Coding and Reimbursement for Endoscopic Endonasal Surgery of the Skull Base - Appendices

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Frequently Asked Coding Questions/Answers about Endoscopic Endonasal Surgery of the Skull Base

1. What Codes Should I Use for Endoscopic Skull Base Procedures?

Currently, only one CPT code exists which describes an endoscopic endonasal approach to a skull base tumor; it is 62165 [*Neuroendoscopy, intracranial; with excision of a pituitary tumor, transnasal or trans-sphenoidal approach*]. CPT 62165 is a stand-alone code which means it includes the approach, tumor resection and closure of the operative field. When two surgeons participate in the case together, such as the otolaryngologist performing the approach while the neurosurgeon resects the tumor, each surgeon bills 62165 appended with modifier 62 [*Two Surgeons*] to reflect the co-surgeon role. Modifier 62 is necessary because neither surgeon performed the entire procedure him/herself.

The endoscopic endonasal pituitary tumor resection code, 62165, was implemented in 2003 to provide an appropriate method for reporting pituitary tumor removal when performed endoscopically. Up until 2003, the only code available was for a pituitary tumor removal via the traditional transnasal or transseptal approach which is reported using 61548 [*Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic*]. This new code (62165) follows CPT's precedent of developing separate codes for endoscopic versus open approaches for performing the same procedure. For example, there are separate codes for open sinus surgery procedures versus endoscopic sinus surgery procedures.

Currently, there are no other CPT codes to report a skull base procedure when performed endoscopically through an endonasal approach. Therefore, an unlisted procedure code must be reported.

The issue becomes which unlisted code should be reported to represent an endoscopic endonasal skull base procedure. Because the skull base surgery codes are in the Nervous System section of the CPT manual, it makes sense to use that system's unlisted procedure code 64999 [*Unlisted procedure, nervous*

system]. However, in reality, practices have found it difficult to obtain reimbursement when both the ENT and NS report the same exact unlisted code.

CPT says that modifiers should not be appended to an unlisted code. So, unlike 62165 where the ENT and NS can report the same code with modifier 62 to denote co-surgery, the two surgeons would report the same unlisted code without the co-surgery or assistant surgeon modifier. But, again, practices have found reimbursement to be difficult in this scenario as payers do not seem to understand why two surgeons of different specialties are using the same unlisted code for the same procedure on the same patient.

Therefore, we have seen better reimbursement success when the ENT and NS each report different unlisted codes. For example, the ENT reports 31299 [*Unlisted procedure, accessory sinuses*] while the NS reports 64999 [*Unlisted procedure, nervous system*]. Each surgeon compares their own unlisted code to the usual open skull base code(s) to determine the value/fee for the procedure.

2. Why Can't I Use 61580–61619 for Endoscopic Endonasal Procedures?

The existing open (involving skin incisions) skull base surgery CPT codes were implemented in 1994, which was prior to skull base surgery being performed via an endoscopic endonasal approach (without skin incisions). The existing skull base codes are valued for an open procedure involving major skin incisions and soft tissue dissection. Endoscopic endonasal techniques were not in use prior to 1994 when the open skull base codes were introduced into CPT.

To illustrate the point about skin incisions being required, the Winter 1993 issue of the CPT Assistant states the following about the anterior cranial fossa approach code (61580) that is frequently misused to report an endoscopic procedure:

"In the surgery described in this code, the nose is cut, (rhinotomy) part of the ethmoid bone is removed (ethmoidectomy), and part of the sphenoid bone is removed (sphenoidectomy) to gain access to the tumor."

In an endoscopic endonasal procedure, a rhinotomy for access to the skull base is not performed. The definitive procedure codes presume an open approach as this was the standard in 1994 when the codes were written. Therefore, it is not appropriate to report an existing skull base code for an endoscopic endonasal procedure.

Additionally, CPT guidelines state if a procedure or service code does not exist for the procedure performed, then the appropriate unlisted procedure code should be reported. CPT guidelines also instruct physicians not to select a CPT code that merely approximates the service provided when there is not a code for the procedure performed.

Therefore, it is not accurate to report an open skull base procedure code (61580–61616) for a procedure performed via an endoscopic endonasal approach.

3. When Can I Use the Existing Skull Base Procedure Codes?

Use these codes when the procedure is performed in an open manner where skin incisions are made for the approach and lesion excision.

4. When is it Appropriate to Use the Dura Reconstruction Codes, 61618–61619?

The CPT Assistant, Spring 1993 describes the typical use of the secondary repair codes in two situations: 1) where a plastic/reconstructive surgeon performs the service, or 2) for repair of a postoperative cerebrospinal fluid leak.

