Nose News UPDATE

American Rhinologic Society - Volume 21:3 Summer 2002

Paul H. Toffel, M.D.
President

The State of Rhinology

I'm soon concluding my term as President of the American Rhinologic Society, and I would like to thank the fine colleagues of our specialty for allowing me the honor to lead this wonderful and dynamic professional organization. As I turn the gavel over to President-Elect, Dr. Don Lanza, I'm thrilled by the marvelous momentum that is building to make our society one of the pre-eminent organizations in Otolaryngology. The tripartite mission of excellent educational programs, outstanding academic research, and targeted socioeconomic response, continues to be carried out, and will improve further with the leaders arising from our Board, consultants, and committees.

Dr. Lanza has proven his capability by organizing the great educational programs at the spring meeting in Boca Raton, and plans for the fall meeting in San Diego. He is an example of the terrific, quality leaders bred by the new American rhinology. Following Dr. Lanza, First Vice President, Dr. Jim Hadley, has already distinguished himself with terrific by-law expertise for our Society and is engaged in consultation with legal counsel to transition our Society to the 501C corporate entity to allow us to continue socioeconomic projects, as well as to continue our educational and research goals under a foundation format. Second Vice President, Dr. Joe Jacobs, has continued to do outstanding work on socioeconomic challenges and will also be an exceptional leader. Our ARS Secretary, Dr. Marvin Fried, and his assistant, Wendi Perez, have been terrific in their taxing and difficult roles, which have kept our organization's productivity high and overhead low. And Dr. David Kennedy has exercised wonderful leadership in his positions of ARS Treasurer, and Editor of the American Journal of Rhinology.

My thanks to all the members of your wonderful Board, and consultants and committees for being so committed to the improvement of our profession and Society. It's been a joy to be associated with such quality men and women. In conclusion, I would like to give a special thanks to my own administrative assistant, Susan Arias, for all the thankless hours of hard work to help me be your President.

> "The state of rhinology in America is very good, indeed"

The momentum of this organization is now irresistible, and I've been honored to be able to help guide it with all these wonderful friends over the past 10 years.

The state of rhinology in America is very good, indeed.

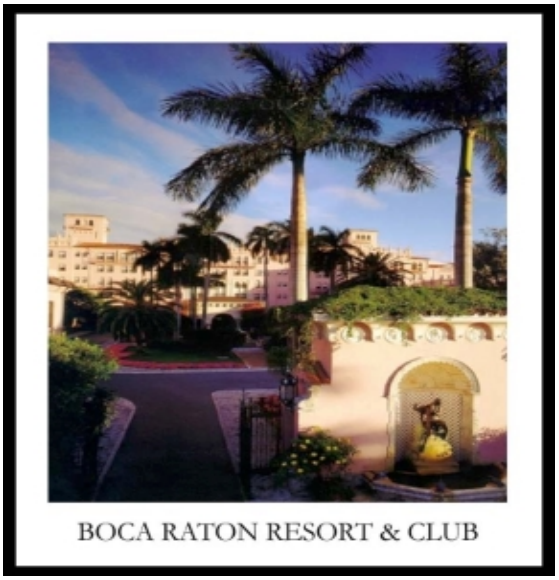

Photo courtesy of Boca Raton Resort & Club

Boca Raton - Site of the May, 2002 ARS Meeting

Come to ARS Spring Meeting in Boca!

May 10-11, 2002

Our meeting will be held at the Boca Raton Resort & Club May 10th-11, 2002. Meeting registration will begin on Friday, May 10th at 12:15 pm and the scientific session kicks off at 1 pm with a panel entitled "Current Management of Epistaxis: Isn't There a Better Way?" At the conclusion of the meeting on Friday 5:00-5:30 pm there will be an ARS business meeting that is open to our membership. It will highlight a discussion of important socioeconomic issues affecting practicing rhinologists. Our Saturday scientific session begins at 8 am and is held in conjunction with the American Academy of Otolaryngic Allergy. During this session we have two more exciting panels, "Controversies in Allergic/ Non-Allergic Inflammation and Rhinosinusitis", and "Controversies in Pediatric Rhinosinusitis".

With regard to the free papers sessions, we received many more abstracts than we could accept, including several from abroad. The quality of the free papers is outstanding, clinically relevant, and spans the breadth of rhinology. Also, we will have a poster session this Spring as well as in the Fall. Authors of all free papers are required to submit their abstracts two weeks in advance of the meeting so that assigned reviewers have ample time to generate appropriate discussion on the scientific information presented. The goal of this change is to greatly enhance the scientific quality of the meeting.

