, August 1998, page 5.
11. **Note:** Both of the following specialty society documents have been considered by Moda Health in the development of this policy.
 - a. “Policy Statement on Debridement of the Sinus Cavity after FESS.” The American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS).
 - b. “Compare & Contrast Modifier 24 & Modifier 79,” AAO-HNS Coding Solutions 2009.
12. TFD. “Functional Endoscopic Sinus Surgery.” Thefreedictionary.com. Last accessed June 16, 2022. <https://medical-dictionary.thefreedictionary.com/functional+endoscopic+sinus+surgery> .

Background Information

Debridement of the sinus cavity is a procedure frequently performed following functional endoscopic sinus surgery (FESS). It involves insertion of the endoscope into the nose for a thorough inspection. Scalpels, forceps, snares, and other instruments are used to remove postsurgical crusting, diseased mucosa, or other contaminated tissue. It is performed under local or general anesthesia in a suitably equipped office setting or an operating room, depending upon the clinical circumstances of the case.

Many of the endoscopic sinus surgery procedure codes have a global period of zero follow-up days. When these are the only procedure codes performed on the date of the original surgical session, all postoperative follow-up care is separately billable.

However, a number of other closely related nasal and/or sinus procedure codes have global periods of 10 or 90 follow-up days. These procedure codes are frequently performed at the same surgical session as the FESS procedures because the conditions they address are commonly contributing or exacerbating factors to the sinus condition(s) requiring treatment with sinus surgery (FESS).

Coding and reimbursement of the postoperative sinus debridement procedures becomes significantly more complex anytime the original surgical session combines one or more procedure codes having a 10-

or 90-day global period with the FESS procedures having zero follow-up global days. There are a variety of opinions about how best to report the postoperative debridement (31237) in this situation.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member’s medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member’s medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member’s medical benefit plan, the member’s medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider’s agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
7/10/2024	Formatting/Update: No content changes.
8/9/2023	Formatting/Update: No content changes.
7/13/2022	Updated Acronyms, Definition of Terms, Coding Guidelines & Sources, and References & Resources. Formatting/Update: No content changes.
7/6/2011	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
10/1/2009	Original Effective Date (with or without formal documentation). Policy based on CMS & NCCI global surgery package policy (CMS ^{2, 3}), definition of staged, related, & unrelated procedures, Medical Director decision, & Moda Health Medical Necessity Criteria(Moda ^C).