The first situation occurs when a plastic/reconstructive surgeon performs reconstruction of a more extensive dura/surgical defect at the same operative session as skull base surgeons have removed the tumor and were unable to close the defect primarily. This situation, which may have been common in the early 1990's when these codes were created, is extremely rare in today's clinical practice. The closure performed at the time of the procedure is included in the global surgical package for the otolaryngologist or neurosurgeon when an intradural open definitive skull base resection code is used (e.g., 61601).

Contemporary surgical techniques now allow skull base surgeons to perform a primary closure of the dura and/or surgical defect created to remove the tumor. Note that all of the intradural skull base resection codes state "intradural, including dural repair, with or without graft." Therefore, a separate code such as 61618 or 61619 is not reported by the tumor resection surgeon.

The second situation where 61618 or 61619 may be reported is when there is a postoperative complication of cerebrospinal fluid leakage following a skull base procedure (where the skull base codes were billed). Modifier 78 [*Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period*] is appended to 61618–61619 when the return to the operating room occurs during the post-operative global period of the prior skull base procedure.

5. How Can I Get Paid for Endoscopic Endonasal Skull Base Procedures?

There are several different strategies to obtain reimbursement for an unlisted code that represents an endoscopic skull base procedure. Successful reimbursement is dependent on the type of payer as well as your organization's managed care contracting and collections skills.

For commercial payers, your contracts should specifically address how payment is determined when an unlisted code is used. Most academic groups routinely include this type of clause in contracts because these organizations perform cutting-edge or new technology procedures that don't have existing CPT codes. Because unlisted codes do not have a value (e.g., associated payer allowable, relative value unit), the contract clause should indicate that a specific percentage of your organization's billed fee will be reimbursed.

In our experience, Medicare will typically reimburse an unlisted code at the amount which would have been allowed for the comparison code(s). Medicaid plans are controlled by each state and experience has demonstrated either relatively low reimbursement or denial for unlisted codes.

In markets where there are a limited number of payers, practices have found it beneficial to meet with the payer's Medical Director to not only discuss reimbursement, but to promote the advantages of endoscopic skull base surgery over traditional approaches. The dialogue with the payer has been invaluable and typically generates goodwill and understanding between both parties.

Written prior authorization, obtaining permission in writing from the payer prior to the procedure, has been another successful strategy for some practices. A written prior authorization is basically a formal effort seeking to guarantee payment from the third party payer for the procedure. There are two sample written prior authorization letters included in this document. One prior authorization letter is intended for the otolaryngologist's role while the other is intended to describe the neurosurgeon's role.

The expectation with a written prior approval request is that the third party payer will respond to you, in writing, granting permission to perform the procedure and acceptance of the proposed codes and fees. Written approval from the third party payer is preferred, since written approval from the payer carries more weight, and may even be legally binding. A verbal or phone precertification is generally impossible to verify and doesn't hold up in an appeal.

Lastly, be sure that Box 19 (Additional Claim Information), on the CMS 1500 claim form, includes a brief description of the procedure for which an unlisted code is used (e.g., "endoscopic skull base surgery").

6. What's the Best Code for the Nasoseptal Flap Used for Closure in Endoscopic Endonasal Skull Base Procedures?

CPT 15740 [*Flap; island pedicle*] and 15750 [*Flap; neurovascular pedicle*] have been misused by practices to report this service. CPT states the following ~15750: "This code includes not only skin but also a functional motor or

sensory nerve(s). The flap serves to reinnervate a damaged portion of the body dependent on touch or movement (e.g., thumb).” Clearly, this is not the procedure being performed in endoscopic skull base cases.

The adjacent tissue transfer codes (14xxx) are described by CPT as surgically freeing skin and subcutaneous tissue and/or fascia; therefore, these codes are also not appropriate for reporting a nasoseptal flap.

Direct closure of the operative tract, and any wound created by the surgeon to perform the procedure not obtained through a separate incision, is included in the CPT code for the procedure performed. For example, the use of a pericranial graft to close the dura at the time of an open craniotomy is not separately reported. Dural closure using local (from the same surgical exposure) graft material is included in the primary procedure code.

One exception is the CPT guideline that allows separately reporting an intermediate (120xx) or complex (131xx) wound repair code with an excision of benign (114xx) or malignant (116xx) skin lesion removal code.