We look forward to seeing you in Boca Raton!

WHAT'S AHEAD?

March 15, 2002	Abstract Deadline for ARS Fall Meeting
May 10-12, 2002	ARS Spring Meeting, Boca Raton, FL
June 15-21, 2002	ERS/ISIAN, Ulm, Germany
July 22, 2002	ARS Cottle Award Deadline (Presented at Fall Meeting)
September 20-21, 2002	ARS Fall Meeting, San Diego, California
November 1, 2002	Abstract Deadline for ARS Spring Meeting
December 16, 2002	Letter of Intent for CORE Research Award

And, Don't Forget....

ARS Annual Meeting September 20-21, 2002 San Diego

Photo Courtesy San Diego Convention and Visitors Bureau

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Case of the Quarter

Peter H. Hwang, MD
Oregon Health Sciences University

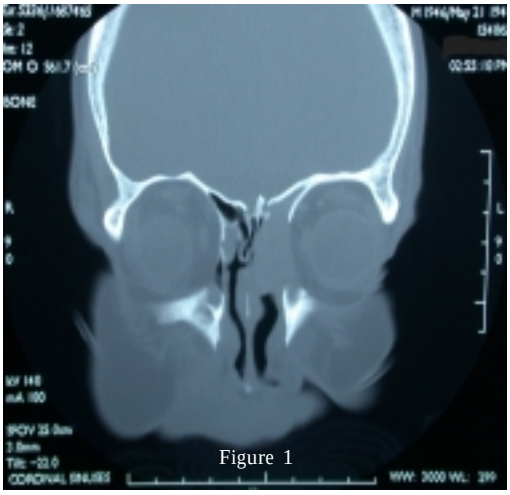
Figure 1

RK is a 55 year-old man with cystic fibrosis, advanced bronchiectasis, and chronic sinusitis. He underwent endoscopic sinus surgery over ten years ago. Most recently, he presented to his pulmonologist with chief complaints of progressive severe left-sided headache, nasal obstruction, and post-nasal drip exacerbating his respiratory failure. A CT scan revealed two large expansile cystic masses in the left frontal and maxillary sinuses; there was also secondary erosion of the medial orbital wall (Figures 1 & 2). On referral to the rhinology service, endoscopic examination confirmed the presence of purulent discharge and a protruding mass of polypoid tissue filling the middle meatus.
The patient's pulmonary status was significantly impaired due to his cystic fibrosis and bronchiectasis, and he required supplemental oxygen by nasal cannula.

Because of his fragile respiratory status, the patient was not a candidate for surgery under general anesthesia. Similarly, he was deemed by his pulmonologist to be unsuitable for any procedure involving intravenous sedation. Given these constraints, the patient ultimately underwent a procedure under local anesthesia without sedation in the clinic setting. Anesthesia was achieved using topical 4% lidocaine, topical 4% cocaine, and submucosal 1% lidocaine with 1:100,000 epinephrine. The patient was positioned sitting upright to minimize aspiration risk and he was not sedated. A 40-degree curved microdebrider was used to clear polyps from the ethmoid, and to marsupialize and drain large mucopyoceles in the frontal and maxillary sinuses. Blood loss was less than 10cc. The patient tolerated the procedure very well, with minimal discomfort and without any compromise of his pulmonary status. He experienced immediate relief of symptoms. His sinuses remain patent and clear at 3 months post-procedure.