It is also not accurate to report 15576 [*Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral*] for the nasoseptal flap as this code is used to report nonadjacent tissue transfers involving skin and subcutaneous tissues – not nasal mucosa – and the formation of direct or tubed pedicles

However, closure may be separately reported if the defect cannot be closed primarily and graft material is harvested through a separate skin incision. In this situation, the closure is included using the graft harvest code (e.g., split thickness skin graft, free flap). For example, if an abdominal fat graft [20926, *Tissue grafts, other (e.g., paratenon, fat, dermis)*] is obtained through a separate skin incision to close the skull base defect after an endoscopic pituitary tumor removal (62165); both codes, 62165 and 20926, may be reported.

An unresolved issue is whether reconstruction with a local vascularized flap (e.g., nasoseptal flap, middle turbinate flap, lateral nasal wall [inferior turbinate] flap) is separately reported. One option for reporting the added work is to append modifier 22 to the primary procedure code, 62165. Alternatively, a separate unlisted code such as 30999 [*Unlisted procedure, nose*] could be reported and compared with a code such as 14060 or 15740 for fee determination.

7. How Do I Code an Endoscopic Endonasal Repair of a Cerebrospinal Fluid (CSF) Leak When Performed at a Different Operative Session? For example, a primary repair of a spontaneous CSF leak or one caused by trauma or even a secondary repair of a delayed post-operative CSF leak. Is the coding different if the CSF leak is an unexpected complication of surgery (e.g., endoscopic sinus surgery for inflammatory disease) which the ENT might repair on their own or invite a skull base surgeon to repair?

There are two existing CPT codes that describe an endoscopic repair of a CSF leak depending on the location of the repair:

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

One of the above codes is used when the CSF leak is performed at a different operative session.

Both surgeons will use an unlisted code if either 31290 or 31291 does not accurately describe the service provided (e.g., if there is also an encephalocele that is repaired endoscopically). Refer to previous discussion about using an unlisted code.

The issue that typically arises is that neither 31290 nor 31291 is paid by Medicare when billed with modifier 80/82 (assistant surgeon) or 62 (co-surgeon). This is because Medicare will not pay an assistant-at-surgery fee for surgical procedures in which an assistant is used in fewer than five percent of the cases for that procedure nationally (this is determined through manual reviews).

There is not a CPT code for placement of an artificial graft in the skull base. This activity would be included in the primary procedure code for the service reported. Alternatively, one could report an unlisted code (17999, *Unlisted procedure, skin, mucous membrane and subcutaneous tissue*) and use +15777 [*Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure)*] as a comparison code.

Remember, the secondary skull base reconstruction codes, 61618 and 61619, are not endoscopic procedures. These codes describe an open procedure just as the other codes, approach and definitive procedure, in the skull base surgery code subset of CPT. Therefore, 61618–61619 cannot be used for an endoscopic repair of a CSF leak. However, they can be used as a comparison code should the decision be made to use an unlisted code for the repair.

Similarly, there is not a specific code for a minimally invasive (extracranial) pericranial flap. The existing pericranial flap code 15733 [*Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)*] is appropriate to use if a separate skin incision is performed to harvest the pericranial flap and it is transferred to a separate location on a named vascular pedicle. A craniotomy is not necessary for 15733.

8. How do You Code Cases That Have Multiple Approaches as Part of the Same Endoscopic Endonasal Skull Base Surgery?

Choose the comparison code(s) as if the case were performed in an open manner. For example, due to the tumor’s large size or location the ENT would have approached the tumor via a craniofacial approach (61580) and the neurosurgeon would have performed a craniotomy approach (e.g., 61583). Both surgeons will report their own unlisted code but use their own different open approach codes as comparison codes.

Bottom line: choose the comparison code(s) as you would if the procedure had been performed in an open manner.

9. How Do I Code When Multiple Approaches Are Used? For example, an endoscopic endonasal approach and an open approach are performed at the same operative session

If endoscopic endonasal skull base surgery is combined with an open approach, then the open approach skull base surgery code may be separately reported. If tumor is removed through the open approach, then the open skull base definitive procedure code may also be separately reported in addition to the unlisted code for the endoscopic endonasal skull base procedure.

10. Is There a Code for Neurophysiological Monitoring or Use of a Nerve Stimulator?

There are codes for intraoperative monitoring but CPT guidelines prohibit the surgeon, assistant surgeon and co-surgeon from reporting these services. Intraoperative neurophysiological

monitoring and/or use of a nerve stimulator is included in the surgeon's global surgical package and should not be separately reported. Additionally, placement of needles for intraoperative monitoring is included in the surgeon's payment as this is considered part of the procedure set up.

11. Does a Transodontoid Approach to The Posterior Cranial Fossa Include a Comparison Code for the Upper Cervical Spine? When is a separate spine resection code used?

If the open skull base approach comparison code chosen includes spine resection then a separate spine resection code is not also reported or included as a comparison code. For example, the open far lateral approach code (61597) includes resection of C1-C3 vertebral body(ies). Therefore, it would not be accurate to also include a separate anterior spine resection code (e.g., 63075) as a comparison code for the unlisted code reported.

Appendix A: Suggested Coding for Endoscopic Endonasal Skull Base Procedures

Pituitary Tumors

Procedure	Specialty/Code to Report	Suggested Comparison Code(s)/wRVU
Endoscopic excision of pituitary tumor (intrasellar)	One specialty: 62165	–Comparison code not applicable. –wRVU = 23.23
Endoscopic excision of pituitary tumor (intrasellar)	Two surgeons, different specialties: ENT = 62165–62 NS = 62165–62	–Comparison code not applicable. –wRVU = 23.23 –Each surgeon will be reimbursed 62.5% of 23.23 (14.52 wRVU)
Endoscopic excision of pituitary tumor (intrasellar)	Two surgeons, same specialty, private practice: Surgeon 1 = 62165 Surgeon 2 = 62165–80	–Comparison code not applicable. –wRVU = 23.23 –Surgeon 1 is reimbursed at 100% of allowable (23.23 wRVU) –Surgeon 2 is reimbursed at 16% of allowable (3.77 wRVU)
Endoscopic excision of pituitary tumor (intrasellar)	Two surgeons, same specialty, academic practice: Surgeon 1 = 62165 Surgeon 2 (attending physician, no qualified resident available) = 62165–82	–Comparison code not applicable. –wRVU = 23.23 –Surgeon 1 is reimbursed at 100% of allowable (23.23 wRVU) –Surgeon 2 is reimbursed at 16% of allowable (3.77 wRVU)

Note: Also append modifier 22 to the code reported by the surgeon removing the tumor when there is some cavernous sinus invasion as this is added complexity.

Anterior Cranial Fossa Lesions

Procedure	Specialty/Code to Report	Example Comparison Code(s)/wRVU
Endoscopic endonasal surgery of anterior cranial fossa for <u>extradural</u> resection (e.g., sinonasal malignancy)	One specialty: 64999	61580, wRVU = 34.51 and 61600, wRVU = 30.01
Endoscopic endonasal surgery of anterior cranial fossa for an <u>intradural</u> tumor	Two specialties: ENT = 31299 NS = 64999	ENT = 61580, wRVU = 34.51 NS = 61601, wRVU = 31.14

Middle Cranial Fossa Lesions

Procedure	Specialty/ Code to Report	Suggested Comparison Code(s)/wRVU
Endoscopic endonasal surgery of middle cranial fossa for resection of an <u>extradural</u> lesion in the parapharyngeal space, infratemporal, midline skull base, or nasopharynx	One specialty: 64999	61590, wRVU = 47.04 and 61605, wRVU = 32.57
Endoscopic endonasal surgery of middle cranial fossa for resection of an <u>intradural</u> lesion in the parapharyngeal space, infratemporal, midline skull base, or nasopharynx	Two specialties: ENT = 31299 NS = 64999	ENT = 61590, wRVU = 47.04 and NS = 61606, wRVU = 42.05
Endoscopic endonasal surgery of middle cranial fossa for resection of an <u>extradural</u> lesion in the internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, or infratemporal fossa	One specialty: 64999	61591, wRVU = 47.02 and 61605, wRVU = 40.93 Note: Use 61607 for parasellar area definitive procedure
Endoscopic endonasal surgery of middle cranial fossa for resection of an <u>intradural</u> lesion in the internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, or infratemporal fossa	Two specialties: ENT = 31299 NS = 64999	ENT = 61591, wRVU = 47.02 and NS = 61606, wRVU = 42.05 Note: Use 61608 for parasellar area definitive procedure
Endoscopic endonasal surgery of middle cranial fossa for resection of an <u>extradural</u> lesion in the cavernous sinus and carotid artery, clivus, basilar artery or petrous apex	One specialty: 64999	61592, wRVU = 43.08 and 61607, wRVU = 40.93
Endoscopic endonasal surgery of middle cranial fossa for resection of an <u>intradural</u> lesion in the cavernous sinus and carotid artery, clivus, basilar artery or petrous apex	Two specialties: ENT = 31299 NS = 64999	ENT = 61592, wRVU = 43.08 and NS = 61608, wRVU = 45.54