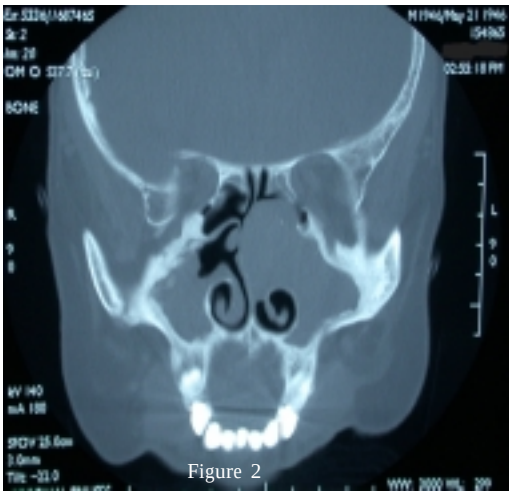
Figure 2

Discussion

Just as local anesthesia can be an attractive and viable option for certain patients undergoing sinus surgery in the operating room, office procedures performed under local anesthesia can be a valuable adjunct to the practice of the rhinologic surgeon. Armed with a basic set of instruments (backbiter, through-cutting Blakesley forceps, frontal curets) and a microdebrider, the rhinologic surgeon can perform a variety of procedures in the office: maxillary sinus revision (removal of retained uncinate, correction of recirculation); polypectomy; turbinate reduction; and selective ethmoid, sphenoid, or frontal revisions. As for any procedure, careful patient selection is of utmost importance. Typically, the best candidates are motivated patients needing minor revision surgical procedures. Anesthesia should be provided meticulously, using topical lidocaine and/or cocaine, augmented by lidocaine injections to the lateral nasal wall and/or greater palatine foramen as needed. Placement of a nasopharyngeal sponge may minimize the risk of aspiration of blood in more extensive cases (Kennedy Intranasal Surgical Sponge, Medtronic-Xomed, Jacksonville, FL). The surgeon should have CT images readily available for reference just as one would in the operating room.

The above patient represents a more complex and higher risk case that should be undertaken only after extensive experience has been gained in office rhinologic procedures. However, for more straightforward cases, office procedures under local anesthesia can provide an effective treatment alternative to the operating room, offering a minimum of morbidity and a high degree of patient satisfaction.

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Socioeconomic Focus

Joe Jacobs, Chairman, Socioeconomic Committee

Members: Steve Marks, Brent Senior, Winston Vaughn, Dan Becker

Socioeconomic issues unfortunately continue to require a significant amount of expenditure of both time and money within the American Rhinologic Society and the Socioeconomic Committee. This issue of the Newsletter contains material which all otolaryngologists need to take notice of since it appears the forces which are presently constraining our practice patterns and diminishing reimbursement are gathering for a second wave of assaults.

The specialty societies within the academy are beginning to carry the burden of reviewing and documenting the practice expense components relating to medicare reimbursement. Dr. Mike Sillers of the ARS Board has provided an in depth view of this process. Many of us will need to become actively involved in this task to avoid a major change in reimbursement relating to rhinologic codes.

The information provided in the following two articles relates to ongoing issues concerning the utilization of CPT 31237. As you probably know, the ARS has aggressively defended this code and has retained a legal team at Hogan and Hartson in Washington, D. C. to actively pursue carrier denials. There exists significant documentation within the ARS website, american-rhinologic.org, that can be utilized on a local level to contest third party payor disputes. The Board of Governors' involvement is provided by Richard W. Waguespack who is actively involved in the Academy CPT process. Both Dr. Waguespack and Dr. Schreibstein fully discuss the introduction of S codes which appear to represent another means of ultimately reducing reimbursement through manipulation of the system by the third parties and their representatives. The ARS will be actively investigating this additional and complex issue and will without question aggressively defend our position.

Please feel free to contact me at joseph.jacobs@med.nyu.edu or 212-263-7398.

Practice Expense Update of RBRVS

Michael Sillers, MD

University of Alabama

The American Rhinologic Society has become actively involved in the practice expense update process in cooperation with the American Academy of Otolaryngology-Head and Neck Surgery. CMS (formerly HCFA) has mandated that the practice expense component of Medicare reimbursement must be reviewed and formally documented for each CPT code. Each specialty society within the Academy has been charged with the task of reviewing and updating existing CPT codes relevant to their society. Each of the nearly 7,500 CPT codes has 3 components based on the resource-based relative value scale (RBRVS) implemented by Medicare in 1992. The *physician work component* comprises an average of 55 % of the total value while the *practice expense component* comprises an average of 42 %. The balance is made up of the *malpractice component*.

The current focus is to review and update the existing data by which the practice expense component of each of the CPT codes is valued. In 1999, HCFA (now CMS) began to transition from an earlier method of calculation to one using resource-based practice expenses. This transition will be completed within this calendar year. Our task, along with the other specialty societies, has been to dissect the expenses associated with each of the procedures we perform. Components that are evaluated include clinical time (non-MD), supplies, and equipment. These components differ depending on the site of service-physician's office, outpatient surgery center, or hospital.

This process becomes quite labor intensive when you begin to consider each of these components. How much time does it take a nurse to organize a patient's chart, obtain x-rays, make follow-up phone calls? How many tongue depressors, 4 x 4's, suture removal kits do you use for any given procedure? What capital equipment does the average otolaryngologist utilize for each CPT code? Each of these responses must fall within certain established guidelines.