Posterior Cranial Fossa Lesions

Procedure	Specialty/ Code to Report	Suggested Comparison Code(s)/wRVU
Endoscopic endonasal surgery of the posterior cranial fossa for resection of an <u>extradural</u> lesion of the posterior cranial fossa, jugular foramen or midline skull base	One specialty: 64999	61596, wRVU = 39.43 and 61615, wRVU = 35.77
Endoscopic endonasal surgery of the posterior cranial fossa for resection of an <u>intradural</u> lesion of the posterior cranial fossa, jugular foramen or midline skull base	Two specialties: ENT = 31299 NS = 64999	ENT = 61596, wRVU = 39.43 and NS = 61616, wRVU = 46.74
Endoscopic endonasal surgery of the posterior cranial fossa for resection of an <u>extradural</u> lesion of the posterior cranial fossa, clivus or foramen magnum	One specialty: 64999	61598, wRVU = 36.53 and 61615, wRVU = 35.77
Endoscopic endonasal surgery of the posterior cranial fossa for resection of an <u>intradural</u> lesion of the posterior cranial fossa, clivus or foramen magnum	Two specialties: ENT = 31299 NS = 64999	ENT = 61598, wRVU = 36.53 and NS = 61616, wRVU = 46.74

Reconstruction Procedures

Procedure	Specialty/Code to Report	Suggested Comparison Code(s)/wRVU
Endoscopic CSF leak repair with local mucosal graft	One specialty: 31290, ethmoid region 31291, sphenoid region	—Comparison code not applicable. —31290 wRVU = 18.61 —31291 wRVU = 19.56
Endoscopic CSF leak repair with local mucosal graft	Two surgeons, different specialties: Each reports the same code, either 31290 or 31291. Append modifier 62 to the code for each surgeon.	—Comparison code not applicable. —Medicare does not allow payment for modifier 62 on either 31290 or 31291. —Some payers will allow each surgeon to be reimbursed 62.5% of the wRVU: 31290 (11.63 wRVU), 31291 (12.13 wRVU).

(Continued)

Appendix A (Continued)

Procedure	Specialty/Code to Report	Suggested Comparison Code(s)/wRVU
Endoscopic CSF leak repair with local mucosal graft	Two surgeons, same specialty, private practice: Surgeon 1 reports either 31290 or 31291. Surgeon 2 reports the same code with modifier 80.	—Comparison code not applicable. —Medicare does not allow payment for modifier 80 on either 31290 or 31291. —Some payers will allow each surgeon to be reimbursed 16% or more of the wRVU: 31290 (3.03 wRVU), 31291 (3.13+ wRVU)
Endoscopic CSF leak repair with local mucosal graft	Two surgeons, same specialty, academic practice: Surgeon 1 reports either 31290 or 31291. Surgeon 2 reports the same code with modifier 82.	—Comparison code not applicable. —Medicare does not allow payment for modifier 80 on either 31290 or 31291. —Some payers will allow each surgeon to be reimbursed 16% or more of the wRVU: 31290 (3.03 wRVU), 31291 (3.13 wRVU)
Harvest of abdominal fat graft	20926 <i>Tissue grafts, other (e.g., paratenon, fat, dermis)</i>	—Reported by the surgeon who harvests the abdominal fat graft. Placement of the graft is inherent in the primary procedure as part of the closure. —wRVU = 5.79 —Do not use 15770 (Graft; derma-fat-fascia) (wRVU = 8.96) as this code represents a composite graft requiring use of two or more layers of tissue. The September 1997 CPT Assistant states the following ~15770: “The tissue used for the graft can be a continuous portion (containing all three of the layered components), individual parts (grafted layer by layer), or inserted in combination (such as a fascia-fat layer, later covered by a dermal layer).” CPT 15770 is not intended for an abdominal fat graft.
Harvest of fascia lata graft with or without fat graft harvest at same site	20922 <i>Fascia lata graft; by incision and area exposure, complex or sheet</i>	—Reported by the surgeon who harvests the graft. Placement of the graft is inherent in the primary procedure as part of the closure. —Code may be reported when a separate incision is made to harvest fascia lata from the thigh. —Use only 20922 if fat is also harvested from the fascia lata graft site. —wRVU = 6.93
Pericranial fascia graft	20926 <i>Tissue grafts, other (e.g., paratenon, fat, dermis)</i>	—Reported by the surgeon who harvests the graft. However, placement of the graft is inherent in the primary procedure as part of the closure. —This is included in all open craniotomy codes and not separately reported. —May separately report 20926 when separate skin incision is made to harvest graft material during an endoscopic endonasal procedure. —wRVU = 5.79
Nasoseptal flap/vascularized pedicle flap	30999 <i>Unlisted procedure, nose</i> Or Use modifier 22	—Reported by the surgeon who harvests the graft via a separate incision. —Use a comparison code (e.g., 14060, 15740) for fee determination. —Alternatively, append modifier 22 rather than report 30999.
Minimally invasive extracranial pericranial flap	15733 <i>Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)</i>	—May be reported if performed through a separate skin incision and transferred to a distant location on a named vascular pedicle. —wRVU = 15.86

Other Procedures

Procedure	CPT Code/wRVU	Comments
Stereotactic navigation, intradural	+61781 <i>Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)</i> wRVU = 3.75	<ul style="list-style-type: none"> –Use when the pathology addressed is intradural. –Code is primarily for the system set up (e.g., registration, calibration, verification of navigation accuracy prior to making the incision) and pre-procedure planning of the surgical procedure. –Intraoperative localization of the pathology, once the incision (exposure) is made, is included in the primary procedure code. –One surgeon (either ENT or NS) reports this code; typically the surgeon who performed the system set up. –Do not report with modifier 62 or 80/82.
Stereotactic navigation, extradural	+61782 <i>Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)</i> wRVU = 3.18	<ul style="list-style-type: none"> –Use when the pathology addressed is extradural. –Code is primarily for the system set up (e.g., registration, calibration, verification of navigation accuracy prior to making the incision) and pre-procedure planning of the surgical procedure. –Intraoperative localization of the pathology, once the incision (exposure) is made, is included in the primary procedure code. –One surgeon (either ENT or NS) reports this code; typically the surgeon who performed the set up. –Do not report with modifier 62 or 80/82. –In some cases, where both the ENT and NS separately perform and document their own system set up and pre-procedure planning of their portion of the procedure, the ENT may report +61782 and the NS may report +61781. However, this is not the usual circumstance and necessity for each surgeon's work must be documented to support coding.
Use of the operating microscope	+69990 <i>Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)</i> wRVU = 3.46	<ul style="list-style-type: none"> –Procedure statement must describe the use of the operating microscope and the body of the operative report must also describe the microscope being used for microdissection/microsurgical technique. –Use of the operating microscope for “magnification” or “illumination” does not support use of +69990. –Do not append modifier 62. –Modifier 80/82 may be justified if the documentation reflects the assistant looking through the dual view finder and the assistant's work performed through the microscope. This must be clearly documented in the operative report. –ENT and NS may both report +69990, though some payers may not reimburse both surgeons.
Lumbar drain	62272 <i>Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)</i> wRVU = 1.37	<ul style="list-style-type: none"> –May be separately reported even if it is removed prior to the patient leaving the operating room.
Use of intraoperative Doppler ultrasound	76998 <i>Ultrasonic guidance, intraoperative</i> wRVU = 1.22 (modifier 26, Professional Component)	<ul style="list-style-type: none"> –Intraoperative localization of the pathology is included in all tumor removal procedure codes and should not be separately reported (even with modifier 26).

Appendix B: Written Prior Authorization Letter - Otolaryngology

Note: This letter is sent to the patient's third party payer prior to the surgery to obtain written approval for the procedure.

Re: Prior Authorization Request

To Whom It May Concern:

I am writing to request your written approval for a procedure that I will be performing with my colleague, _____ MD/DO who is a neurosurgeon, on [state name of patient]. The procedure is planned for [insert date] to address a skull base tumor.

We plan to remove the tumor through the nose via an endoscopic endonasal approach. With this approach, the entire procedure (approach, tumor resection, defect reconstruction) is performed using a minimally invasive approach through the nasal cavity and paranasal sinuses.

In contrast to a traditional open approach for select tumors, endoscopic endonasal surgery provides improved visualization and direct access that can provide improved outcomes with less morbidity (less vision loss, less hormone loss) and a faster recovery (decreased length of hospitalization). Avoidance of brain manipulation minimizes the risk of serious complications and preserves maximal brain function.

Overall, endoscopic endonasal surgery achieves equivalent (or better) tumor control with less morbidity and decreased cost of care.

Currently, there are no CPT codes for endoscopic endonasal skull base surgery; therefore, we will use CPT 31299 (*Unlisted procedure, accessory sinuses*) for my services in the endoscopic endonasal approach, resection assistance and closure/defect reconstruction to remove this skull base tumor through the nose.