Finally, there needs to be consistency among similar codes (code families) and between different codes. To that end the Academy has sponsored 2 workshops with members of each of the specialty societies working together to accomplish this monumental task. The American Rhinologic Society has established a new committee to address the CPT process. It is vital for our membership as well as that of the entire Academy to be willing to become involved. If we do not examine and fairly value our services, the will certainly become undervalued with subsequent decrease in reimbursement.

Battling the S-Code

Jerry Schreibstein, MD

President-elect

Massachusetts Society of Otolaryngology

Ever heard of an "S code"? Well I had not until our state Blue Cross Blue Shield carrier (BCBSMA) notified us that they were implementing S2343 to identify post-operative debridement following endoscopic sinus surgery. I asked myself, "Don't we already have a code to cover that service (31237)?" That's when I got a crash course in how the CPT system works.

It began in November 2000, when the Massachusetts Society of Otolaryngology (MSO) attempted to get BCBSMA to reimburse our members for post-operative debridement (31237) following FESS combined with septoplasty. We were having no problems with reimbursement of 31237 in the post-operative period of 0-day global surgeries. However, BCBSMA refuses to pay for 31237 when FESS and septoplasty (90-day global procedure) performed on the same day. After several months discussion, we were unable to convince them to cover this procedure despite using the arguments of unrelated sites of surgery, -79 modifiers, etc. We were still working on that problem, when they informed us they would be seeking a new CPT code for post-operative debridement. Thinking that BCBSMA through their national CPT representative would go through the usual channels (AMA CPT, ARS and AAO-HNS) we didn't think much of their effort.

In August 2001, just prior to the ARS and Academy meetings, we were notified that there was a new S code to delineate post-operative debridement following FESS. I immediately contacted George Roman from the Practice Management Department at the AAO-HNS, and was put in touch with Richard Waguespack, Chair of the Carrier Relations Committee of the Board of Governors. I also contacted Joe Jacobs, the Socioeconomic Chair of the ARS. It was through the efforts of Mr. Roman that I discovered there are really 3 levels of CPT codes. Level I codes are those codes we are most familiar with to describe the E/M services and the procedures we perform. Level II and III codes fall under the Health Care Financing Administration's Common Procedure Coding System (HCPCS). Level II codes typically identify products, supplies and services not included in the existing CPT codes. Level III S codes were local codes used by the insurance industry to identify procedures not included in level I. These codes, unlike level I codes, are developed by CMS (Formerly HCFA) and the insurance industry *without organized medicines involvement*.

In a letter to Thomas Scully, Administrator CMS, Dr Richard Holt, EVP of the AAO-HNS, pointed out that the adoption of level III S codes (local codes) as level II codes undermines the current CPT system and violates the intent of the Health Insurance Portability and Accountability Act (HIPPA). Unfortunately, HIPPA is not yet in effect. The inclusion of S codes also undermines the larger RBRVS system that established work values for CPT code 31237. No work values are assigned to S 2342, as this code was developed outside the RBRVS system. To my knowledge no formal action has been taken by CMS on this issue.

"...adoption of level III S codes (local codes) as level II codes undermines the current CPT system and violates the intent of the Health Insurance Portability and Accountability Act (HIPPA)."

After Dr. Holt's letter, it became apparent that BCBSMA would implement this code in October 2001, regardless of our objection. The MSO was successful in delaying the implementation of this code until January 2002 and met with representatives of BCBSMA in early December 2001 to discuss these issues. Peter Friedensohn (MSO President) and myself, along with representatives of the Massachusetts Medical Society met with BCBSMA. They claimed not to be trying to replace 31237, but rather identify a lesser degree of service that they felt many providers were actually performing. Poor documentation of the services rendered by providers clearly opened the door for their arguments. We took this at face value and tried to negotiate the best compromise we could. It was clear they were not going to eliminate the idea of implementing S2343.

The following is the compromise reached and published in the BCBSMA January/February 2002 ProviderFocus:

HCPCS code S 2343: "Nasal endoscopy for post-operative debridement following functional sinus surgery, *unilateral or bilateral.*"

This code would be used to report "The limited removal of secretions, crusts, or debris from the middle meatus or middle turbinate using suction, irrigation, or straight forceps, requiring topical anesthesia (i.e., debridement after functional endoscopic sinus surgery (FESS))"

CPT 31237: "Nasal sinus endoscopy, surgical with biopsy, polypectomy or debridement (separate procedure)"

To report "The removal of crusts, debris or devitalized tissue from the ethmoid, maxillary, and frontal sinus cavities requiring topical or general anesthesia and instrumentation (i.e., debridement of the posterior ethmoid cavity, frontal recess or maxillary sinus)."