The CPT guidelines instruct physicians not to select a CPT code that merely approximates the service provided. Additionally, CPT guidelines state if no such procedure or service exists, then the appropriate unlisted procedure or service code is reported. We are following CPT guidelines by reporting an unlisted CPT code, 31299, because the current open skull base CPT codes do not describe an endoscopic endonasal procedure.

The following table, below left, shows the procedures we plan to perform (represented by the CPT code we will report) as well as my fee using the appropriate unlisted code. The table below on the right shows a comparison to the current open skull base surgery CPT code and our associated fee so you will understand how we derived our charge for this patient's procedure.

Endoscopic Procedure Planned/Fee	
Unlisted CPT Code	Description
31299	Unlisted procedure, accessory sinuses
Endoscopic endonasal approach and skull base repair as well as assisting the neurosurgeon during the tumor resection	
Fee:	

Comparison to Open Codes/Fee	
Comparison CPT Code	Description
Fee:	

Please note that I have included in the fee all postoperative Evaluation and Management (E/M) services for 90 days as is included in the comparison base open CPT code(s) listed above. However, necessary endoscopic sinus debridements (31237) will be separately reported with modifier 58 (staged or related procedure in the global period).

We request a written response to our request. Thank you in advance for kindly approving this procedure in an expeditious and appropriate manner.

Sincerely,

Dr. Otolaryngologist

Appendix C: Claim Denial Appeal Letter - Otolaryngology

Note: This letter is sent to the patient's third party payer after the claim has been denied.

Re: Claim denial

To Whom It May Concern:

I am writing to request your reconsideration for payment on a procedure that I performed with my colleague, _____ MD/DO who is a neurosurgeon, on [state name of patient]. [Insert patient's name here] presented with a skull base tumor that we removed via a new technique using an endoscope through the nose. There are few institutions around the country that perform this technically challenging procedure.

With this approach the entire procedure (approach, tumor resection and defect reconstruction) is performed using a minimally invasive approach through the nasal cavity and paranasal sinuses.

In contrast to a traditional open approach for select tumors, endoscopic surgery provides improved visualization and direct access that can provide improved outcomes with less morbidity (less vision loss, less hormone loss) and a faster recovery (decreased length of hospitalization). Avoidance of brain manipulation minimizes the risk of serious complications and preserves maximal brain function.

Overall, endoscopic endonasal surgery achieves equivalent (or better) tumor control with less morbidity and decreased cost of care.

Currently, there are no CPT codes for endoscopic endonasal skull base surgery; therefore, we reported CPT 31299 (*Unlisted procedure, accessory sinuses*). This one unlisted code describes multiple services including my performance of the endoscopic endonasal approach and closure/skull base defect reconstruction as well as assistance to the neurosurgeon in the tumor resection to remove this skull base tumor through the nose.

The CPT guidelines instruct physicians not to select a CPT code that merely approximates the service provided. Additionally, CPT guidelines state if no such procedure or service exists, then the appropriate unlisted procedure or service code is reported. We are following CPT guidelines by reporting an unlisted CPT code, 31299, because the current open skull base CPT codes do not describe an endoscopic endonasal procedure.

The following table, below left, shows the unlisted code we reported and the comparison code(s). The table, below right,

shows a comparison to the current open skull base surgery CPT code(s) and our associated fee so you will understand how we derived our charge for this patient's procedure.

Endoscopic Procedure Performed/Fee		Comparison to Open Codes/Fee	
Unlisted CPT Code	Description	Comparison CPT Code	Description
31299	Unlisted procedure, accessory sinuses		
Endoscopic endonasal approach and skull base repair as well as assisting the neurosurgeon during the tumor resection			
Fee:		Fee:	

Please note that I have included in the fee all postoperative Evaluation and Management (E/M) services for 90 days as is included in the comparison base open CPT code(s) listed above. However, necessary endoscopic sinus debridements (31237) will be separately reported with modifier 58 (staged or related procedure in the global period).

Thank you in advance for kindly processing this claim in an expeditious and appropriate manner.

Sincerely,

Dr. Otolaryngologist

Appendix D: Written Prior Authorization Letter - Neurosurgery

Note: This letter is sent to the patient's third party payer prior to the surgery to obtain written approval for the procedure.

Re: Prior Authorization Request

To Whom It May Concern:

I am writing to request your written approval for a procedure that I will be performing with my colleague, _____MD/DO who is an otolaryngologist, on [state name of patient]. The procedure is planned for [insert date] to address a skull base tumor.

We plan to remove the tumor through the nose via an endoscopic endonasal approach. With this approach the entire procedure (approach, tumor resection and defect reconstruction) is performed using a minimally invasive approach through the nasal cavity and paranasal sinuses.

In contrast to a traditional open approach for select tumors, endoscopic surgery provides improved visualization and direct access that can provide improved outcomes with less morbidity (less vision loss, less hormone loss) and a faster recovery (decreased length of hospitalization). Avoidance of brain manipulation minimizes the risk of serious complications and preserves maximal brain function.

Overall, endoscopic endonasal surgery achieves equivalent (or better) tumor control with less morbidity and decreased cost of care.

Currently, there are no CPT codes for endoscopic endonasal skull base surgery; therefore, we will use CPT 64999 (*Unlisted procedure, nervous system*) for my services in the endoscopic endonasal tumor resection as well as assisting

the otolaryngologist with the approach to remove this skull base tumor through the nose.

The CPT guidelines instruct physicians not to select a CPT code that merely approximates the service provided. Additionally, CPT guidelines state if no such procedure or service exists, then the appropriate unlisted procedure or service code is reported. We are following CPT guidelines by reporting an unlisted CPT code, 64999, because the current open skull base CPT codes do not describe an endoscopic endonasal procedure.

The following table, below left, shows the procedures we plan to perform (represented by the CPT code we will report) as well as my fee using the appropriate unlisted code. The table below on the right shows a comparison to the current open skull base surgery CPT code and our associated fee so you will understand how we derived our charge for this patient's procedure.

Endoscopic Procedure Planned/Fee		Comparison to Open Codes/Fee	
Unlisted CPT Code	Description	Comparison CPT Code	Description
64999	Unlisted procedure, nervous system		
Endoscopic endonasal tumor resection as well as assisting the otolaryngologist during the approach			
Fee:		Fee:	

Please note that I have included in the fee all postoperative care for 90 days as is included in the comparison base open CPT code(s) listed above. This includes at least [insert number here] hospital days and [insert number here] office visits.

We request a written response to our request. Thank you in advance for kindly approving this procedure in an expeditious and appropriate manner.

Sincerely,

Dr. Neurosurgeon

Appendix E: Claim Denial Appeal Letter - Neurosurgery

Note: This letter is sent to the patient's third party payer after the claim has been denied.

Re: Claim denial

To Whom It May Concern:

I am writing to request your reconsideration for payment on a procedure that I performed with my colleague, _____MD/DO who is an otolaryngologist, on [state name of patient]. [Insert patient's name here] presented with a skull base tumor that we removed via a new technique using an endoscope through the nose. There are few institutions around the country that perform this technically challenging procedure.

With this approach, the entire procedure (approach, tumor resection and defect reconstruction) is performed using a minimally invasive approach through the nasal cavity and paranasal sinuses.

In contrast to a traditional open approach for select tumors, endoscopic surgery provides improved visualization and direct access that can provide improved outcomes with less morbidity (less vision loss, less hormone loss) and a faster recovery (decreased length of hospitalization). Avoidance of brain manipulation minimizes the risk of serious complications and preserves maximal brain function.

Overall, endoscopic endonasal surgery achieves equivalent (or better) tumor control with less morbidity and decreased cost of care.

Currently, there are no CPT codes for endoscopic endonasal skull base surgery; therefore, we reported CPT 64999 (*Unlisted procedure, nervous system*). This one unlisted code describes multiple services including my performance of the endoscopic endonasal tumor resection and assistance to the otolaryngologist with the approach to remove this skull base tumor through the nose.

The CPT guidelines instruct physicians not to select a CPT code that merely approximates the service provided. Additionally, CPT guidelines state if no such procedure or service exists, then the appropriate unlisted procedure or service code is reported. We are following CPT guidelines by reporting an unlisted CPT code, 64999, because the current open skull base CPT codes do not describe an endoscopic endonasal procedure.

The following table, below left, shows the unlisted code we reported and the comparison code(s). The table, below

right, shows a comparison to the current open skull base surgery CPT code(s) and our associated fee so you will understand how we derived our charge for this patient's procedure.

Endoscopic Procedure Performed/Fee	
Unlisted CPT Code	Description
64999	Unlisted procedure, nervous system
Endoscopic endonasal tumor resection as well as assisting the otolaryngologist during the approach	
Fee:	

Comparison to Open Codes/Fee	
Comparison CPT Code	Description
Fee:	

Please note that I did include in my fee all postoperative care for 90 days as is included in the comparison base open CPT code(s) listed above. This includes at least [insert number here] hospital days and [insert number here] office visits.

Thank you in advance for kindly processing this claim in an expeditious and appropriate manner.

Sincerely,
Dr. Neurosurgeon