I suspect this will be attempted in other states and likely serve as a precursor to a new CPT code requested by the national BCBS Association.

The representatives from BCBSMA clarified that:

1) S2342 would be for limited debridement unilateral or bilateral.
2) CPT 31237 would remain unilateral (billable bilaterally when appropriate).
3) If CPT 31237 performed unilaterally and S2342 performed on second side both can be billed accordingly. (There would be the appropriate multiple procedure discount for the secondary procedure S2342).

31237 Revisited

Becky Gaughan, MD

Chair-elect

Board of Governors, AAO-HNS

Richard Waguespack, MD

Chair, Carrier Relations Committee

Board of Governors, AAO-HNS

Editor's Note: A recent article surveying the practice habits of several ARS members with regard to post-operative debridement and examination following FESS (ARS Newsletter Summer, 2001) prompted several comments from throughout the ARS membership. The article was a simple survey of several individuals and was not intended to provide "practice parameters" in this area.

ARS members Becky Gaughan and Richard Waguesback now weigh in with their thoughts on this critical issue.

The following article is in response to discussion generated from Dr. Brent Senior's informative article in last summer's edition of the *ARS Newsletter* entitled Packing and Post-operative Care Following Endoscopic Sinus Surgery: Who's Doing What? As Chair-Elect of the Board of Governors (BOG) I have heard reports of misinterpretation of this article.

I asked Dr. Richard Waguespack, Chair of the Carrier Relations Committee for the BOG and the Academy's Advisor to the CPT Editorial Panel, to co-author this article with me. Hopefully, with your input, improvements in the number of denials or limitations on the payment of code 31237 in the office or clinic setting will be made.

Dr. Senior published the responses to two questions of members of the Board of Directors of the ARS. The question "What is your usual schedule of post-operative care?" was answered differently by eight experts. Their responses varied from 4-7 post-operative visits with some including debridement and others not.

Caution, however, must be taken in interpreting the data collected. This was simply a survey asking experts in the field how they usually care for the routine post-operative sinus patient.

The experts did not answer the following questions:

- Are there a set number of post-operative debridements recommended for any patient?
- Are there special types of sinusitis patients that require multiple debridements?

The 2001 socioeconomic survey performed by the AAO-HNS Practice Management Department showed that nearly 40% of respondents never billed for post-endoscopic sinus surgery debridement [CPT 31237]; this result was not stratified into those that 1] did not perform the debridement or 2] did not routinely get paid, thus being "conditioned" not to submit claims. Of those who did file, only 15% always received third-party payment but over 40% were never reimbursed for the service.

One of the more recent developments has been creation of S2342, a Level II HCPCS code not recognized by Medicare, to describe bilateral, office-based, local or topical postop sinus debridement. This use of an S-code to reimburse [supplanting 31237] is of real concern to the AAO-HNS and has been brought to the AMA CPT Editorial Panel's attention.

One logical extension of the debate is whether otolaryngologists and their patients would be better served with an *additional* CPT code to specifically describe only office/clinic, local/topical postop debridement. The BOG would like your opinion on the following questions:

1. Do you typically perform 31237 for post-endoscopic sinus surgery debridement *but do not submit a claim* because your commercial carrier routinely disallows payment or bundles the service into the surgical global?

2. Do your commercial carriers reimburse based on Medicare RVUs? [Please comment on carrier or percentile breakdowns in your locale.]

3. Do any of your commercial carriers utilize S2342?

4. On balance, would you benefit from a new CPT code to describe only office/clinic, local/topical postop debridement? [Please comment.]

Please voice your opinion by sending your response to Emily Pogash epogash@entnet.org or via fax 703 299 1125 in the AAO-HNS Practice Management Department. Please indicate where you practice and who you represent.

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Upcoming Rhinology Meetings

April 12-13, 2002	Carolina Course in Sinus Surgery and Facial Plastics	
	University of North Carolina, Chapel Hill, NC	Fax: 919-966-7941
April 19-21, 2002	New York Rhinology and Sleep Disordered Breathing Update	
	New York University, New York, NY	www.med.nyu.edu/cme/
June 21-23, 2002	Image-Guided Sinus Surgery for the Otolaryngologist	
	University of Illinois at Chicago, Chicago, IL	www.uic.edu/depts/ci/IGS2002

If you would like to have your upcoming rhinology meeting noted here, simply provide the editor with pertinent information: newsletter@american-rhnologic.org

The American Rhinologic Society does not endorse these meetings but simply provides this list as a service to its members

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